NHS
Mersey Care
NHS Foundation Trust

Community and Mental Health Services

Learning from Deaths

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Lead Author(s):	**Patient Safety Director & Mortality & Incident Review Practitioners**

TRUST-WIDE POLICY DOCUMENT

2018 – Version 2

Striving for perfect care for the people we serve

TRUST-WIDE POLICY DOCUMENT

Learning from Deaths

Further information about this document:

Document name	**SA45 Learning from Deaths**
Document summary	**The purpose of this policy is to ensure that the Trust sets out in place how it responds to the deaths of patients who die under its management and care. It will ensure that the board takes a systematic approach to the issue of potential avoidable mortality and have robust mortality governance processes in place to ensure the delivery of safe care.**
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To be read in conjunction with	**SA03 Reporting, management and review of adverse incidents** **SD02 Death of a Service User** **SA13 Being Open (including Duty of Candour)**

This document can be made available in a range of alternative formats including various languages, large print and braille etc

Version Control:

		Version History:
Version 1	Mortality Review Group Approval Policy Group Board of Directors	19 July 2017 29 August 2017 27 September 2017
Version 2	Policy Group Lead Executive approval	28 August 2018

SUPPORTING STATEMENTS

This document should be read in conjunction with the following statements:

SAFEGUARDING IS EVERYBODY'S BUSINESS

All Mersey Care NHS Foundation Trust employees have a statutory duty to safeguard and promote the welfare of children and adults, including:

- being alert to the possibility of child/ adult abuse and neglect through their observation of abuse, or by professional judgement made as a result of information gathered about the child/ adult;
- knowing how to deal with a disclosure or allegation of child/adult abuse;
- undertaking training as appropriate for their role and keeping themselves updated;
- being aware of and following the local policies and procedures they need to follow if they have a child/adult concern;
- ensuring appropriate advice and support is accessed either from managers, *Safeguarding Ambassadors* or the Trust's safeguarding team;
- participating in multi-agency working to safeguard the child or adult (if appropriate to your role);
- ensuring contemporaneous records are kept at all times and record keeping is in strict adherence to Mersey Care NHS Foundation Trust policy and procedures and professional guidelines. Roles, responsibilities and accountabilities, will differ depending on the post you hold within the organisation;
- ensuring that all staff and their managers discuss and record any safeguarding issues that arise at each supervision session

EQUALITY AND HUMAN RIGHTS

Mersey Care NHS Foundation Trust recognises that some sections of society experience prejudice and discrimination. The Equality Act 2010 specifically recognises the *protected characteristics* of age, disability, gender, race, religion or belief, sexual orientation and transgender. The Equality Act also requires regard to socio-economic factors including pregnancy / maternity and marriage/civil partnership.

The Trust is committed to equality of opportunity and anti-discriminatory practice both in the provision of services and in our role as a major employer. The Trust believes that all people have the right to be treated with dignity and respect and is committed to the elimination of unfair and unlawful discriminatory practices.

Mersey Care NHS Foundation Trust also is aware of its legal duties under the Human Rights Act 1998. Section 6 of the Human Rights Act requires all public authorities to uphold and promote Human Rights in everything they do. It is unlawful for a public authority to perform any act which contravenes the Human Rights Act.

Mersey Care NHS Foundation Trust is committed to carrying out its functions and service delivery in line the with a Human Rights based approach and the FREDA principles of **F**airness, **R**espect, **E**quality **D**ignity, and **A**utonomy

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1. PURPOSE AND RATIONALE

1.1 This policy will set out the governance arrangements that will support all reviews of mortality in the trust. This policy should be read in conjunction with national guidance, National Quality Boards National Guidance on Learning from Deaths (March 2017) and NHS England's Serious Incident Framework (2015) and will enable the trust to demonstrate its duties to investigate, learn and meet its obligations of Duty of Candour.

1.2 Monitoring and reviewing all deaths in the trust will lead to understanding of practice and quality of care being imparted. Staff can then use the learning from such reviews to improve their practice, quality of care and patient safety.

1.3 Nationally, there are concerns about mortality, their reviews and learning from such serious incidents. This policy will allow us to establish if the care that has been provided contributed in any way to an adverse outcome in a patient and how we can learn from such incidents to prevent a recurrence in other patients.

1.4 This standardised Trust-wide process, integrating mortality reviews into the governance framework, will provide greater levels of assurance to the Trust Board. It will help to ensure that the organisation is using mortality data and indicators alongside others such as incidents and complaints to monitor the quality of care, share good practice and learn from errors.

2. OUTCOME FOCUSED AIMS AND OBJECTIVES

2.1 The outcomes that adherence to this policy will achieve include:

i. All deaths of people who are under the scope of this policy will be reviewed using at least one of the mechanisms identified.

ii. All deaths in scope of service users with a diagnosed Learning Disability have been referred to the LeDeR (Learning Disabilities Mortality Review programme) process.

iii. All deaths of service users who were under the care of the drugs and alcohol service will be referred to the Public Health Institute at John Moores University as nationally agreed

iv. Families of deceased service users will be offered support to be involved as per National Guidance set out in NHS England's Serious Incident Framework 2015, as soon as a serious incident is being investigated.

v. The Trust's Board of Directors will receive information on the number of deaths that have occurred, number reviewed and learning points identified and actions taken.

vi. A summary of the findings of the mortality review process will be published in the Trust Quality Report from June 2018.

vii. Learning from deaths data dashboard will be available within the Trust and used to provide information to the Board and its sub committees.

2.2 The aim of the mortality review process is to:

i Identify and minimise ‘avoidable' deaths within the entire Trust
ii Ensure that patients’ wishes have been identified and met where appropriate
iii Improve the experience of patients’ families and carers through improved involvement in investigations and reviews where appropriate
iv Identify and minimise avoidable admissions or late presentation
v Enable informed reporting with a transparent methodology
vi Promote organisational learning and improvement

3 LEARNING AND QUALITY IMPROVEMENT

3.1 The Trust will ensure that lessons learnt from mortality reviews and analysis of mortality data will result in change in organisational culture and practice by;

3.2 Identifying Themes and Trends at the monthly Mortality Review Group and alerting clinical services when appropriate.

3.3 Learning points identified within the Quality Assurance Committee are actioned within an agreed timescale.

3.4 Thematic Reviews are commissioned on a regular basis by the Mortality Review Group and associated action plans implemented.

3.5 Action plans from Mortality Related RCA Reviews are fully implemented and their implementation is audited for assurance.

