Corporate Policy for the Review of Clinical Care following the Death of a Patient in Hospital

Document Control

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1. Introduction

Patient safety and scrutiny of mortality rates has intensified with investigations into NHS hospital failures leading to publication of the Keogh (2013) and Frances (2013) reports. It is essential that Barnsley Hospital NHS Trust Board have assurance that when patients have died in hospital the quality of care the patient received was in accordance with current good practice.

Measures of mortality such as Summary Hospital-level Mortality Indicator (SHIMI) and Hospital Standardised Mortality Ratio (HSMR) can be used an indicator of quality of care provided by the Trust. These indicators are within the public domain and can therefore be viewed by patients, members of the public, and regulators. This provides information on actual deaths, for both inpatients and patients cared for outside of the hospital, compared to the expected deaths for our hospitals demographics.

Mortality indicator statistics do not in themselves give evidence on the standard of care provided. This can be ascertained by reviewing the care episode of a patient who has died to identify any preventable factors that may have influenced the likelihood of death. Findings and learning from the reviews can be used to make appropriate improvements to patient care.

Nationally there has been a recent review of learning from deaths and both the Care Quality Commission (CQC) and NHS Improvement (NHSI) have published guidance (applicable to adult patients) on learning from deaths. A new formalised process addresses the CQC's publication (2016) on the way NHS Trusts review and investigate the deaths of patients, and this aims to maximise learning from deaths.

As well as ensuring there are surveillance processes in place within the Trust to promptly and accurately record deaths, and to interrogate and understand mortality measures (also known as indices*), it is also important to ensure that there are independent clinical reviews of deaths within the Trust to accommodate the complexity of modern healthcare.

*The mortality indices used within Barnsley Hospital NHS Trust are:

- Hospital Standardised Mortality Ratio (HSMR). The HSMR is calculated each month for each hospital in England. It looks at deaths in the most common conditions in hospital which account for around 80% of deaths in hospital.
- Summary Hospital-level Mortality Indicator (SHMI). The SHMI score looks at all deaths in hospital and within 30 days of discharge from hospital
- Crude Mortality data. The number of monthly recorded deaths

The Trust Mortality Review Process (MRP) has therefore been aligned to the National Mortality Case Record Review (NMCRR) Programme, which is a collaborative project led by the Royal College of Physicians (RCP) in partnership with Yorkshire and Humber Academic Health Science Network's (AHSN's) Improvement Academy. It is commissioned by the Health Quality Improvement Partnership (HQIP). The NMCRR programme introduced a standardised methodology for reviewing case records of adult patients who have died in acute general hospitals in England and Scotland, known as the Structured Judgement Review

2. Objective

The Structured Judgement Review (SJR) ensures a consistent and coordinated approach for the review of deaths in hospital.

This policy recognises the need to consider mortality rates and national mortality indicators using information available at individual patient level. The objective is to review whether the quality of care the patient received was in accordance with current good practice.

The aim of this process is to identify any areas of practice both specific to the individual case and beyond that could potentially be improved, based upon peer group review. Areas of good practice are also identified and used to improve care.
The process will ensure that there are clear reporting mechanisms in place, to escalate any areas of concern and to identify appropriate actions in order to:

- Identify and minimise poor quality care
- Review the quality of end of life care
- Review if patients' wishes were identified and met
- Improve the experience of patients' families and carers
- Escalate any untoward findings for further investigation
- Enable informed reporting with a transparent methodology
- Promote organisational learning and improvement

3. Scope of Policy

National guidance ('Learning from Deaths') makes recommendations on which cases should be reviewed. However, the national guidance suggests that not all deaths require a Structured Judgement Review (SJR) but in order to ensure robust systems are in place, it is essential that a screening process is undertaken on all deaths. At BHNFT all adult deaths have a Consultant led Mortality Case Note Screening Review which is used to determine if a more in depth Structured Judgement Review (SJR) is required.

The following criteria (using recommendations from the National guidance 'Learning from Deaths') is used to determine if a Mortality Case Note Screening Review should proceed to a more in depth Structured Judgement Review (SJR) and therefore provides the scope of this policy:

- Death after an elective procedure (unless reviewed as part of the surgical NCEPOD Mortality and Morbidity process).
- Death where the screening review process has raised a concern.
- Deaths where learning will inform QI work
- Deaths of those with learning disabilities (Process in Appendix 2)
- Deaths of those with a severe mental illness (as defined by the Royal College of Psychiatrists)
- Deaths where the screening review process has identified a lack of compliance with policy or current good practice.

