Learning from Deaths Policy

Document Reference No.	CLIN041v4
Version No.	4
Issue Date	16/11/2017
Review Date	1st September 2020
Document Author	Deputy Medical Director
Document Owner	Deputy Medical Director
Accountable Executive	Medical Director
Approved by	Clinical Executive Group
Approval Date	16th November 2017
Document Type	Policy
Scope	All
Restrictions	None

VERSION CONTROL/REVIEW AND AMENDMENT LOG

Version No	Date	Description of change
2.4	3rd August 2017	Full Revision of Policy
3	1st September 2017	Minor revisions
4	16th November 2017	Inclusion of Trust Board, NED and Executive Director Lead roles Minor alterations to EIA Changes to letter to relative template

ENGAGEMENT AND CONSULTATION

Key Individuals/Groups Involved in Developing this Document

Role/Description
Mr Paul Curley
Mortality Review Steering Group

Circulated to the following for consultation

Date	Role/Designation
Oct 17	Divisional Clinical Directors
Oct 17	Heads of Clinical Service
Oct 17	Deputy Chief Nurses, Assistant Deputy Chief Nurse - Quality
Nov 17	Trust Chair
Nov 17	Chief Executive

Evidence Base
List any national guidelines, legislation or standards relating to this subject area Learning from Deaths – National Quality Board

EQUALITY IMPACT ASSESSMENT SUMMARY

Directorate: Medical Directorate	**Area:** Quality and Patient Safety
Policy/Project Summary: The Policy describes processes that should be embedded within each Clinical Unit, should be actioned and delivered through the monthly Clinical Governance Half Day Meetings, should be governed by the Divisional Governance structures, should be supported by Clinical Audit where necessary and should report to the Trust Wide Mortality Review Steering Group	
What are you seeking to achieve with this work? *What has prompted this change? What are the intended outcomes of this work?*	Update existing policy Include guidance on Learning from Deaths
Who will be affected by it and why? *(e.g. Public, patients, service users, staff, etc.)*	Patients Staff
Information	
What information is available about the current situation to assist decision making? *(e.g. data, intelligence, research or national guidelines; staff and patient experience)*	

Impact Analysis			
Based on the information available, an assessment of the current situation and the changes being proposed is there the possibility of a differential impact (positive or negative) on the groups listed below? *(Enter Y/N against each characteristic and a rationale with evidence)*			
	Y/N		**Y/N**
Disability	N	**Gender Reassignment & Transgender**	N
Gender/Sex	N	**Religion or Belief**	N
Race	N	**Pregnancy and Maternity**	N
Age	N	**Marriage & Civil Partnerships:**	N
Sexual Orientation	N	**Carers**	N
Rationale for Answers Above: *(Explain for each characteristic, why it is considered that there may or may not be an impact)* The policy relates to the review of deaths regardless of characteristics of the deceased			
Summary of Actions Planned as a Result of the Assessment *(Indicate timescales and lead officers for each action)*			
Assessed By Paul Curley			

1. Policy Statement

Review of the care provided to patients who die within the Trust is embedded within Clinical Audit Practice. This Policy incorporates most recent guidance from the National Quality Board.

The Policy describes processes that should be embedded within each Clinical Unit, should be actioned and delivered through the monthly Clinical Governance Half Day Meetings, should be governed by the Divisional Governance structures, should be supported by Clinical Audit where necessary and should report to the Trust Wide Mortality Review Steering Group.

It is expected that "business as usual" processes within clinical units will review the deaths of patients occurring in Hospital or within 30 days of Discharge.
In addition groups of patients for detailed review may be identified internally by normal governance processes, by the use of clinical outcome tools such as Dr Foster intelligence portal, externally by alerts from Dr Foster Unit, the CQC or others.

Mortality review is the process by which the circumstances surrounding the care of patients who die unexpectedly during hospitalisation, 30 days post discharge or within 30 days of SACT (systemic anti-cancer therapy) are systematically examined. The purpose of this policy is to support the delivery of safe services by ensuring the Trust has a consistent and coordinated approach to ensure that:

- All deaths in hospital are reviewed using a screening template to identify any evidence of care that indicates the need for detailed review **Form 1**
- Deaths meeting criteria published by the National Quality Board (Learning from Deaths) are subjected to a detailed review such as Structured Judgment Review **Form 2**
- Appropriate actions and learning are shared at a specialty, clinical division and Trust level. **Form 3**
- Any alerts from external data such as the Hospital Standardised Mortality Rate (HSMR) or Standardised Hospital Mortality Index (SHMI), are investigated and any learning shared and appropriate actions taken

The intention is that these reviews would take place as part of the Clinical Governance Half Day **Meeting** agendas. For some specialties this may be through a separate meeting.