3.6 Ensuring learning is cascaded to frontline clinical staff and divisions on a regular basis by use of: -

a) Quality Practice Alerts
b) Dare to Share Events
c) Oxford Model Events
d) Divisional News Letters

4 SCOPE

4.1 This policy relates to all staff who may be involved in the mortality review process:

4.2 The mortality review process is applicable to:

i a. All Trust deaths for those patients who have had contact with mental health services in the Trust in the last 6 months and where the Trust is the main care provider. Potential suicide incidents will be excluded as they will be subject to immediate review under Trust policy SA03 Reporting, Management and Review of Adverse Incidents.

AND

ii b. All Trust deaths for those patients who have had contact with clinical community physical health services in the last 30 days and where the Trust is the main care provider.

5 SHMI/HSMR DATA

5.1 The Trust does not collect Summary Hospital Level Mortality Indicator (SHMI) or Hospital Standardised Mortality Ratio (HSMR) data as Acute Trusts are required to do so. The Trust has implemented a process by which mortality is managed and reviewed in a systematic way according to national guidance in line with other organisations who do not have these measures.

6 CROSS SYSTEM MORTALITY REVIEWS AND INVESTIGATIONS

6.1 Where problems are identified relating to other NHS Trusts or organisations, the Trust should make every effort to inform the relevant organisation so they can undertake any necessary investigation or improvement.

6.2 This process should be undertaken by the Mortality and Incident Review Practitioner within 7 working days of identifying the problem. All incidents should be reported on the Trust's risk management system and to the Mortality Review Group.

6.3 The Trust should ensure that every effort is made to work collaboratively with neighbouring NHS organisations in relation to the Mortality Agenda. The sharing of personal identifiable information will be underpinned by an Information Sharing Agreement signed by each organisation in order observe the duty of confidentiality owed to service users and protect their personal information, and also encourage learning and improvement on a regional level.

7 DUTIES

7.1 Medical Director

7.1.1 The Medical Director will be the executive lead for the learning from deaths agenda and main duties will include: -

i Chairing the monthly Mortality Review Group.
ii Presenting reports to the Board and ensuring that national standards are met by the Trust.
iii Ensuring that learning from mortality reviews is integral to the Trust's clinical governance and quality improvement work.

7.2 Non Executive Director

7.2.1 The Trust is required by national guidance to have a nominated lead Non Executive Director who will: -

i Understand the review process – ensure the processes for reviewing and learning from deaths are robust and can withstand external scrutiny.
ii Champion quality improvement – that leads to actions that improve patient safety.
iii Assure that published information – fairly and accurately reflects the organisation's approach, achievement and challenges.

7.2.2 Appendix 2 gives more detail on the questions that will provide assurance on mortality processes.

7.3 **Board of Directors**

7.3.1 The Board should ensure that the organisation:

i has an existing Board-level leader to take responsibility for the learning from deaths agenda and an existing Non-Executive Director to take oversight of progress;
ii pays particular attention to the care of patients with a learning disability or mental health needs;
iii has a systematic approach to identifying those deaths requiring review and selecting other patients whose care they will review;
iv adopts a robust and effective methodology for case record reviews of all selected deaths (including engagement with the LeDeR programme) to identify any concerns or lapses in care likely to have contributed to, or caused, a death and possible areas for improvement, with the outcome documented;
v ensures case record reviews and investigations are carried out to a high quality, acknowledging the primary role of system factors within or beyond the organisation rather than individual errors in the problems that generally occur;
vi ensures that mortality reporting in relation to deaths, reviews, investigations and learning is regularly provided to the Board. The reporting should be discussed at the public section of the Board level with data suitably anonymised;
vii ensures that learning from reviews and investigations is acted on to sustainably change clinical and organisational practice and improve care, and reported in the annual Quality Account;
viii shares relevant learning across the organisation and with other services;
ix ensures sufficient numbers of nominated staff have appropriate skills through specialist training and protected time as part of their contracted hours to review and investigate deaths;
x offers timely, compassionate and meaningful engagement with bereaved families and carers in relation to all stages of responding to a death;
xi acknowledges that an independent investigation (commissioned and delivered entirely separately from the organisation(s) involved in caring for the patient – Level 3 Independent Investigation in keeping with Mersey Care Policy Management and Review of Adverse Incidents SA03) may in some circumstances be warranted, for example, in cases where it will be difficult for an organisation to conduct an objective investigation due to its size or the capacity and capability of the individuals involved; and,
xii works with Commissioners to review and improve their respective local approaches following the death of people receiving care from their services. Commissioners should use information from providers from across all deaths, including serious incidents, mortality reviews and other monitoring, to inform their commissioning of services. This should include looking at approaches by providers to involving bereaved families and carers and using information from the actions identified following reviews and investigations to inform quality improvement and contractual performance indicators etc.

7.4 Associate Medical Director – Learning Reviews

i The post holder will provide medical oversight and knowledge in relation to all stages of the review process to ensure that there is appropriate and proportionate scrutiny of medical practices, working closely with the Mortality and Incident Review Practitioners to ensure the quality of reviews.
ii They will also act as vice chair for the Mortality Review Group and provide a medical perspective on the strategic development of the mortality review process.
iii They will ensure that the Medical Director is kept up to date with progress regarding the implementation of this policy and on any individual safety issues that require the Medical Director's attention.
iv Where appropriate they will lead specific investigations that require medical leadership to ensure that they are conducted with sufficient rigor.
v They will promote cross organisational learning via Mortality Review Groups in neighbouring NHS organisations

7.5 Director of Patient Safety

7.5.1 This role is responsible at an operational level for the implementation of agreed policies and procedures on the management of mortality within the Trust which includes Duty of Candour. They will collate reports on behalf of the Mortality Review Group and share them with the Trust Board and its sub committees. They are responsible for raising risks and trends with appropriate Executives to ensure that appropriate remedial actions can be put in place. Additionally risks and trends will be shared with appropriate Groups and Committees to inform clinical services including;

a. Themes identified
b. Learning points and actions taken
c. Outcomes of thematic reviews

7.6 Quality Assurance Committee

7.6.1 This group will receive information on a bi-monthly basis on the number and types of deaths that have occurred, using the Trust's agreed dashboard which will include information on: -

a) Number of deaths occurred.
b) Age range
c) Service Line.
d) Type of review conducted.
e) Avoidability scores.
f) Evidence of good and poor care
g) Equality information

7.6.2 The committee will consider the data provided and request further assurances on the processes used and learning identified, where this is needed.

7.7 Divisional Safety Huddle Meetings

7.7.1 Each Safety Huddle meeting will consider the deaths that have occurred in their division and identify what initial safety action needs to be put in place. They will monitor the number and type of deaths that are occurring, to identify any trends and

themes, sharing these findings with the Mortality Review Group as well as

considering available data to identify if there are other concerns about the teams / services involved.

