MORTALITY REVIEW – RESPONDING TO, AND LEARNING FROM, THE DEATH OF PATIENTS UNDER THE MANAGEMENT AND CARE OF THE TRUST

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EXECUTIVE SUMMARY/ INTRODUCTION

The National Guidance on Learning from Deaths (National Quality Board, March 2017) requires that NHS Foundation Trust Boards must "ensure robust systems are in place for recognising, reporting, reviewing or investigating deaths and learning from avoidable deaths that are contributed to by lapses in care".

This policy sets out how these aims will be achieved and describes the governance that will assure consistency, reliability and resilience of delivery.

PURPOSE AND SCOPE

This purpose of this policy is to detail the process of mortality review at the Countess of Chester Hospital NHS FT and how learning from the reviews will be disseminated.

The policy is to assist and advise in the following:

- The structure and governance of the process of review and learning from deaths and the oversight of the process
- How cases will be selected
- How, and by whom, reviews will be carried out
- How this process will link in to existing national reporting requirements e.g. indivduals with learning difficulties or mental health needs, an infant or child death and a stillbirth or maternal death
- How the Trust will comply with the requirements of the National Guidance on Learning from Deaths (National Quality Board, March 2017)

DUTIES AND RESPONSIBILITIES

Medical Director

On delegation of the Chief Executive, is accountable to the Board of Directors for ensuring compliance with this policy across the Trust and, as such, has responsibility for the learning from deaths agenda.

Will be responsible for writing the quarterly Board report and the report for the Quality Accounts.

Designated Non-Executive Director

Will Chair the Mortality Surveillance Group (MSG) and will be responsible for oversight of the investigation, review and learning process.

Trust Governor

Will represent the patients of the Trust in the process.

APPENDIX 1

Mortality Surveillance Group

Terms of Reference

1. Purpose

The Mortality Surveillance Group (MSG) reports to the Quality, Safety and Patient Experience Committee (QSPEC) and is responsible for overseeing the Trust's responses to, and learning from, the death of patients under the care of the Trust

2. Duties

- To provide a quarterly report to the Board which demonstrates that the Trust is responding to, and learning from, the death of patients in the Trust's care, and builds into a statutory annual Quality Account
- To ensure that mortality case review and investigation, and the learning derived from those, reporting mechanisms are properly established and working so assurance can be given to the Board
- To receive the policies and reports that give assurance of the quality of the mortality review process, to include NICE, NCEPOD and clinical audit.
- To ensure that the Trust fulfils its responsibility to involve the bereaved in the review process if they wish and to feed back the findings of any case review or investigation to them.
- To review the data available from clinical benchmarking (HED) relating to mortality and to use this to determine particular areas of focus for future case record reviews.
- To receive details of serious clinical incidents involving patient death and ensure that the Trust's response and the learning from these is shared across the organisation and that, when necessary, these direct future case record reviews.

4. Membership

The MSG will comprise:

- Non-Executive Director (Chair)
- Medical Director (Executive lead for mortality)
- Director of Nursing and Quality
- Associate Medical Director for Safety and Quality