2. Objectives

Mid Yorkshire Hospitals NHS Trust will have between 1700 and 2500 deaths per annum of inpatients under its care. Distribution of these deaths

between clinical groups is uneven. Most deaths occur under the care of Acute Medicine, Respiratory Medicine and Elderly Care Medicine.

It is expected that all deaths will have a screening tool (Form 1) completed at the time of certification of death by the certifying doctor.

In some specialties where there are low numbers of monthly deaths, it is expected that all deaths will be reviewed on a monthly basis through the Morbidity and Mortality review structure.

For specialties where there are large numbers of deaths it is expected that those where the screening tool indicates issues will be reviewed as a minimum.

Other categories requiring a more detailed review include:

- Deaths where there has been a clinical incident causing severe or moderate harm during the month of death or the calendar month before death
- Deaths after low risk admissions (for example elective surgery)
- Deaths in patients with learning disabilities (refer to the LeDeR process)
- Deaths in all patients with severe mental illness (with support from the appropriate mental health Trust) – specifically those sectioned under the Mental Health Act, those undergoing active treatment for psychosis or severe depression or those admitted from a mental health facility

The Trust will ensure that there is professional, timely, empathetic and honest communication with families of bereaved to ensure that any questions from relatives or family members are addressed in the Mortality Review process.

The Trust will endeavor to ensure that all deaths that are reviewed in detail will use the Structured Judgement case note review tool approved by the Royal College of Physicians (Form 2). Appropriate training is provided within the Trust in this technique.

Learning from the review of deaths within each clinical group will be captured on a consistent template (Form 3), will be forwarded to Divisional Clinical Governance managers who will in turn ensure these are received by the relevant Divisional Governance meeting. Monthly reports from each Division will be forwarded to the Mortality Review Steering Group and Clinical Audit.

Incoming alerts received from external bodies such as the CQC or the Dr Foster Unit will be received by the Mortality Review Steering Group who will then commission the Divisional Governance Groups to deliver appropriate reviews.

3. Scope

The Policy relates to all deaths in adults occurring within the Trust or within 30 days of Discharge from the Trust and applies to all staff who are engaged in the mortality review process for adults. The policy **does not** apply to **Paediatric patients** who are covered by a distinct policy.

4. Roles and Responsibilities

Trust Board

- Ensure systems for reporting and investigating deaths are robust
- Ensure the Trust learns from problems in healthcare identified by reviews or investigations
- Provide visible and effective leadership to staff to improve
- Ensure needs of patients and the public are central to how the Trust operates

Lead Non-Executive Director

- At September 2017 Lenore Ogilvy
- Understand the review process
- Champion Quality Improvement that leads to improved patient safety
- Assure that published information accurately reflects the Trust's approach, achievements and challenges

Lead Executive Director

- At September 2017 David Melia, Chief Nurse, Deputy CEO

Medical Director

- Assure the Trust Board that the mortality review process is functioning correctly

Deputy Medical Director (Quality and Safety)

- To chair the Trust Mortality Review Steering Group
- To ensure that arrangements are in place for all Clinical Staff to be aware of their responsibilities within the Policy
- To review and amend the Mortality Review Policy as required to ensure it is current and accurately reflects national and local policies.
- To ensure that there are regular reports on lessons learnt from Mortality review to the Quality Committee
- To ensure that centrally available comparative data such as the Dr Foster intelligence portal HSMR data is reviewed monthly and is made available to the Divisional Clinical Director and Heads of Clinical Service to support Mortality review within the Trust.

Divisional Clinical Directors

- Ensure arrangements are in place in their Division to deliver the process described in the policy
- To ensure that monthly reports are produced by their Governance mechanism and submitted to the Mortality Review Steering Group reflecting appropriate learning points.
- To ensure that action plans arising from Mortality Review are monitored, performance managed and enacted.

Heads of Clinical Services

- Ensure Specialty Mortality Review Meetings take place in all specialties and are attended by all relevant disciplines and professional groups in the areas they manage
- Ensure the outcome of Specialty Mortality Review meetings are reported to the Divisional Governance Meeting
- Ensure that Consultant and SAS grade doctors are participating in Mortality Reviews, a core part of their SPA/audit responsibilities.
- To ensure that the junior staff are supported and have the opportunity to be trained in and undertake mortality structure judgement reviews
- To ensure that there is a monthly report from the Specialty Mortality Review meetings submitted to the Divisional Governance Committee meeting (usually via the Clinical Governance Manager within the Division)
- To ensure that Doctors certifying deaths undertake screening assessments to identify potentially avoidable deaths and are suitably trained to do so
- May delegate some of these responsibilities to Governance or Specialty Mortality Leads

Specialty Mortality Leads

- Ensure processes are in place to monitor deaths at Mortality review meetings
- Report significant non-attendance at Specialty meetings to the Divisional Governance Meeting (less than 60% of attendance at the meetings which took place in the year)
- Ensure all clinicians certifying deaths are aware of their responsibility to complete screening tool **Form 1**
- Ensure Case Note reviews are undertaken of appropriate deceased patients and reported to Specialty Mortality Meetings using the Detailed Mortality Review proforma **Form 2**
- Ensure that Learning and actions from the Specialty Mortality Review Meetings are captured on the agreed mortality review shared learning template (**Form 3**) and submitted to the Clinical Audit Team

Divisional Clinical Governance Manager.