6.7.2 Divisional Safety Huddles will also identify areas for improvement and share learning within the division and its teams. The identified areas will also be discussed at the mortality review group meetings as and when necessary.

7.8 Chief Operating Officer

7.8.1 The post holder will be responsible for ensuring that appropriate staff within their division attend the Mortality Review meeting and are sufficiently knowledgeable and have the capacity to participate fully in meetings and follow through on actions required. They are also responsible for having divisional governance systems in place which will monitor the implementation of actions following individual and thematic mortality reviews (see appendix 3).

7.9 Mortality Review Group (Appendix 4)

7.9.1 The Mortality Review Group will be chaired by the Medical Director and the vice chair will be the Associate Medical Director – Learning Reviews or Director for Patient Safety.

7.9.2 The Mortality Review Group will: -

i Provide assurance to the Trust Board on patient mortality based on review of care received by those who die

ii Agree and approve the mortality review screening proforma and Structured Judgement Review methodology

iii Review Mortality audit data and action plans

iv Identify areas of high risk and agreeing and monitoring improvement plans

v Identify themes and trends and commission appropriate thematic reviews ensuring that protected characteristics are considered

vi Ensure that feedback and learning points are shared with the divisions / specialties so that learning outcomes and action points are included in audit programmes as appropriate.

vii Lead on sharing learning across the Trust

viii Proactively work with Mortality Review Groups of neighbouring NHS Organisations to improve understanding and learning.

7.10 Mortality and Incident Review Practitioner Team

7.10.1 The team comprises of a minimum of 4 clinical practitioners whose duties include:

i Daily monitoring and cross reference of deaths reported via the Trust's risk

management and clinical records system.

ii Completion of Mortality Screening Tool on the Trust's risk management system.

iii Completion of Structured Judgement Reviews

iv Completion of Root Cause Analysis Reviews

v Ensuring Duty of Candour responsibilities are undertaken

vi Ensuring that patients' families and carers are given an opportunity to be engaged with the review process, including providing feedback on the outcomes of the review as appropriate.

vii Ensuring that all pertinent cases and findings from reviews are presented to the Mortality Review Group.

viii Ensuring that outcomes and learning from reviews are recorded and action plans for improvement are developed where required

ix Ensuring that findings are evaluated and reported to divisional governance meetings to promote learning

x Overseeing progress on the implementation of action plans and keeping governance informed.

xi Take the lead on the completion of any thematic reviews.

xii Collation and production of mortality data to the Quality Assurance Committee and Mortality Review Group. This data should include: -

(a) the total number of the Trust's deaths and
(b) how many deaths were judged more likely than not to have been due to problems in care.

7.11 LeDeR (Learning Disabilities Mortality Review programme)

7.11.1 The Trust will fully participate with the national learning disabilities deaths review programme.

7.11.2 Learning from the LeDeR programme will be presented at the Mortality Review Group meetings on a quarterly basis and learning disseminated.

7.12 Public Health Institute at John Moores University Drug related deaths panel

7.12.1 The Trust will fully participate with the national learning from drug related deaths by reporting all deaths of service users to Public Health England via the Public Health Institute at John Moores University as agreed.

7.12.2 The feedback from the review of such deaths will be presented on a quarterly basis by a representative from Mersey Care's drugs and alcohol service, at the Mortality Review Group meetings to ensure that learning is shared and disseminated.

7.13 Review of Child deaths and the CDOP process

7.13.1 The Trust will fully participate with the requirements of the Child Death Overview Panel

process for reporting of child deaths as an agreed national procedure for oversight of all child deaths. Trust Policy (SD13) Safeguarding and Protection of Children details the arrangements in place.

7.13.2 The feedback from the review of child deaths will be managed by the Safeguarding team through the established format already in place and detailed in the Safeguarding Policy. The Safeguarding team will share any learning including cross divisional learning through their existing processes.

8 PROCESS

The process for the conduct of mortality reviews is outlined in the flow chart, appendix 5. Key steps are described below: -

Step 1 – Initial Screening

8.1 All deaths will be reported to the Mortality and Incident Review Practitioner via the Trust's risk management system.

8.2 Mortality reviews are completed:

i. If the patient had contact with mental health services within a 6 month period prior to their death
ii. if the patient had contact with community physical health clinical services within the 30 days prior to their death

8.3 If the patient did have contact within the parameters set out in 8.2 above then the Mortality and Incident Practitioner will use a Mortality Screening Tool to complete an initial review of the care provided to the patient. This will be done using the clinical notes and any other current information available at the time for example post mortem/inquest results.

8.4 Each screening where possible will consider whether factors have been identified that affected the service user's death.

8.5 The following Care Score will be given:

1 - Very poor care
2 - Poor care
3 - Adequate care
4 - Good care
5 - Excellent care

8.6 If Score 1 or 2 is indicated a Structured Judgement Review will be undertaken and Step 2 will be commenced. This will be recorded on the Trust's risk management system (i.e. Datix).

8.7 If Score 3, 4 or 5 is indicated the incident will require no further action and this will be recorded on the Trusts risk management system (Datix). Identified themes or learning will be shared with the relevant teams.

Step 2 – Structured Judgement Review Methodology

8.8 The Structured Judgement Review process will be used on all incidents that have received an initial screening care score of 1 or 2.

8.9 This will be facilitated within a 30 day period by the Mortality and Incident Review Practitioner and must involve a consultant psychiatrist or General Practitioner and other senior clinician/s as appropriate to the patient's care pathway prior to death.

8.10 To ensure objectivity, review of case records and other sources of evidence should, wherever possible be conducted by clinicians other than those directly involved in the care of the deceased. If the specific clinical expertise required only resides with those who were involved in the care of the deceased, the review process should still involve clinicians who were not involved in order to provide peer challenge.

8.11 If Care Score 1 or 2 is still indicated following completion of the 1st stage then the 2nd Stage of the Structured Judgement Review should be undertaken. This will involve making a decision about whether death was avoidable or not using the following scale: -

1. Definitely Avoidable
2. Strong Evidence of Avoidability
3. Probably Avoidable
4. Possibly Avoidable but not very likely (Less than 50/50)
5. Slight Evidence of Avoidability
6. Definitely Not Avoidable

8.12 If Score 1, 2 or 3 is indicated this should be escalated immediately to the Director of Patient Safety, the appropriate Divisional Service Manager and a STEIS (Strategic Executive Information System) report should be considered if appropriate.

8.13 At this stage immediacy of actions should be considered to prevent any potential of further harm. The Trust risk assessment procedure (HS1) should be utilised to guide this decision and further actions.

8.14 This should be recorded on the Trusts risk management system. Step 3 should then be undertaken when the incident is considered a serious adverse incident.