- Deaths of those who are identified to be significantly disadvantaged in some way. (Learning Disabilities follow the process in Appendix 2)
- All deaths in a service specialty, particular diagnosis or treatment group where an 'alarm' has been raised through whatever means (e.g. HSMR, CQC Alert, SHMI, Audit)
- All deaths of patients subject to care interventions from which a patient's death would be wholly unexpected
- A further sample of other deaths may be selected that do not fit the identified categories for example to take learning from where excellent care has been delivered.

Exclusions to the processes covered by this policy:

Deaths in hospital of patients under the age of 18 years, maternal deaths, stillbirths and deaths of patients with a learning disability are excluded from this process document because they are reviewed under other established Trust processes. The interface between this process and the Learning Disability Review process is documented in appendix 2.

Learning and outcomes of the reviews on deaths of patients under the age of 18 years, maternal deaths, stillbirths and deaths of patients with a learning disability are fed through to the Mortality Leads and to the Learning from Deaths Steering Group.

Staff groups who will be involved in the process include and is not exhaustive:

- Medical Staff (all grades)
- Nursing Staff
- Clinical Coding Staff
- Clinical Audit & Effectiveness Staff
- Performance Analysts
- Quality Improvement Staff
- Revalidation Co-ordinator

4. Process

The process flow chart is detailed in Appendix 3 of this policy.

Bereavement Office supplies a weekly list of deaths to Clinical Coding and the Mortality Overview Group. Clinical Coding allocate notes for the Mortality Review screening process to consultants on a rotational basis. The number of requested screening review forms allocated to each consultant is recorded. Consultant compliance with the screening process is monitored by the revalidation co-ordinator. Completed Mortality Case Note Screening Review Forms will be reviewed by the Mortality Overview Group who will allocate any SJR's required in accordance with the screening criteria in Section 3 of this policy. The number of Mortality Case Note Screening Review forms allocated to each Consultant will depend on the number of deaths. This is reviewed at the Learning from Deaths Steering Group and the annual expected number adjusted accordingly. The time frame for returning reviews is also reviewed at the Learning from Deaths Steering Group and the expected time frame adjusted accordingly.

The notes screening process is a duty to be carried out by all Consultants. The process is for any patients who have died in the Trust in order to identify:

1. any non compliance with policy or current good practice
2. any learning from good or excellent care
3. any issues in coding (used to identify co-morbidities and expected deaths).
4. any deaths that may require a more in-depth review through the SJR process

Where the screening process highlights any coding issues, the issues will be raised with clinical coding at the Mortality Overview Group meeting. Where the screening process indicates an SJR is required, it will be conducted in line with the Royal College of Physicians documentation. Both the medical and nursing records will be reviewed by individuals trained in the SJR process. The expected time to complete a SJR is about 2 hours.

The Mortality Overview Group (specifically the information officer/analyst) will be responsible for maintaining the library of completed SJR forms that inform themes and a cascade of learning.

If any structured judgement reviewer has difficulty in deciding what level to rate the care, or if on assessment of healthcare problems the findings are that the problem may have led to harm, a second stage review may be needed.

4.1 Outcomes- Learning from completed Structured Judgement Review

Findings are reported via the learning from deaths bulletin with individual feedback given by letter or in person where appropriate. Learning is also reported via clinical governance meetings where appropriate actions to improve care are generated and managed. Other relevant platforms to share learning are utilised as appropriate. The Mortality Overview Group reports on statistical and qualitative measures through the Learning from Deaths Steering group.

Discussions, outcomes and learning from the Learning from Deaths Steering group, including conclusions about outstanding care and sub-optimal care, are formally recorded and reported using the Trust Governance Structure via the Clinical Effectiveness Group to Quality and Governance.

Escalations of findings of concern that have been corroborated through a second structured judgement review and may require further investigation are reported to the patient safety panel for review and decision. If a High level Investigation or Serious Incident is commenced as a result of the findings in an SJR, the SI process supersedes the SJR. The Duty of Candour Policy should also be followed as part of any further investigation process.