- Escalate areas of concern identified at the Specialty Mortality review meetings promptly to their Divisional Clinical Director and/or the Medical Director's Office via the Deputy Medical Director (Quality and Patient Safety) or Lead Nurse for Patient Safety
- Ensure any incidents identified during the course of the mortality reviews are logged on Datix
- Where deaths requiring Structured Judgement Case Review are identified, a standard letter (appendix 1) to be sent to the family inviting any issues to be identified.
- Attend weekly Patient Safety Panel to escalate any significant issues arising from Specialty Mortality Review Meetings
- Report and disseminate areas of good practice, and lessons learned, from the specialty Mortality review meetings to other specialties within the Division
- Collate specialty mortality review meetings and ensure actions for improvement and learning points are reported to the Divisional Governance Meeting
- Ensure a Monthly Divisional report goes to the Mortality Review Steering Group

Medical staff

- All consultant and SAS medical staff are required to participate fully in the Mortality review process
- All junior and senior medical staff are expected to participate fully in all Mortality review meetings that are relevant to their practice unless precluded from doing so by absence due to leave or urgent clinical matters
- The doctor certifying a death must complete the Clinical Audit **Form 2** and Mortality Review screening pro forma **Form 1.** This should be discussed with the consultant who was responsible for the care of the patient

Nurses, allied health professionals and other clinical staff

- Where appropriate, should be involved in Mortality reviews as part of their clinical practice, ranging from being aware of the outcome as this affects their practice to full involvement in the collection of data and implementation of recommendations

Clinical Audit Department

- Will receive all Mortality Review Screening Proformas (**Form 1)** and log the classification on a central data base of deaths
- Ensure that records for all deaths are available for the Specialty Mortality review meetings. Audit the number of mortality review proformas submitted vs. actual deaths and produce statistics on

compliance.

5. Policy Detail

- The Mortality Review Screening Pro-forma is attached as **Form 1.** This will be completed by the doctor certifying the death following discussion with the patient's consultant or a senior medical colleague within the relevant specialty. This form must be completed early on the next working day following the patient's death. The reporting of appropriate deaths to the Coroner will be done using the Trust electronic tool available on the Intranet

- The Bereavement Office will ensure a copy of form 1 is sent to the Clinical Audit Department who will add the categorisation of death to a central list of all deaths. The Bereavement Office will send the medical records to clinical coding who will code the death and the send all the records to Clinical Audit

- Clinical Audit will provide a list to the Specialty meetings of patients who have died in the month under review along with whether they meet the criteria for Structured Judgment review

- Divisional Governance Managers will send a letter to the families of deceased patients where a SJCR is to be performed informing them of the review and inviting input from them (Appendix A)

- Every month each relevant department / specialty will hold a Specialty Mortality Review Meeting (this could be part of the NCEPOD Governance Half Day). The expectation is that this meeting will always review all deaths. For high volume specialties it would be acceptable for only those deaths where Structured Judgment Case Note Review is indicated based upon Form 1 (plus the additions from Clinical Audit) are discussed. Each detailed review will use the Structured Judgment Review template **Form 2.**

- The Specialty meetings will be multidisciplinary where appropriate. The outcome of the meetings will be captured in the mortality review shared learning template **Form 3** with a copy being provided to the Divisional Governance Manager and Clinical Audit Department

- The Divisional Governance Manager will ensure the outcomes of the Specialty Governance Meetings are discussed at the Divisional Governance Meeting - this is to enable key actions to be shared and followed through to completion

- The Clinical Audit Department will ensure that any cross Trust actions or learning from the Specialty Mortality Meetings are available for discussion at the monthly Mortality Review Steering Group Meetings. The Trust Wide Mortality Review Steering Group will review what action is required to be taken or cross-Trust learning and ensure these are followed through to completion. The meeting will ensure the clinical service groups follow up and resolve any issues identified from Specialty Mortality Review Meetings

- The Divisional Governance Team and Committee will be responsible for tracking actions against action plans for Divisional actions identified during the Mortality Review Process. Central learning collated by the Mortality Review Steering Group will be cascaded to the Divisional Governance structures for addition to that action log

- The Deputy Medical Director, or their team, will ensure that Mortality alerts identified through tools such as the Dr Foster intelligence portal are identified to the Divisional Governance structures for action

- Any Dr Foster alerts will be identified monthly by the Medical Directors Office and a specialty lead will be identified to undertake a review of deaths using **Form 2.** The outcome will be reported to the Trust Wide Mortality Review Steering Group using the standard template **Form 3**

6. Implementation and dissemination

The Medical Director will take a lead in ensuring the policy is adopted consistently across all clinical divisions. S/He will discharge this responsibility through the Divisional Clinical Directors and the named mortality leads within each specialty.