8.15 If Score 4, 5 or 6 is indicated an action plan for improvement and further learning should be considered if appropriate and the incident closed. This should be recorded on the Trusts risk management system ensuring a full rationale for the decision not to review any further.

Step 3 - Root Cause Analysis Review

8.16 A full Root Cause Analysis (RCA) Review should be commenced according to Trust policy and procedure. The Trust policy on Being Open which includes Duty of Candour should be fully implemented. This should be recorded on the Trusts risk management system.

9 FAMILY ENGAGEMENT

9.1 The Trust will engage meaningfully and compassionately with bereaved families and carers in relation to all stages of responding to a death and operate according to the following key guiding principles (as set out in 'Learning from deaths - Guidance for NHS Trusts on working with bereaved families and carers – National Quality Board, July 2018) by ensuring that they: -

i are treated as equal partners following bereavement.

ii always receive a clear, honest, compassionate and sensitive response in a sympathetic environment.

iii receive a high standard of bereavement care which respects confidentiality, values, culture and beliefs, including being offered appropriate support. This includes providing, offering or directing people to specialist suicide bereavement support.

iv are informed of their right to raise concerns about the quality of care provided to their loved one.

v help to inform decisions about whether a review or investigation is needed.

vi receive timely, responsive contact and support in all aspects of an investigation process, with a single point of contact and liaison.

vii are offered the option to be partners in an investigation to the extent, and at whichever stages, that they wish to be involved, as they offer a unique and equally valid source of information and evidence that can better inform investigations.

viii who have experienced the investigation process should be supported to work in partnership with the Trust in delivering training for staff in supporting family and carer involvement where they want, to enable being open and honest about care .

10 GOVERNANCE AND OVERSIGHT

10.1 Data will be shared on mortality management at each of the Quality Assurance Committee's meetings, this will be included as part of the Safety Report. It will include the number of deaths that have occurred (across age groups, causes of death, protected characteristics and those identified as avoidable/unavoidable) and the number reviewed at each stage of the Trust's process: -

a) Screening
b) Structured Judgement Review
c) Root Cause Analysis Review
d) LeDeR reviews and feedback
e) Deaths of those with Drug and Alcohol related deaths

10.2 Learning points will be highlighted within the report and any actions taken to mitigate risks and prevent further deficits occurring. The minutes of this meeting are then shared with the Trust Board.

10.3 The Lead Executive and Non-Executive Directors will ensure that the above reports are provided to a high standard and that any actions emanating from the meetings are undertaken with the agreed timescale.

10.4 The Trust will provide a summary of findings within in its Quality Report from June 2018 as per national guidance.

11.0 CONSULTATION

11.1 The following staff / groups were consulted with the development of this policy document:

1. Mortality Review Group
2. Patient Safety Committee
3. Patient/Carer Forum
4. Divisional Senior Management Teams
5. Mazars UK
6. Equality and Human Rights Officer
7. Independent Patient Carer Representative
8. Director of Clinical Improvement and General Practitioner
9. Patient Advisory Liaison Officer

12 TRAINING AND SUPPORT

12.1 No specific training is required for the implementation of this policy. A plan to raise awareness about the policy and its impact will need to be developed and rolled out.

12.2 The Trust will ensure that staff involved in mortality reviews will have appropriate skills through specialist training and protected time under their contracted hours to review and investigate deaths to a high standard. The Mortality and Incident Practitioners will have training for their Duty of Candour role, which will provide them with a specific understanding of how to address different cultural requirements and beliefs. This will also include an understanding of possible relationship differences in relation to sexual orientation and transgender. - This will include a definition for the understanding of culture which extends to communities such as LGBT.

13 MONITORING COMPLIANCE

Standard/process/issue	Method of monitoring/ audit	By	Committee/Group	Frequency
Surveillance of Mortality data	Report (dashboard) detailing current mortality data according to NHS England guidance	Patient Safety Director	Trust Board / Quality Assurance Committee / Mortality Review Group	Monthly
Screening Tool Quality	Completed Screening Tool	Mortality Review Practitioners		
Quality &Timely Completion of Structured Judgement and RCA Reviews	Completed report	Mortality Review Practitioners	Mortality Review Group	Monthly

14 REFERENCES

14.1 National Guidance on Learning from Deaths (March 2017), A Framework for NHS Trusts and Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care. National Quality Board

14.2 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.

14.3 Independent Review of Deaths of People with a Learning Disability or Mental Health Problem within Southern Health NHS Foundation Trust - Mazars December 2016.

14.4 National Mortality Case Record Review Programme – Royal College of Physicians 2016.

14.5 Valuing People: A New Strategy for Learning Disability for the 21st Century, Department of Health, 2001. LeDeR briefing paper

14.6 Learning from Deaths Guidance for Trusts (July 2018), Guidance for NHS Trusts on dealing with bereaved families and carer. National Quality Board.

Appendix 1

Glossary of Terms	Definition
Mortality Rate	The mortality rate (or death rate) is a measure of the number of deaths that occurred during a particular time period divided by the total size of the population during the same time frame. It is typically expressed in units of deaths per 1,000 individuals per year.
Mortality	For the purpose of Mortality Meetings, mortality relates to any death of a patient that had contact with the Trust within a 6 month period.
Avoidable/Preventable	These terms are used interchangeably in the NHS and for the purpose of this policy 'preventable' or 'unpreventable' will be used with reference to whether anything could have been done to change the outcome.
Summary Hospital – Level Mortality Indicator (SHMI)	The SHMI is a ratio of the observed number of deaths to the expected number of deaths for a provider and is the main mortality indicator reported nationally and is supported by the Department of Health. The observed number of deaths is the total number of patient admissions to the hospital which resulted in a death either in-hospital or within 30 days post discharge from the hospital. The expected number of deaths is calculated from a risk adjusted model with a patient case-mix of age, gender, admission method, year index, Charlson Comorbidity Index and diagnosis grouping.
Hospital Standardized Mortality Ratio (HSMR)	This is a methodology developed by Dr Foster to compute the risk of death for hospital patients on the basis of clinical and hospital characteristic data. It is a ratio of the observed number of in-hospital deaths at the end of a continuous inpatient spell to the expected number of in- hospital deaths (multiplied by 100) for 56 specific Clinical Classification System (CCS) groups; in a specified patient group.
Structured Judgment Review	Produced by the Royal College of Physicians. The Structured judgement review blends traditional, clinical-judgement based review methods with a standard format. This approach requires reviewers to make safety and quality judgements over phases of care, to make explicit written comments about care for each phase, and to score care for each phase. The result is a relatively short but rich set of information about each case in a form that can also be aggregated to produce knowledge about clinical services and systems of care.
Expected Death	Those whereby the General Practitioner/ Consultant/Medical Officer concerned has diagnosed the patient as suffering from a terminal illness and has been seen by a registered medical practitioner within the previous 14 days and is not a case reportable to the coroner (in the community the registered medical practitioner is

