**Trust Mortality Review Group**

**Draft Terms of Reference**

**Date last reviewed**

13th April 2016

**Role and Purpose**

The role of the Mortality Review Group is to:

* Improve our understanding and use of the trusts information about mortality; identifying and being curious about any outliers
* Review the themes and learning from deaths across the trust
* To identify and lead on trust wide changes as required to reduce avoidable deaths
* Review findings from thematic reviews and commission further reviews as required
* Develop robust reporting and assurance around mortality
* Develop sharing and learning with other organisations across the healthcare system
* Ensure the trust remains in line with national guidance and recommendations around the governance and review process for deaths
* Review and recommend for approval the submission of any regulatory or national mortality data provided.

Initially the group will focus on implementing the key work streams identified from the self-assessment against national guidance and recommendations.

**Main responsibilities:**

* To review data on patient deaths, including results and learning generated by local mortality reviews, and consider strategies to improve care and reduce avoidable mortality.
* To review on a regular basis, the mortality rates by service
* To consider the mortality data in conjunction with other qualitative clinical data and identify areas for future investigation
* To investigate any alerts received from the Care Quality Commission (CQC) or identified by the other organisations or regulators
* To develop data collection systems to ensure the Trust’s mortality data is timely, robust and in line with national and international best practice.
* To assign clinical leads to address raised mortality in particular clinical areas by the deployment of strong evidence based interventions such as care bundles. The Mortality Review Group will receive regular reports on implementation and the measurable impact of these interventions on mortality.
* To review and monitor compliance with other policies including DNAR and Death Certification Policy.
* To ensure adequate policy, procedures and processes are in place to report, review, investigate and minimise the possibility of avoidable deaths
* To share best practice and learning across the Trust by monitoring themes, trends, audits, learning and actions taken around avoidable and unavoidable deaths

**Membership and responsibilities of members**

* Mark Hancock –Medical Director or deputy (chair)
* Ros Alstead – Director of Nursing
* Jane Kershaw – Acting Head of Quality and Risk
* Susan Haynes – Deputy Director of Nursing
* Vivek Khosla – Consultant Psychiatrist, Adult directorate
* Pete McGrane – Clinical Director, Older People’s directorate
* Ian Neale – GP lead, Older People’s directorate
* Kate Riddle – Head of Nursing, Children and Young People directorate
* Hannah Faux – Inquests and Claims Manager
* Rebecca Kelly – Trust Professional Lead, Occupational Therapy
* Karen Lascelles – Lead Nurse for Suicide Prevention
* Paul Butler – Patient Safety Lead
* Medic/ clinician from the Oxford University Hospitals Trust
* Governor representative (patient, carer or general public)

***Co-opted members***:

* Keith Hawton – Consultant Psychiatrist and Professor of Psychiatry at OxfordUniversity; Centre for Suicide Research
* Dominic McKenny – Chief Information Officer
* Commissioner representatives
* Other professions internally and externally to the organisation as required

***Chairing Arrangements:*** Medical Director

***Nominated deputy***: Head of Quality and Safety

**The responsibilities of each member of the Mortality Review Group are to:**

* To support the Board of Directors to ensure that where applicable, clinical consideration is given to the work undertaken and meets the necessary quality requirements
* To commit to share learning within different teams, groups and committees

**Frequency of meetings**

At least quarterly

**Standing Items**

Work plan to be agreed.

**Reporting**

The group will report to the Safety Quality Sub-Committee and Board of Directors quarterly.

The Executive Team and Board will use the following 5 key questions to gain assurance around processes overseen by the group;

1. Do we identify and report deaths correctly?
2. Do we review and investigate unexpected deaths properly and without delay?
3. Do we meet our obligations to others?
4. Do we learn from deaths?
5. Are we being transparent and open in our reporting and investigating of deaths?

The following groups will report or share information with the Mortality Review Group i.e. Older People’s directorate mortality review, physical health group, weekly clinical review meeting, end of life care steering group, multi-agency, local safeguarding boards (child death and overview process).