The document will also be placed on the Trust intranet in the Clinical Policies section.

7. Monitoring Compliance, Audit and Review

Compliance with this policy will be monitored by the Divisional Governance Boards, and the Trust Mortality Review Meeting. The Quality Committee will receive a quarterly report from the Trust Mortality Review Meeting on the following:

- The required meetings have been held and a record kept of all proposed actions

- The actions proposed have been completed within timescales agreed

- Mandated staff have attended 60% of meetings

- Death outcome forms have been fully completed on 100% of all deaths in hospital

8. References

- NHS Improvement guidance at https://improvement.nhs.uk/resources/learning-deaths-nhs/ Last accessed 13th August 2017

- The Royal Cornwall Hospitals NHS Trust 'Policy on the Adult Mortality Review process' Revised April 2013

- The Leeds Teaching Hospitals NHS Trust Mortality and Morbidity Policy, September 2009

- The University Hospitals of Leicester Morbidity and Mortality Reviews Policy, January 2011, revised 2017

- The Mid Staffordshire NHS Foundation Trust Inquiry; Independent Inquiry into care provided by Mid Staffordshire NHS Foundation Trust; January 2005 – March 2009; Volume I. Chaired by Robert Francis QC. Published 24 February 2010

Form 1

Midyorks Hospitals NHS Trust
Mortality Review Screening Tool

Name: DOB: Gender:

NHS Number: Address:

In March 2017 the Department of Health issued 'National Guidance on Learning from Deaths' which mandates that certain criteria are present, NHS organisations must undertake a case record review of a patients care, with a view to develop an understanding of themes relating to mortality, in order to drive quality improvement work.

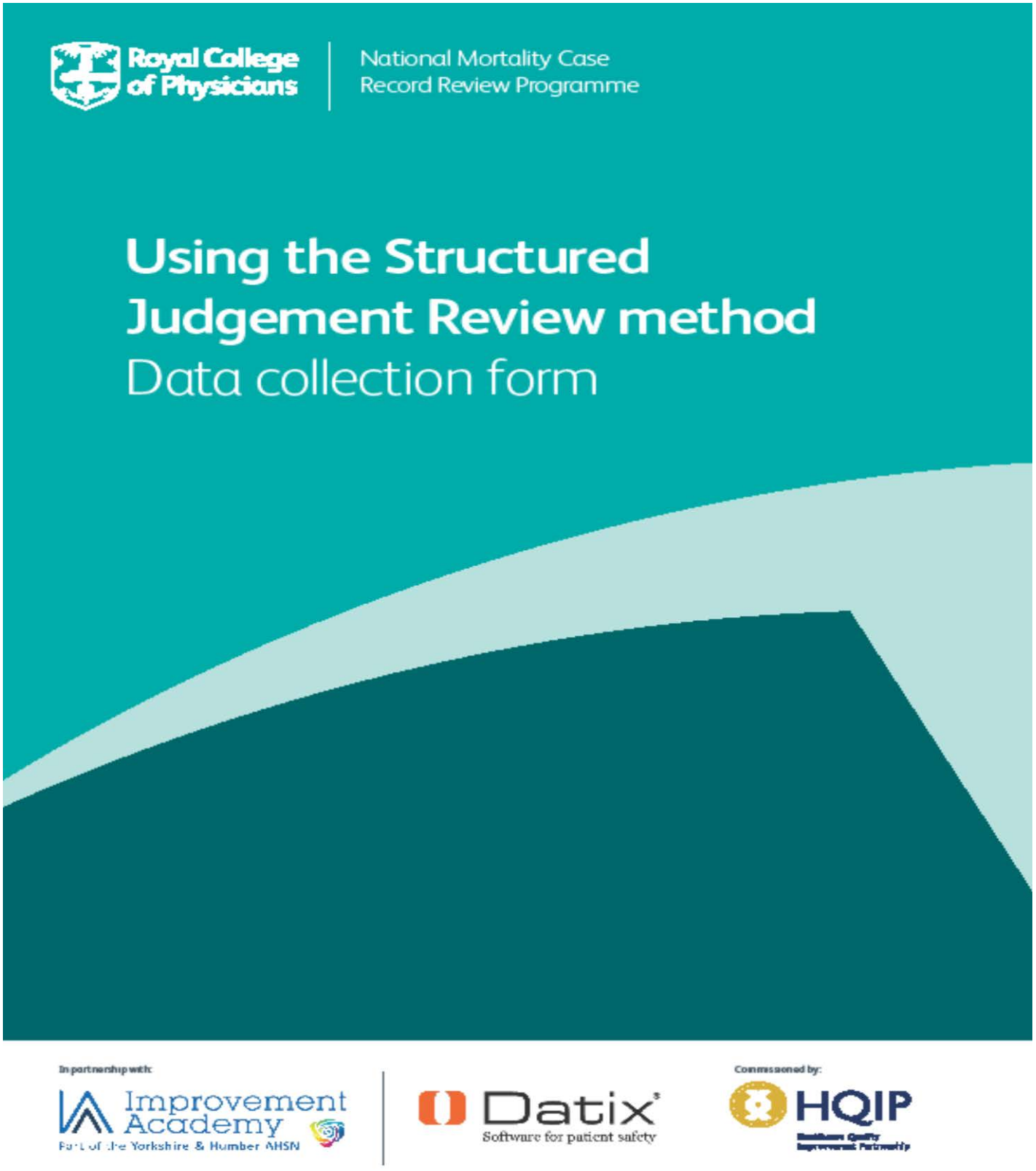
The mandatory criteria indicating case record review is necessary are present in the fields below.