	usually the patients own GP)
Unexpected death	This term is specifically used when deaths occur in unexplained or suspicious circumstances.
LeDeR	The Learning Disabilities Mortality Review Programme was set up as a result of one of the key recommendations of the Confidential Inquiry into premature deaths of people with learning disabilities (CIPOLD). CIPOLD reported that people with learning disabilities three times more likely to die from causes of death amenable to good quality healthcare than people in the general population. The LeDeR Programme (2015-2018) is run by the University of Bristol and commissioned by the Healthcare Quality Improvement Partnership (HQIP) on behalf of NHS England.
John Moores University/Public Health Institute	The Public Health Institute (PHI) specialises in applied research and educational programmes addressing health issues at all levels from policy development to service delivery. PHI is committed to a multidisciplinary approach to public health and works in partnership with health services, local authorities, judicial bodies, environmental services and community groups.
Regulation 20: Duty of Candour	A regulation within the Health and Social Care Act 2008. The intention of this regulation is to ensure that providers are open and transparent with people who use services and other 'relevant persons' (people acting lawfully on their behalf) in general in relation to care and treatment. It also sets out some specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong.
Oxford Model Event	These are sessions that are facilitated by the Division in association with the Director of Patient Safety. It is aimed at sharing either one incident or a group of similar incidents with staff. Attendees will be provided with the chronology of events and then will work on identifying the issues or concerns and actions to prevent a re-occurrence. Staff should be invited who will be able to take learning back to their place of work and effect changes.
Dare to Share Event	These sessions are normally scheduled for a day and will focus on one issue that the Trust recognises as being a concern; they can be identified from within the organisation or following the publication of a national report. They will usually focus on a board topic area and not on one or two individual service users they will though where possible always be service user focused and aimed at identifying any future changes to practice required.
Quality Practice Alert (QPA)	These are alerts that are shared across the organisation via electronic communication. The issues raised usually emanate from adverse incidents including safeguarding incidents,

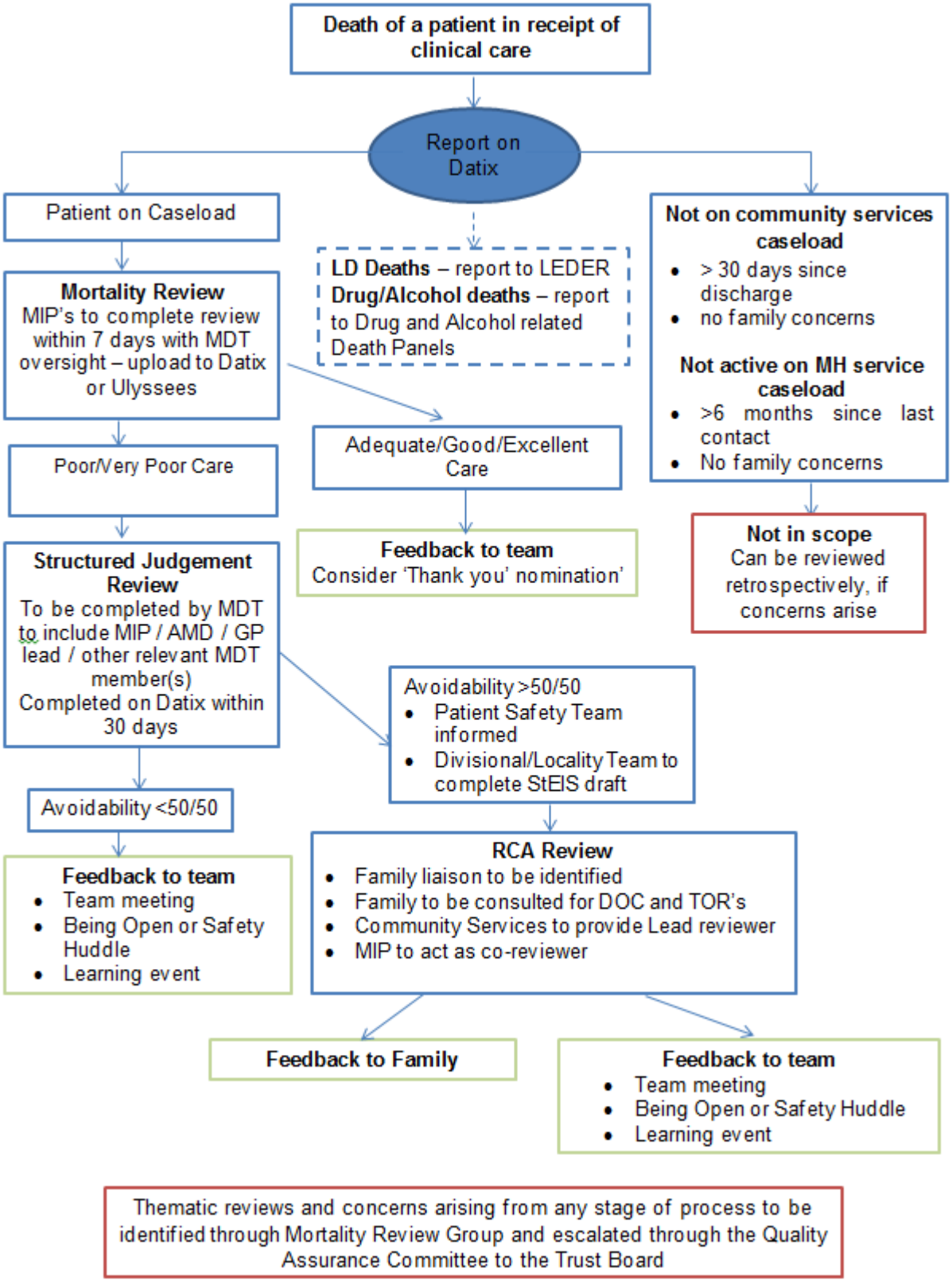
	complaints or claims but not exclusively. It is important to note that this process will be used to disseminate and monitor the response to Safeguarding alerts.
Cumulative Review	In order to prevent issues from being considered in isolation and common trends from being missed, investigation reports and action plans will be reviewed collectively by Trust on a six monthly basis. A more collective approach can help to make the delivery of multiple action plans more manageable and can also help inform wider strategic aims.
News Letters	Each division will share learning from incidents via a monthly newsletter to all staff.