Themes of learning and good practice will be shared in a monthly mortality report via the governance structure and through Board reports which will be produced quarterly. This will include the HSMI and SHMI dash board and qualitative learning themes.

4.2 Mortality Alerts

If there are concerns about mortality in any particular patient group, for example a higher than expected HSMR for a particular diagnostic group, or global high weekend mortality, it may be necessary to undertake an in-depth case note review using the SJR process

If an alert is received by the Trust then the Medical Director and/or Deputy Medical Director must be informed.

A list of patients relevant to the alert will be produced by Management Information which will also be shared with clinical coding to check for coding accuracy.

A review of the patients relevant to the alert will take place by the Mortality Overview Group who will then determine the way forward for a multi-disciplinary review team to be set up and the SJR process implemented.

Once this review has been completed and a report is produced and agreed within the Trust, it should be submitted to the CQC by the governance process with BHNFT The report should be constructed demonstrating methodology, findings, learning and recommendations.

5. Roles and Responsibilities

Medical Director

The Medical Director is the Lead Executive for Mortality Review within the Trust and will ensure that appropriate processes are in place to review mortality data and learning. This will be monitored through the Trust Governance Structure. The reporting outcomes and findings from the Mortality Review Group will go to the Trust Board via the Trust Governance Structure. If the Medical Director is absent the Deputy medical Director will deputise

Deputy Medical Director

The Deputy Medical Director will deputise as the Lead Executive in the absence of the Medical Director for Mortality Review within the Trust and as such will adopt the same responsibilities as the Medical Director.

Trust Board Executive and Non – Executive Directors

The Board of Directors must be assured that 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. The roles and responsibility of the Trust board includes

- Understanding the Mortality Review process
- Ensuring it can withstand external scrutiny
- Champion and supports learning and quality improvements
- Assure published information is fair and accurate
- Appoint a designated Non-Executive Director to attend the Mortality Review Group meetings.

Associate Medical Director for Mortality

The Associate Medical Director will be responsible for:

- Overall oversight and regular review of the mortality peer review process
- Identifying a cohort of senor medical and nursing staff who are trained and have the capacity to complete the structured judgement reviews
- Carrying out notes reviews with clinical coding where coding issues are i dentified
- Identifying clinicians to complete the mortality peer reviews and recording findings on the SJR proformas
- Ensuring that national and regional guidance (when developed) is in place for family and carer involvement.
- Ensuring that all pertinent cases and findings from mortality peer reviews are presented by the appropriate clinical leads at specialty clinical governance meetings to promote learning

- Ensuring that outcomes and learning from reviews are escalated to the appropriate governance meeting for discussion and inclusion in the groups action plan if appropriate.

Head of Patient Safety and Quality Improvement

Head of Patient Safety and Quality Improvement will be responsible for:

- Supporting the Associate Medical Director with ensuring that Screening, SJR's and Learning from Deaths takes place
- Ensuring links with the regional groups are maintained and new developments reported to the Learning from Mortality Steering group.

Medical and Nursing Staff

Will be responsible for:

- Participating in mortality peer reviews wherever possible, either in person or by nominated staff being available for advice on medical and nursing issues

Clinical Coding Staff

Clinical Coding staff will be responsible for:

- Participating in mortality peer reviews where coding issues have been Identified
- Disseminate the notes for screening reviews and collate them in preparation for the mortality overview group meetings
- Report on the distribution and returns of the Screening Forms and SJR's to the Learning from Mortality Steering Group
- Issues arising from the reviews regarding clinical coding the notes should be sent to Associate Medical Director whereby feedback will be given to clinicians to promote learning and improvement

Performance Analysts (Management Information)

The Performance Analyst will be responsible for:

- Sending a list of Trust deaths to the Associate Medical Director, Clinical Coding, Governance and Clinical Audit & Effectiveness which will include inpatient PAS/EHR information
- Providing patient lists to the Clinical Coding Team each month
- Maintain and produce the mortality reports and dashboards

Clinical Audit & Effectiveness Team

The Clinical Audit & Effectiveness Team will be responsible for:

- Producing reports based on information recorded from the structured judgment reviews if and when required
- Feeding back the reports and outcomes to the clinical leads for each area
- Analysis of the database to identify themes and trends

Patient Safety Team

The Patient Safety Team will be responsible for:

- Overseeing the process of mortality alert reviews and production of associated reports