If 'Yes' is selected, your speciality Mortality Lead will be informed and this will trigger a case notes review. Thank you for your help.
Specialty:
Clinician Name: GMC Number:

It is **Mandatory** that this form is completed following discussion of the criteria in relation to the case, with a Consultant. Please select below the name of the consultant that this form was discussed with.
Consultant:

1 a	
b	
c	
2	

Criteria for Case Record Review	Yes	No / NA
1. Do you believe the death unexpected? There will be some patients with frailty and multiple comorbidities in whom death was not unsurprising to the clinical team -these do not require case record review unless other concerns are present.		
2. Was the patient subject to a cardiac arrest call which failed to lead to return of spontaneous circulation?		
3. Was this death within 30 days of an elective procedure		
4. If the death was expected, was there an absence of end of life care planning or DNACPR form?		
5. Are you concerned that any problems in health care occurred? *A problem in healthcare is defined as 'any point where the patients' healthcare fell below an acceptable standard and led to harm·. E.g. Avoidable healthcare associated infection, avoidable acquired pressure ulcer, failure to respond in a timely manner to deterioration etc.*		
6. Have you any concerns that this death was avoidable? *Even if you have slight concerns that this death was avoidable, you should refer for case Record Review*		
7. Has there been a complaint or moderate / severe harm incident		
8. Did the family / carers have significant concern regarding the quality of care		
9. Was there evidence of severe mental illness: • Was this patient sectioned under the mental health act • Was this patient having treatment for psychosis or severe depression • Was this patient admitted from a mental health facility		



National Mortality Case Record Review Programme: structured case note review data collection

Please enter the following.

Age at death (years):

Gender: M/F

First 3/4 digits of the patient's postcode:

Day of admission/attendance:

Time of arrival:

Day of death:

Time of death:

Number of days between arrival and death:

Month cluster during which the patient died:

Jan/Feb/Mar Apr/May/June Jul/Aug/Sept Oct/Nov/Dec

Specialty team at time of death:

Specific location of death:

Type of admission:

The certified cause of death if known:

Guidance for reviewers

1. Did the patient have a learning disability?

   - No indication of a learning disability.
     Action: proceed with this review.

   - Yes – clear or possible indications from the case records of a learning disability.
     Action: after your review, please refer the case to the hospital's clinical governance group for linkage with the Learning Disability Mortality Review Programme.

2 Did the patient have a serious mental health issue?

   - No indication of a severe mental health issue.
     Action: proceed with this review.

   - Yes – clear or possible indications from the case records of a severe mental health issue.
     Action: after your review, please refer the case to the hospital's clinical governance group.

3 Is the patient under 18 years old?

   - No, the patient is 18 years or older.
     Action: proceed with this review.

   - Yes – the patient is under 18 years old.
     Action: after your review, please refer the case to the hospital's clinical governance group for linkage with the Child Death Review Programme.

Structured case note review data collection

Phase of care: **Admission and initial management (approximately the first 24 hours)**

Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice (for example, your professional standards or your professional perspective). If there is any other information that you think is important or relevant that you wish to comment on then please do so.

Please rate the care received by the patient during this phase.

1 = very poor care 2 = poor care 3 = adequate care 4 = good care 5 = excellent care

Please circle only one score.

Phase of care: **Ongoing care**

Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice (for example, your professional standards or your professional perspective). If there is any other information that you think is important or relevant that you wish to comment on then please do so.

Please rate the care received by the patient during this phase.

1 = very poor care 2 = poor care 3 = adequate care 4 = good care 5 = excellent care

Please circle only one score.