Appendix 2

Questions for a Board Assurance Framework focussing on reducing unexpected deaths and improving investigation	
Do we identify and report deaths correctly?	Do we investigate unexpected deaths properly and without delay?
How many deaths are there amongst our service users? How do we know our data is accurate/consistent and comparable How many of our inpatients die? Where and how do our service users die? How do we identify unexpected deaths correctly? How do we report unexpected deaths as incidents?	How so we know we are making the right decisions at IMA stage? How do we know we are investigating the right cases? What is the quality of our investigations? How do we know our quality review processes adequate? How do we know if we have any delays in completing investigations? How do we know if we working with other agencies well? How do we know we are informing other agencies when we are concerned about a case in their care?
Do we meet our obligations to others?	Do we learn from deaths?
How do we know how many of our service users in detention die? Have we reported and investigated all deaths in detention and how do we know this is accurate? Have we reported appropriate deaths to NRLS in line with Trust policy and best practice and how do we know this is accurate? How many deaths require our involvement with the coroner and are we meeting accepted standards? How many deaths require an inquest? How do we know we are providing the right information to the inquest? How many SIRIs are being signed off? How many are outstanding? How do we know? Have we met our obligations to inquests and are we reporting our deaths in accordance with guidance? Are we meeting our safeguarding obligations? How do we know?	What are the causes of deaths? What do our investigations tell us about our services? What themes are arising and are we refining our services as a result? What learning is there? How is it shared? How is it monitored? How do we know we are making changes to help prevent future deaths?
Are we being transparent and open in our reporting and investigating?	
Are we involving families in the right way? How do we know? Why are families not involved in our investigations? How can we improve involvement? What is best practice for family involvement and do we meet it? Has the coroner commented on our services or our investigations? How do we know we've responded properly? Is it clear what we mean when we report unexpected deaths in our Annual Report?	

Appendix 3

Flowchart – Mortality Review Process



Appendix 4

Mortality Review Group

Terms of Reference

Duties

The Mortality Review Group will consider all deaths that occur to patients being treated by Mersey Care NHS Trust.

- Set up a system to collect and analyse Trust mortality data.
- Identify themes that require further exploration i.e. in relation to areas where deaths occur, causes of death and ages of death.
- Commission specific in-depth reviews of potential trends.
- Share information based on specific cases to prevent similar incident reoccurring.
- Consider best practice in the care pathways used nationally to prevent the unexpected/early deaths of people and its implications for practice in the Trust.
- Consider whether protected characteristics have influenced quality of care
- Regular communication of findings and work streams with clinical services using existing structures.
- Facilitate the learning of information across the Trust of preventative measures using:
    - Clinical updates
    - Existing education forums
    - Holding annual Mortality Learning Events

Membership

- Chair – Medical Director
- Associate Medical Director – Learning Reviews (Deputy Chair)
- Director of Patient Safety (Deputy Chair)
- Divisional Risk Managers
- Divisional Clinical Leads
- Legal Advisor
- Suicide Lead
- Involvement of a clinician representative from our services for specific work streams as required e.g. Lead Nurse from Alcohol Services.
- Mortality and Incident Review Practitioners.

Quorum

A quorum shall be three members including the Chair or Deputy Chair.

Meeting Frequency

Every three months.

Reporting

The minutes of the committee meetings shall be formally recorded and submitted to the Medical Director.

i. Any issues that require(d) disclosure to the Trust Board via exception reporting.
ii. Key risks identified through the work of the committee which are recommended for inclusion in the Corporate Risk Register and/or Board Assurance Framework.

The outcomes of the committee will be formally reported to the Medical Director by means of an annual report. The Deputy Chair is responsible for the development of the annual report.

Other Matters

The group will as a minimum annually review its Terms of Reference and will ensure that the committee is able to report to the Medical Director and through it to the Board, significant risks or other issues of concern.

Date of Review

The Terms of Reference are to be reviewed annually. Date of next review is September 2019.

Mersey Care NHS Trust

Mortality Review Screening Tool

To be completed for all deaths within the Trust with the exception of potential suicide cases. All Learning disability deaths will be subject to LeDeR programme regardless of phase of care score.

Name of Patient **Date of Birth** **Age**

Home Address Post Code **GP** *(list name & post code)*

Web Number **Epex Number**

Date of Death **Place of death**

Diagnosis **Legal Status** **Consultant**

Date last seen by service:

Cause of death (taking all information into account including PM)

1a 1b

1c 11

Primary Carer at time of death

NHS Trust (please specify) GP Residential Home

Nursing Home Family Unknown

Other (please specify)

1. **Trigger Questions** *(please indicate by using X)*

Question	Yes	No	N/A	N/K	Comments
Was the death preventable?					
Was incident reported on both risk management and clinical records system?					
Is there evidence of a Care Plan/Statement of Care in place?					
Is there evidence of a current risk assessment in place?					
Was there a delay in diagnosis/assessment?					
Was there a delay in initiating treatment?					
Was the deterioration in the patient recognised and responded to in a timely manner? Use of MEWS/NEWS?					
If signs of SIRS (systematic inflammatory response syndrome) were actions initiated?					
Were there sufficient medical/nursing intervention reviews at agreed time intervals?					

Was there incorrect or misinterpretation of information?					
Did the care management deviate from the policy / good practice guidance?					
Was there a complication due to treatment /procedure/operation?					
Was there a medication error?					
If history of falls – was a FRAT undertaken?					
Was there evidence of adequate Clozapine monitoring?					
Was there a lack of or misuse of equipment?					
Was there a delay in accessing appropriate resources / assistance to treat the patient?					
Was documentation completed to acceptable Trust standard?					
Were the family fully involved in the patients care?					
Have the family at this stage raised any concerns?					
Is there evidence of liaison with primary care colleagues?					
If difficulties swallowing - was a SALT referral made?					
All safeguarding issues were identified and acted upon?					
Was an annual health check carried out?					

If **RED** to any of the above please complete section 2 below if further learning is required.

2. Learning points and actions

Concern/Problem	Solution	Person Responsible	Date Due	Completed date

3. **Phase of Care Score** *(please circle)*

Based on a review of the trigger questions above the overall score for the level of care is:

	Very Poor Care – 1st Stage Structured Judgement Review is required within 10 days
	Poor Care - 1st Stage Structured Judgement Review is required within 10 days
	Adequate Care – No further action required.
	Good Care – No further action required.
	Excellent Care – No further action required.