Learning from Mortality Steering Group

The Learning from Mortality Steering Group will be responsible for:

- Providing assurance to the Trust Board via the Trust Governance Structure on patient mortality based on the SJR's
- Agreeing and approving the mortality screening review form and make changes as required
- Agreeing and approving the number of mortality screening review forms for completion by each consultant and the turnaround times.
- Identifying areas of high risk and escalating through the governance committees

- Ensuring that feedback and learning points are shared with the trust and specialties so that learning outcomes and action points are included in the specialty audit programmes as appropriate
- They will meet bimonthly and report through the Trust Governance Structure to the Clinical Effectiveness Group

Mortality Overview Group

This group will meet weekly and review the mortality screening review forms and completed SJR's in accordance with this policy.
This group will comprise of – Management Information, Clinical Coding, Head of Patient Safety and Quality Improvement (or delegated deputy) and Associate Medical Director (or delegated deputy).
The group will feed into the Learning from Mortality Steering Group.

6. Associated documentation and references

References

Francis R (2013) Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry. London: The Stationery Office. London: Department of Health.

Keogh B (2013) Review into the quality of care and treatment provided by 14 hospital trusts in England: overview report. London: NHS England.

NHS England, Mortality Governance Guide

Morbidity & Mortality Meetings: A guide to good practice, Royal College of Surgeons (2015)

Care Quality Commission (December 2016), Learning, candour and accountability: a review of the way NHS trusts review and investigate the deaths of patients in England

Higginson J, Walters R, Fulop N, *BMJ Qual Saf (2012)*, Mortality and morbidity meetings: an untapped resource for improving the governance of patient safety?

7. Training & Resources

- In order for Structured Judgement Reviews to be completed the reviewers must have undertaken the formal training.
- Dedicated on-going trainers to ensure consistency
- Training will be recorded on the NMLS data base.
- The Associate Medical Director has to have job planning that reflects their mortality review role.
- Structured Judgement reviewers have a process for remuneration to recognise the time taken to complete an SJR.

8. Monitoring and Audit

Minimum requirement to be monitored	Compliance of screening and SJR turnaround times
Process for monitoring e.g. audit	Audit
Responsible individual/ group/ committee	Management information team
Frequency of monitoring	Monthly
Responsible individual/ group/ committee for review of results	Learning from Mortality Steering Group
Responsible individual/ group/ committee for development of action plan	Learning from Mortality Steering Group
Responsible individual/group/ committee for monitoring of action plan and Implementation	Learning from Mortality Steering Group

9. Equality and Diversity

Trust is committed to an environment that promotes equality and embraces diversity in its performance as an employer and service provider. It will adhere to legal and performance requirements and will mainstream equality and diversity principles through its policies, procedures and processes. This policy should be implemented with due regard to this commitment.

To ensure that the implementation of this policy does not have an adverse impact in response to the requirements of the Equality Act 2010 this policy has been screened for relevance during the policy development process and a full equality impact analysis conducted where necessary prior to consultation. The Trust will take remedial action when necessary to address any unexpected or unwarranted disparities and monitor practice to ensure that this policy is fairly implemented.

This policy and procedure can be made available in alternative formats on request including large print, Braille, moon, audio, and different languages. To arrange this please refer to the Trust translation and interpretation policy in the first instance.

The Trust will endeavor to make reasonable adjustments to accommodate any employee/patient with particular equality and diversity requirements in implementing this policy and procedure. This may include accessibility of meeting/appointment venues, providing translation, arranging an interpreter to attend appointments/meetings, extending policy timeframes to enable translation to be undertaken, or assistance with formulating any written statements.

EQUALITY IMPACT ASSESSMENT TEMPLATE
INITIAL ASSESSMENT STAGE 1 (part 1)