Phase of care: **Care during a procedure (excluding IV cannulation)**

Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice (for example, your professional standards or your professional perspective). If there is any other information that you think is important or relevant that you wish to comment on then please do so.

Please rate the care received by the patient during this phase.

1 = very poor care 2 = poor care 3 = adequate care 4 = good care 5 = excellent care

Please circle only one score.

Phase of care: **Perioperative care**

Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice (for example, your professional standards or your professional perspective). If there is any other information that you think is important or relevant that you wish to comment on then please do so.

Please rate the care received by the patient during this phase.

1 = very poor care 2 = poor care 3 = adequate care 4 = good care 5 = excellent care

Please circle only one score.

Phase of care: **End-of-life care**

Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice (for example, your professional standards or your professional perspective). If there is any other information that you think is important or relevant that you wish to comment on then please do so.

Please rate the care received by the patient during this phase.

1 = very poor care 2 = poor care 3 = adequate care 4 = good care 5 = excellent care

Please circle only one score.

Phase of care: **Overall assessment**

Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice (for example, your professional standards or your professional perspective). If there is any other information that you think is important or relevant that you wish to comment on then please do so.

Please rate the care received by the patient during this phase.

1 = very poor care 2 = poor care 3 = adequate care 4 = good care 5 = excellent care

Please circle only one score.

Please rate the quality of the patient record.

1 = very poor care 2 = poor care 3 = adequate care 4 = good care 5 = excellent care

Please circle only one score.

Assessment of problems in healthcare

In this section, the reviewer is asked to comment on whether one or more specific types of problem(s) were identified and, if so, to indicate whether any led to harm.

Were there any problems with the care of the patient? (Please tick)

No ☐ (please stop here) **Yes** ☐ (please continue below)

If you did identify problems, please identify which problem type(s) from the selection below. Please indicate whether it led to any harm and in which phase(s) of care the problem was identified. Please tick all that relate to the case.

Problem types

1. **Problem in assessment, investigation or diagnosis** *(including assessment of pressure ulcerrisk, venous thromboembolism (VTE) risk, history of falls)* **Yes** ☐ **No** ☐

   Did the problem lead to harm? No ☐ **Probably** ☐ **Yes** ☐

   In which phase(s) did the problem occur?

   Admission and initial assessment Ongoing care ☐ Ongoing care ☐

   Care during procedure Perioperative care ☐ Perioperative care ☐

   End-of-life care ☐

2. **Problem with medication / IV fluids / electrolytes / oxygen** *(other than anaesthetic)*
   Yes ☐ **No** ☐

   Did the problem lead to harm? No ☐ **Probably** ☐ **Yes** ☐

   In which phase(s) did the problem occur?

   Admission and initial assessment Ongoing care ☐ Ongoing care ☐

   Care during procedure Perioperative care ☐ Perioperative care ☐

   End-of-life care ☐

3. **Problem related to treatment and management plan** *(including prevention of pressure ulcers, falls, VTE)*
Yes ☐ No ☐
Did the problem lead to harm? No ☐ Probably ☐ Yes ☐

In which phase(s) did the problem occur?

Admission and initial assessment Ongoing care ☐ Ongoing care ☐

Care during procedure Perioperative care ☐ Perioperative care ☐

End-of-life care ☐

4. **Problem with infection management Yes ☐ No ☐**
Did the problem lead to harm? No ☐ Probably ☐ Yes ☐

In which phase(s) did the problem occur?

Admission and initial assessment Ongoing care ☐ Ongoing care ☐

Care during procedure Perioperative care ☐ Perioperative care ☐

End-of-life care ☐

5. **Problem related to operation / invasive procedure** *(other than infection control)* **Yes ☐ No ☐**
Did the problem lead to harm? No ☐ Probably ☐ Yes ☐

In which phase(s) did the problem occur?

Admission and initial assessment Ongoing care ☐ Ongoing care ☐

Care during procedure Perioperative care ☐ Perioperative care ☐

End-of-life care ☐

6. **Problem in clinical monitoring** *(including failure to plan, to undertake, or to recognise andrespond to changes)*
Yes ☐ No ☐
Did the problem lead to harm? No ☐ Probably ☐ Yes ☐

In which phase(s) did the problem occur?

Admission and initial assessment Ongoing care ☐ Ongoing care ☐

Care during procedure Perioperative care ☐ Perioperative care ☐

End-of-life care ☐

7. **Problem in resuscitation following a cardiac or respiratory arrest** *(includingcardiopulmonary resuscitation (CPR))* **Yes ☐ No ☐**

   Did the problem lead to harm? No ☐ Probably ☐ Yes ☐

   In which phase(s) did the problem occur?