1st Judgement Review to be undertaken by:	

Organisation if not MCT:	
Date required by:	
2nd Judgement Review required:	**Yes / No**
Date required by:	
Avoidability Death Scale:	**1 2 3 4 5 6**
Thematic Review Category:	**Clozapine Physical Health Drugs and Alcohol Learning Disability**
Death Category: *please tick*	
	Expected Natural (EN1*) – deaths that were expected to occur in an expected timeframe e.g. terminal illness. Unlikely to be preventable – no further investigation needed.*
	Expected Natural (EN2) – *deaths that were expected but not expected to happen within timeframe e.g. cancer or liver cirrhosis but dies earlier than anticipated - may be preventable – some would benefit from investigation.*
	Expected Unnatural *EU – deaths that are expected but not from the cause expected or timescale e.g. misuse of drugs, alcohol dependant, eating disorder – likely to be preventable should consider further investigation.*
	Unexpected Natural (UN1) – *death from a natural cause e.g. sudden cardiac condition, stroke – may have been preventable – may need further investigation.*
	Unexpected Natural (UN2) – *death from natural cause but didn't need to be e.g. Alcohol, and drug dependency, care concerns – likely to be preventable – consider further investigation.*
	Unexpected Unnatural (UU) – *suicide, homicide, abuse/neglect – preventable - needs investigating.*

Please justify in point form the reasons why no further investigation is required:

For example

- *Expected death*
- *Care Score 3*
- *No learning points identified*

Review completed by: **Date:**

Appendix 7

Structured Judgement Case Note Review Method

Adapted from: The Royal College of Physicians 2016 – National Mortality Case Record Review Programme: *Using the Structured Judgement Review Data collection form*

Guidance

Main aim and objectives when completing this document:

1. **To make clear safety and quality Judgements over phases of care**
2. **To make clear explicit written comments about care for each phase**
3. **To look for strengths and weaknesses in the caring process**
4. **To provide clear information about what can be learnt from systems where care goes well**
5. **To identify points where there may be gaps, problems of difficulty in the care process**
6. **To provide a clear commentary that other health professionals can readily understand if they subsequently look at this completed review.**

Please remember:

An important feature of this method is that the quality and safety of care is judged and recoded whatever the outcome of the case, and good care is judged and recorded in the same detail as care that has judged to be problematic. Evidence shows that most care is of good or excellent quality and that there is much to be learned from the evaluation of high quality care.

Examples of phase of care structured Judgement comments:

- ***Continued omission to provide medication at prescribed times – poor care.***
- ***There was evidence of family and social work involvement at every MDT meeting – good care.***
- ***Although patient discussed with consultant once and a specialist registrar once, for 4 days they were only seen by a junior doctor – this is completely unsatisfactory.***
- ***Regular dysphagia reviews took place.***

Examples of overall care structured Judgement comments:

- ***Overall, a fundamental failure to recognize the severity of this patients self harming behavior***
- ***Good multi disciplinary team involvement throughout admission.***
- ***On the whole, good documentation of clinical findings, investigation results, management plan and discussion with other teams.***
- ***Poor practice not to be aware that diazepam should not have been prescribed on discharge especially when this was clearly agreed with the patient and community team at the last MDT.***

Please enter the following:

Age at death (years):

Sex: M/F

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

Day of admission:

Time of admission:

Day of death:

Time of death:

Number of days between admission/ last contact by Trust and death:

Month cluster during which the patient died:

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

Specialty team at time of death:

1 - Complex Care, 2 – Specialist LD, 3 – Assessment Services, 4 - AMH Service (Community), 5 - Specialist Service, 6 – High Secure Services, 7 - AMH Inpatient.

Type of admission: 1 – Inpatient, 2 – Outpatient,

Recorded cause of death:

1a **1b**

1c **2**

Risk factors

Did the patient have a learning disability?

1. No indication of a learning disability – proceed with this review.
2. Yes – clear or possible indications from the case records of a learning disability. Action: after your review, this will go forward to the Learning Disability Mortality Review Programme.

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 & Involvement of Family / Significant Others**

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: **Physical Health 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: **Medication Management** ***(please specify if any clozapine issues)***

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: **Inter/agency team working and communication** *(this should include links with alcohol services, Talk Liverpool, GP and acute services and number of transfers of the patient between services)*

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 (if appropriate)**

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.

Implicit structured case note review data collection sheet

Phase of care: **Overall assessment**

Please record your explicit Judgements about the quality of care the patient received overall and whether it was in accordance with current good practice (for example, your professional standards). 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 overall 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)

Problem types:

1. **Problem in assessment, investigation or diagnosis?**
   Yes ☐ **No** ☐
   Did the problem lead to harm? **No** ☐ **Probably** ☐ **Yes** ☐

2. **Problem with medication?**
   Yes ☐ **No** ☐
   Did the problem lead to harm? **No** ☐ **Probably** ☐ **Yes** ☐

3. **Problem related to treatment and management plan?**
   Yes ☐ **No** ☐
   Did the problem lead to harm? **No** ☐ **Probably** ☐ **Yes** ☐

4. **Problem access to other therapies?** (Psychology, O.T)
   Yes ☐ **No** ☐
   Did the problem lead to harm? **No** ☐ **Probably** ☐ **Yes** ☐

5. **Problem related to transfer of care?**
   Yes ☐ **No** ☐
   Did the problem lead to harm? **No** ☐ **Probably** ☐ **Yes** ☐

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

7. **Problem in resuscitation following a cardiac or respiratory arrest?** (including cardiopulmonary resuscitation (CPR))
   Yes ☐ **No** ☐
   Did the problem lead to harm? **No** ☐ **Probably** ☐ **Yes** ☐

8. **Problem of any other type not fitting the categories above?**
   Yes ☐ **No** ☐
   Did the problem lead to harm? **No** ☐ **Probably** ☐ **Yes** ☐

Avoidability of death Judgement score (only at second-stage reviews)

We are interested in your view on the avoid ability of death in this case. Please choose from the following scale.

Score 1 Definitely avoidable

Score 2 Strong evidence of avoid ability

Score 3 Probably avoidable (more than 50:50)

Score 4 Possibly avoidable but not very likely (less than 50:50)

Score 5 Slight evidence of avoid ability

Score 6 Definitely not avoidable

Please explain your reasons for your judgment of the level of avoidability of death in this case, including anything particular that you have identified.