Department:	Quality / Governance	**Division:**	Corporate
Title of Person(s) completing this form:	Deborah Firth	**New or Existing Policy/Service**	New
Title of Policy/Service/Strategy being assessed:	Policy for the Review of Clinical Care following the death of a patient in Hospital	**Implementation Date:**	September 2017
What is the main purpose (aims/objectives) of this policy/service?	The Structured Judgement Review (SJR) ensures a consistent and coordinated approach for the review of all deaths in hospital. This policy recognises the need to consider mortality rates and national mortality indicators available at diagnosis and individual		

	patient level. That all preventable deaths are identified and patient safety improved			
Will patients, carers, the public or staff be affected by this service? Please tick as appropriate.		Yes	No	If staff, how many individuals/which groups of staff are likely to be affected?
	Patients	x		
	Carers		x	
	Public		x	
	Staff		x	
Have patients, carers, the public or staff been involved in the development of this service? Please tick as appropriate.	Patients		x	If yes, who did you engage with? Please state below: Consultation of the mortality Committee
	Carers		x	
	Public		x	
	Staff	x		
What consultation method(s) did you use?	Staff review at relevant meetings			

DATA COLLECTION AND CONSULTATION

1a In relation to this service/policy/procedure – Do you currently record/have any of the following patient data?

Protected Characteristic	Indicate yes or No	If Yes – State where Recorded
Age	**YES**	**On the screening tool**
Sex	**YES**	**On the screening tool**
Ethnicity	**NO**	
Religion or Belief	**NO**	
Disability	**YES**	**On the screening tool**
Sexual Orientation	**NO**	
Gender Re-assignment	**NO**	
Marriage & Civil Partnership	**NO**	
Pregnancy & Maternity	**Yes**	**On the screening tool**
Carer Status	**NO**	

Please indicate Yes or No

Equality Impact Assessment Stage 1 PART 2

What does this data tell you about each of the above protected characteristics? Are there any trends/inequalities?

No inequalities – the screening tool is used to ensure deaths are reviewed correctly

What other evidence have you considered? Such as a 'Process Map' of your service (assessment of patient's journey through service) / analysis of complaints/ analysis of patient satisfaction surveys and feedback from focus groups/consultations/national & local statistics and audits etc.

National Guidance

Equality Impact Assessment Stage 1 PART 3

ACCESS TO SERVICES

What are your standard methods of communication with service users?

Please tick as appropriate.

Communication Methods	Yes	No
Face to Face Verbal Communication		x
Telephone		x
Printed Information (E.g. leaflets/posters)		x
Written Correspondence		x
E-mail		x
Other (Please specify)	X we may need to communicate with relatives	

If you provide written correspondence is a statement included at the bottom of the letter acknowledging that other formats can be made available on request?

Please tick as appropriate.

Yes	No
	x

Are your staff aware how to access Interpreter and translation services?

Interpreter & Translation Services	Yes	No
Telephone Interpreters (Other Languages)	x	
Face to Face Interpreters (Other Languages)	x	
British Sign Language Interpreters	x	
Information/Letters translated into audio/braille/larger print/other languages?	x	

ACCESS

Please tick as appropriate

Is the building where the service is located wheelchair accessible?	Yes	No
Does the reception area have a hearing loop system?	x	
Does the building where the service is located have a unisex wheelchair accessible 'disabled toilet?	x	
Does the building have car parking space reserved for Blue Badge holders?	x	
Does the building have any additional facilities for disabled people such as a wheelchair, hoist, specialist bath etc?	x	
Does the building/hospital sire where the service is provided have access to prayer and faith resources?	x	

EQUALITY IMPACT ASSESSMENT – STAGE 1 (PART 4)

Protected Characteristic	Positive Impact High Low None	Negative Impact High Low None	Reason/comments for positive Impact Why it could benefit any/all of the protected characteristics	Reason/Comments for Negative Impact Why it could disadvantage any/all of the protected characteristics	Resource Implication Yes / No
Men	Low				Staff to complete the reviews
Women	Low				
Younger People (17 – 25) and Children	Low				
Older people (60+)	Low				
Race or Ethnicity	Low				
Learning Disabilities	Low				
Hearing impairment	Low			.	
Visual impairment	Low				
Physical Disability	Low				
Mental Health Need	Low				
Gay/Lesbian/Bi sexual	Low				
Trans	Low				
Faith Groups (please specify)	Low				
Marriage & Civil Partnership	Low				

Pregnancy & Maternity	**Low**				
Carer Status	**Low**				
Other Group (please specify)					
Applies to ALL Groups	**Low**				

INITIAL ASSESSMENT (PART 5)

Have you identified any issues that you consider could have an adverse (negative) impact on people from the following protected groups?

IF 'NO IMPACT' IS IDENTIFIED Action: No further documentation is required.

IF 'HIGH YES IMPACT' IS IDENTIFIED Action: Full Equality Impact Assessment Stage 2 Form must be completed.