   Admission and initial assessment Ongoing care ☐ Ongoing care ☐

   Care during procedure Perioperative care ☐ Perioperative care ☐

   End-of-life care ☐

8. **Problem of any other type not fitting the categories above** *(including communication andorganisational issues)* **Yes ☐ No ☐**

   Did the problem lead to harm? No ☐ Probably ☐ Yes ☐

   In which phase(s) did the problem occur?

   Admission and initial assessment Ongoing care ☐ Ongoing care ☐

   Care during procedure Perioperative care ☐ Perioperative care ☐

   End-of-life care ☐

Form 3

MORTALITY REVIEW - SHARED LEARNING TEMPLATE

Date of Meeting	DD/MM/YY		
Title of the Meeting			
Specialty			
Completed Structured Judgement Casenote Review (SJCR)	**Hospital Number**	**Month of Death**	**Reviewer**
Key Learning points			
Agreed Actions to address key learning			
Additional Comments			

Appendix A

<Name of Department>
Address line 1
Address line 2
Address line 3
Address line 4
postcode
Tel: xxxxx xxxxxx
Email: firstname.surname@midyorks.nhs.uk

Your ref: (to be completed if known)
Our ref:
Date:

Address:

Dear …..,

On behalf of the Mid Yorkshire Hospitals NHS Trust I would like to express our condolences after your recent bereavement.

When a patient dies the Trust reviews the care provided and we I would like you to know that this will be happening.

If you have any questions or concerns about the service your relative received please contact the individual below and we will endeavour to include these in our review.

Contact :

Division of –

Name –

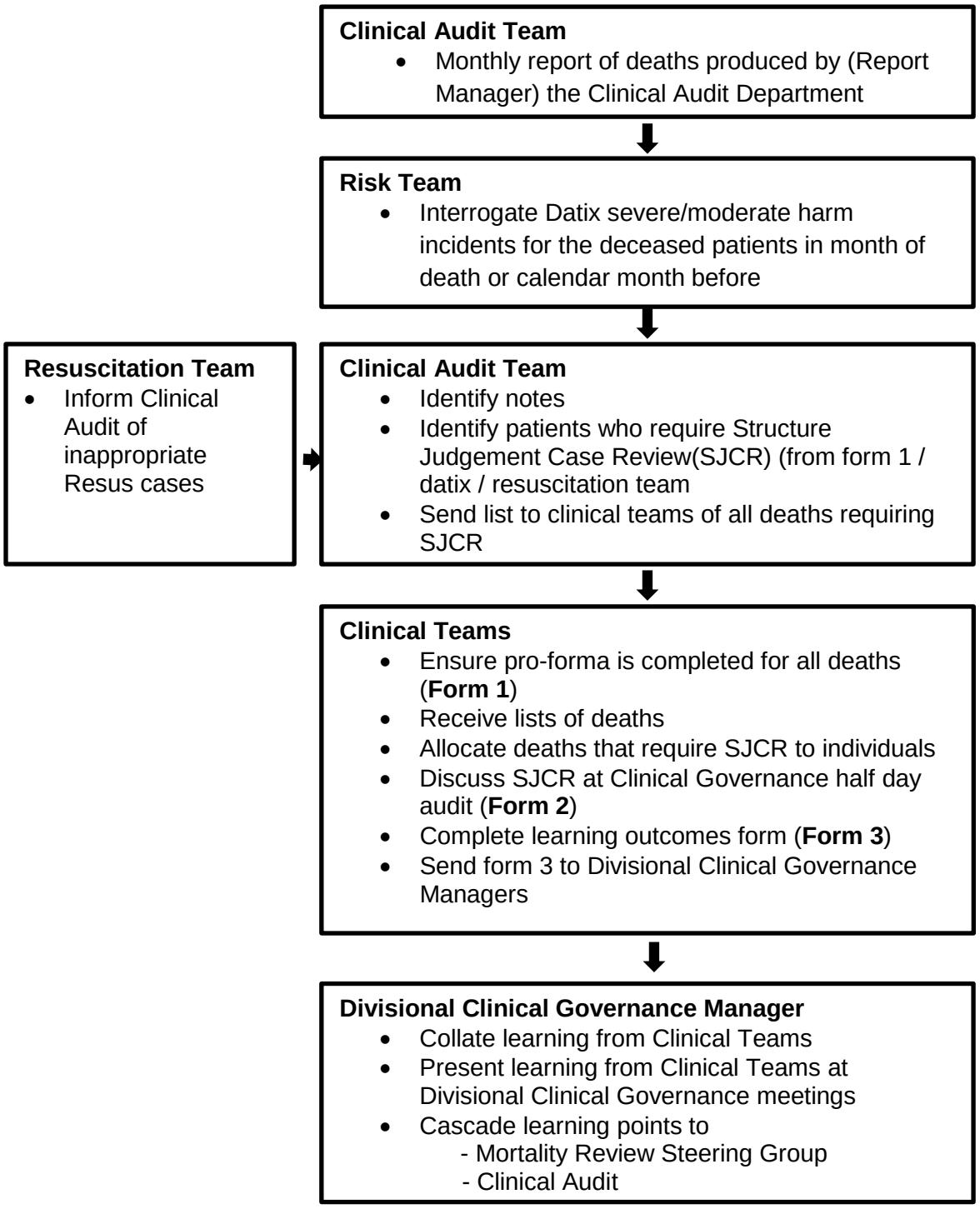
Title –

Phone number –

When the review is complete it would be helpful to know if you want us to discuss our findings with you.