Appendix 8

Equality and Human Rights Analysis

Title:	Learning from Deaths Policy
Area covered: Mortality review of patients who die under MCT care	

What are the intended outcomes of this work? To ensure the Trust meets it legal, contractual, ethical and moral obligation to review and learn from deaths occurring to patients under its care
Who will be affected? All people who die within 6 months of receiving care from MCFT as indicated by the policy

Evidence
What evidence have you considered? National guidance relating to mortality reviews and related matters
Disability (including learning disability) All relevant patients are to be considered for review regardless of disability
Sex Noted data re sex is included in demographic information See cross cutting.
Race Noted Race is not included in demographic information Noted culture is included in the family engagement. See cross cutting
Age Noted data re age is included in demographic information See cross cutting. The appropriate reporting pathway will be invoked for any one under the age of 18 years.
Gender reassignment (including transgender) Noted Transgender is not included in demographic information See cross cutting

Sexual orientation Noted sexual orientation is not included in demographic information See cross cutting
Religion or belief Noted some inclusion re the need to understand culture and belief within family engagement See cross cutting
Pregnancy and maternity See cross cutting
Carers Family engagement is included within the policy. See cross cutting
Other identified groups See cross cutting
Cross Cutting 6.7 and 6.11 this needs to include an action to understand any inequality /discrimination issues and to complete analysis of data re protected characteristics at least annually. For this to be included in annual reporting to committees and board. 7.11 for analysis re protected characteristics to be completed at a minimum of annually for scores of 4, 5 and 6. For this to be included in annual reporting to committees and board. 8 to include a requirement for people who do family engagement to have training and specific understanding re addressing different cultural requirements and beliefs. This also includes an understanding of possible relationship differences in relation to sexual orientation and transgender. - This could include a definition for the understanding of culture which extends to communities such as LGB and T. 9.1 and 9.2 To include the requirement that any data shared will include protected characteristics at a minimum annually. Appendix 2 To include Obligation to meet the Public Sector Equality Duty from the Equality Act- this will in box – **identification** add thematic analysis re protected characteristics **investigation** add need to investigate where inequalities may have occurred or discrimination that has led/ been a factor in the death. Appendix 4

TOR
To include requirements of the Public Sector Equality Duty from the Equality Act- data analysis re protected characteristics and identifying where inequalities or discrimination may have been a significant factor.

Appendix 7 and 8
This does not include a full range of equality data – is this found from other sources- should this be included within this form?

Human Rights	**Is there an impact?** **How this right could be protected?**
Right to life (Article 2)	The policy needs to indicate in purpose and rationale the understanding that this process is supporting the trust to meet its duties in relation to protecting people's right to life. This also relates to the trust's responsibilities in relation to Duty of Candour by demonstrating that we are doing everything we should in relation to protecting life.
Right of freedom from torture, inhuman and degrading treatment (Article 3)	This policy ensures that we are meeting our obligations under Article 3
Right to liberty (Article 5)	This article is not engaged
Right to a fair trial (Article 6)	This policy provides the trust with a clear process to ensure we conduct a robust investigation and clear accountability into the deaths of all patients in its care.
Right to private and family life (Article 8)	This policy is conducive to a human rights based approach
Right of freedom of religion or belief (Article 9)	This policy is conducive to a human rights based approach
Right to freedom of expression **Note: this does not include insulting language such as racism (Article 10)**	This article is not engaged
Right freedom from discrimination (Article 14)	This article is not engaged

Engagement and Involvement
Section 11 with main policy document details consultation undertaken this includes staff within the Trust. This also includes patient/carer forum – this does not indicate which forum within the Trust. Also an independent carer representative- unclear what this means.
Summary of Analysis This policy has sought to ensure a thorough examination is undertaken in relation to the deaths of people who are within Mersey Cares services. This has not taken account of possible inequalities or discrimination which may have contributed. It has identified the need to have an understanding and respect for different cultural and beliefs within the family engagement process.
Eliminate discrimination, harassment and victimisation The policy has looked at issues that relate to Age and sex.
Advance equality of opportunity The policy has looked at issues that relate to Age and sex.
Promote good relations between groups This has not been identified as an issue.

Addressing the impact on equalities
There needs to be greater consideration re inequalities and the impact of discrimination on each individual and the Trusts responsibilities in relation to the public sector equality duties.

Action planning for improvement
To develop a detailed action plan and ensure it includes an effective governance process to support the implementation of positive actions.

For the record **Name of persons who carried out this assessment:** Margaret Brown - Equality and Human Rights Officer George Sullivan - Equality and Human Rights advisor Meryl Cuzak- Equality and Human Rights Lead
Date assessment completed: 25th August 2017
Name of responsible Director: Steve Morgan
Date assessment was signed:

Action Plan template

Category	Actions	Target date	Person responsible and their area of responsibility
Monitoring	• Reports on the implementation of national standards outlined with in the policy will be shared with the Board of Directors. Mitigation plans will be put in place if certain aspects of the policy cannot be implemented.	September 2017 and onwards	Director of Patient Safety
	• The Mortality Review Group will monitor the completion of all parts of this policy on a monthly basis.	September 2017 then monthly.	Chair of Review Group
	• The lead Non Executive Director will via regular oversight meetings review the impletion of the policy and its effectiveness.	November 2017	Non Executive Director – Mortality Lead
	• MIAA Audit will be requested to follow up on the audit that was undertaken in 2016.	September 2018.	Executive Lead -Executive Director of Nursing.
	• Bi Monthly reports to the Quality Assurance Committee (QAC) will contain data on the number of deaths reviewed and learning obtained.	September 2017 and onwards.	Director of Patient Safety.
	• Mazars an external specialist agency will provide guidance and oversight re the quality and effectiveness of the implementation.	September 2017 for a further 12 months.	Director of Patient Safety.

	• Attendance at national benchmarking groups will allow the processes used to implement national guidance to be monitored and amended to ensure that all standards are achieved. • Sharing required information externally will provide further monitoring of the implementation of national standards.	April 2017 and onwards. April 2018	Director of Patient Safety. Director of Patient Safety.
Engagement	• The Completed policy will be shared with each of the Clinical Division's via the Trust's Mortality Review Group. • Corporate leads will attend Divisional Governance meetings to share processes agreed. • Each of the Mortality and Incident Practitioners will link with specific clinical divisions to enable them to build up relationships with clinical leaders in the services.	September 2017 October 2017 and onwards. October 2017.	Chair of the Mortality Review Group Director of Patient Safety. Director of Patient Safety.
Increasing accessibility	• Mortality Learning events will be held within the Trust to share the work that has been undertaken in this area with a particular focus on learning. • Outcomes of the processes used will be incorporated into the learning newsletters for each division. • Each Morality and Incident Practitioner will be available to	March 2018 January 2018 October	Director of Patient Safety. Director of Patient Safety. Director of Patient Safety.

	discuss any aspects of the policy within their link area. • Each Mortality and Incident Practitioner will ensure that their contact details are available to appropriate clinical colleagues.	2017 October 2017	 Director of Patient Safety.
Impact Assessment	• Review the contents of the assessments to consider if they can have specific criteria included regarding possible inequalities or discrimination and their effect on the care given. • Include a section within the policy on the assessment of the key characteristics. • To use the Public Sector Equality Duty from the Equality Act- data analysis re protected characteristics on at least a six monthly basis and identify where inequalities or discrimination may have been a significant factor.	October 2017 August 2017 January 2017	Director of Patient Safety Director of Patient Safety Director of Patient Safety