(a) In relation to each group, are there any areas where you are unsure about the impact and more information is needed?

(b) How are you going to gather this information?

(c) Following completion of the Stage 1 Assessment, is Stage 2 (a Full Assessment) necessary? NO

Assessment Completed By: ……Deborah Firth **Date Completed:** 30/08/2017

Line Manager …….. Date……..

Head of Department …… Date……..

Title of Service/Policy being assessed:	
Assessment Date:	
Is the service/policy aimed at a specific group of users?	

When is the next review? Please note review should be immediately on any amendments to your policy/procedure/strategy/service.

1 Year	**2 year**	**3Year**

STAGE 2 – FULL ASSESSMENT & IMPROVEMENT PLAN

MUST be completed if any negative issues have been identified at stage 1

Protected Characteristic	What adverse (negative) impacts were identified in Stage 1 and which groups were affected?	What changes or actions do you recommend to improve the service to eradicate or minimise the negative impacts on the specific groups identified?	Lead	Time-scale
Men Younger People (17-25) and Children Older People (50+) Race or Ethnicity Learning Disability Hearing Impairment Visual Impairment Physical Disability Mental Health Need Gay/Lesbian/Bisexual Transgender Faith Groups (please specify) Marriage & Civil Partnership Pregnancy & Maternity Carers Other Group (please specify) Applies to ALL Groups				
How will actions and proposals be monitored to ensure their success? Which Committee will you report to? (i.e. Divisional DQEC / Governance Meeting).				
Who will be responsible for monitoring these actions?				

Recording and Monitoring of Equality & Diversity

The Trust understands the business case for equality and diversity and will make sure that this is translated into practice. Accordingly, all policies and procedures will be monitored to ensure their effectiveness.

Monitoring information will be collated, analysed and published on an annual basis as part Equality Delivery System. The monitoring will cover the nine protected characteristics and will meet statutory duties under the Equality Act 2010. Where adverse impact is identified through the monitoring process the Trust will investigate and take corrective action to mitigate and prevent any negative impact.

The information collected for monitoring and reporting purposes will be treated as confidential and it will not be used for any other purpose.

Review Process Prior to Ratification:

Name of Group/Department/Committee	**Date**
Mortality Overview Group	
Mortality Review Group	

10. Appendices

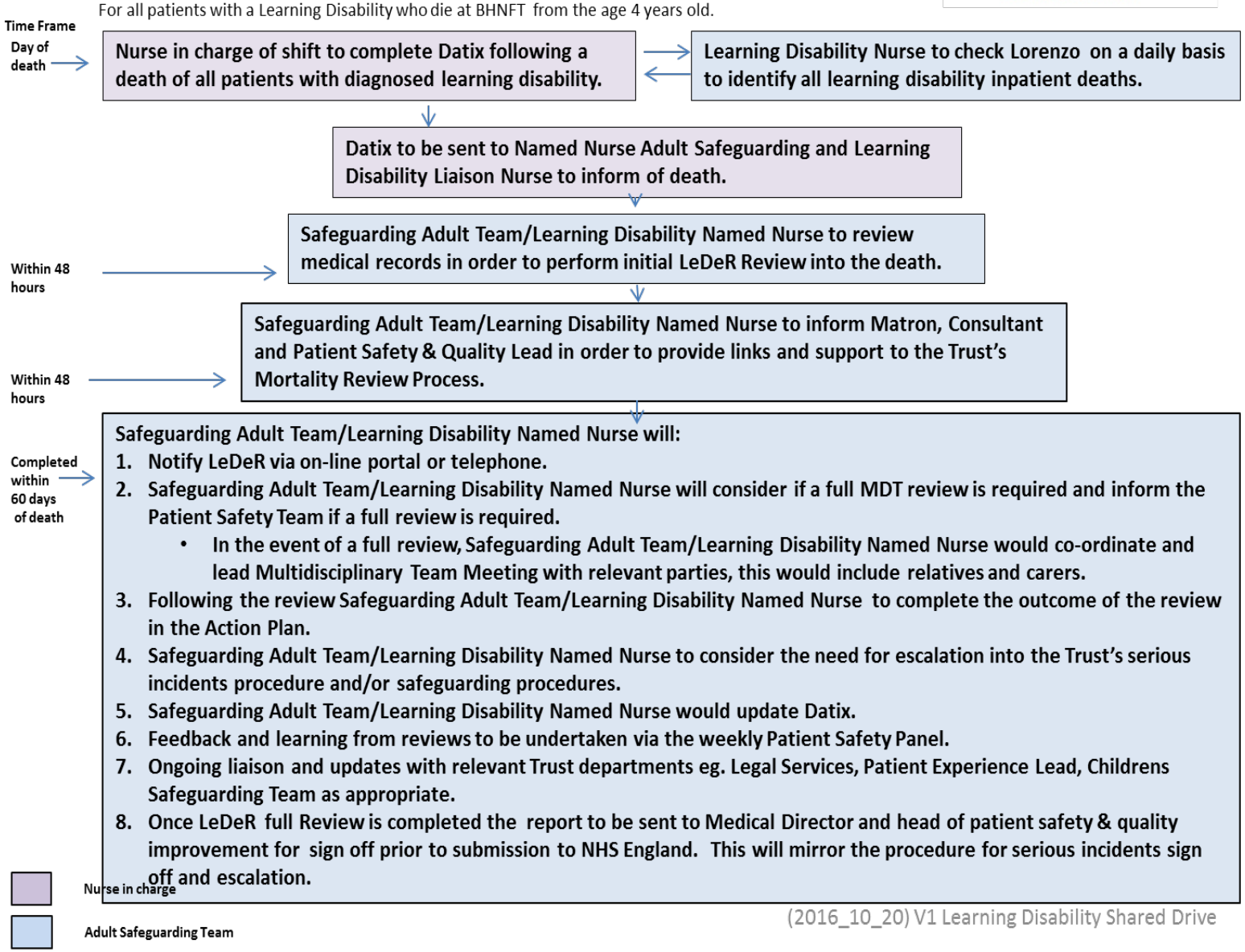
Appendix 1: Glossary of Terms used within Policy