Yours sincerely,

Mortality Review Process Chart



TOOL 5 CONSULTATION FEEDBACK FORM

Date	Individual Job Title or Group Feedback	Actions taken in response
1.6.17	Directorate of Nursing	Modification of the wording of letter to bereaved families
2.8.17	Divisional Clinical Governance Managers	• Alteration of flow chart for responsibilities • Alteration of wording of letter to bereaved
16.8.17	Heads of Clinical Service	No comments received
16.8.17	Divisional Clinical Directors	No comments received
1.8.17	Clinical Audit	Changes to process map

TOOL 6 CHECKLIST FOR POLICIES AND WRITTEN CONTROL DOCUMENTS

	Title of document being reviewed:	Yes/No/ Unsure	Comments
1.	**Title**		
	Is the title clear and unambiguous?		
	Is it clear whether the document is a guideline, policy, protocol or standard?		
2.	**Rationale**		
	Are reasons for development of the document stated?		
3.	**Development Process**		
	Is the method described in brief?		
	Are the roles involved in the development identified?		
	Do you feel a reasonable attempt has been made to ensure relevant expertise has been used?		
	Is there evidence of consultation with relevant stakeholders and users?		
4.	**Content**		
	Is the objective of the document clear?		
	Is the target population clear and unambiguous?		
	Are the intended outcomes described?		
	Are the statements clear and unambiguous?		
5.	**Evidence Base**		
	Is the type of evidence to support the document identified explicitly?		
	Are key references cited?		
6.	**Approval**		
	Does the document identify the approving Director?		
	If appropriate, have the joint Human Resources/staff side committee (or equivalent) approved the document?		
7.	**Dissemination and Implementation**		
	Is there an outline/plan to identify how this will be done?		
	Does the plan include the necessary training/support to ensure compliance?		

		Yes/No/ Unsure	Comments
8.	**Document Control**		
	Does the document identify where it will be held?		
	Have archiving arrangements for superseded documents been addressed?		
	Is there a plan to review or audit compliance with the document?		
9.	**Review Date**		
	Is the review date identified?		
	Is the frequency of review identified? If so, is it acceptable?		
10.	**Overall Responsibility for the Document**		
	Is it clear who will be responsible for coordinating the dissemination, implementation and review of the documentation?		

TOOL 7 WRITTEN CONTROL DOCUMENT SUBMISSION FOR APPROVAL FORM

<table>
<tr><td colspan="4">WRITTEN CONTROL DOCUMENT SUBMISSION FOR APPROVAL FORM</td></tr>
<tr><td colspan="4">What type of document is this: (highlight)</td></tr>
<tr><td>Policy</td><td></td><td></td><td></td></tr>
<tr><td colspan="3">Title of Document
Learning from Deaths Policy 2017</td><td>Reference</td></tr>
<tr><td colspan="4">Reason for submission (highlight)</td></tr>
<tr><td></td><td>Revised legislation</td><td></td><td>3 year review</td></tr>
<tr><td colspan="4">Does this document supersede/replace any other documents, please provide details:
Mortality Policy 2014</td></tr>
<tr><td colspan="2">Accountable Executive Director</td><td colspan="2">Dr Karen Stone MD</td></tr>
<tr><td colspan="2">Document Owner</td><td colspan="2"></td></tr>
<tr><td colspan="2">Document Author</td><td colspan="2">Mr Paul Curley, Deputy MD</td></tr>
<tr><td colspan="4">Any Other Comments</td></tr>
<tr><td colspan="4">Date
12/9/17</td></tr>
<tr><td colspan="4">Return this form with the Policy to PolicyManagementMYHT@midyorks.nhs.uk or the Company Secretariat</td></tr>
</table>

TOOL 8 STAFF SIGN OFF DOCUMENT

Title of Policy	
Document Reference	
Document Owner	
Your name and Job Title	
Department	
Declaration I confirm that I have read and understood the above Policy and I have received any training on its implementation as necessary (this may be limited to reading the policy and aware of location on intranet)	**Signature**
If you have not understood the policy, or, where required, received the necessary training, please describe the issue and the actions that you will take, for example, raise with your line manager	
Return this sign off document to the document owner	