Term	Meaning
(SHIMI)	Summary Hospital-level Mortality Indicator
(HSMR)	Hospital Standardised Mortality Ratio
(NHSI)	NHS Improvement

Learning Disability Patients Mortality Review (Appendix 1)
LeDeR Review (NHS England)

For all patients with a Learning Disability who die at BHNFT from the age 4 years old.

Barnsley Hospital NHS
NHS Foundation Trust



(2016_10_20) V1 Learning Disability Shared Drive

APPENDIX 3 Process Flow Chart:

1
- Bereavement Office supply a weekly list of deaths to Clinical Coding and the Mortality Overview Group.
- Management Information supply a weekly list of deaths (from Lorenzo, Datix, Clinical Coding and ED)to the Mortality Overview Group
- Both lists are reviewed weekly by the Mortality Overview Group

2
- Clinical Coding allocate notes for the Mortality Review screening process to consultants on a rotational basis
- The Mortality Overview Group will record the number of requested screening review forms allocated to each consultant

3
- Consultant compliance with the screening process is monitored by the revalidation co-ordinator

4
- Completed Mortality Case Note Screening Review Forms will be reviewed by the Mortality Overview Group who will allocate any SJR's required
- Reviewers have 20 working days to complete the SJR in accordance with the SJR process taught during formal training

5
- Returned SJR's are evaulated by the Mortality Overview Group.

6
- Findings are reported via the learning from deaths bulletin with individual feedback given by letter where appropriate. Learning is also reported via clinical governance meetings where appropriate actions to improve care are generated and managed. Other relevant platforms to share learning are utilised as appropriate. The Mortality Overview Group reports on statistical and qualitative measures through the Learning from Deaths Steering group.

7
- Discussions, outcomes and learning from the Learning from Deaths Steering group, including conclusions about outstanding care and sub-optimal care, are formally recorded and reported using the Trust Governance Structure via the Clinical Effectiveness Group to Quality and Governance.

8
- Escalations of findings of concern that have been corroborated through a second structured judgement review and may require further investigation are reported to the patient safety panel for review and decision.

Appendix 4 (must always be the last appendix)

Version	Date	Comments	Author
1	12/09/2017	Policy replaced previous due to national guidance in how mortality review is carried out.	D.Firth T.Radnall S.Orme
2	19/06/2018	Reviewed in light of changing regional and national process	T.Radnall S.Orme