# Mortality Review Policy

**Classification:** Policy  
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**Authors Division:** Corporate  
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**Group Arrangements:** Salford Royal NHS Foundation Trust (SRFT) Pennine Acute Hospitals NHS Trust (PAHT)

<table>
<thead>
<tr>
<th>What is this document for?</th>
<th>It sets out standards, roles and responsibilities for the Trust’s mortality review process.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Who needs to know?</td>
<td>The policy is aimed at Senior Medical (Care Organisation Medical Directors, Clinical Directors and Consultants) and Managerial staff (Board members, Care Organisation Directors and Directorate Managers).</td>
</tr>
</tbody>
</table>
| Related PAHNT Documents:  | PAHT & SRFT Mortality Review Strategy (EDQ043)  
Incident Reporting & Investigation Policy including Serious Incident Framework & Duty of Candour & Learning from Deaths (EDQ008)  
End of Life Care Strategy (under review)  
Care after Death (Adult) (EDN033)  
Process document for the Coding Mortality Validation Tool  
Bereavement Policy (in progress) |
| Related Legislation/ Obligations: | Care Quality Commission  
National Quality Board guidance  
SI Framework  
Royal College of Physicians’ guidance on methodology  
MBRRACE-UK: Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK  
Paediatric mortality review recommendations |
| Accountable Executive:   | Chief Medical Officer, Dr Chris Brookes |
| Document Author(s):      | Dr Tim Fudge, Consultant Intensivist (SRFT) Beverley Cook, Senior Programme Manager QI (PAHT) |
| Developed with:          | Matt Makin, NMGH Medical Director (MD with responsibility for PAHT mortality)  
Information and Coding Teams  
Mortality Surveillance Group  
Women’s and Children’s leads  
End of Life Care leads |
| Ratified by:             | Dr. Chris Brookes, Chief Medical Officer |
| Date Ratified:           | 21st September 2017 |
| Replaces:                | New policy |
| How is this different from the previous document? | Compliant with latest guidance from CQC and NQB  
Reflects new governance arrangements of the organisation |
| What dissemination & training arrangements have | This policy will be available via the Document Management System (also called the Policies & Documents page) of the Trust intranet. |
| been made? | It will be disseminated to Care Organisations (CO) by the nominated mortality leads through the CO Mortality Oversight Groups. |
| Review arrangements: | Review will be undertaken by the author or a delegated person every three years or earlier should a change in legislation best practice or other circumstance dictate. **Specifically, this policy will be reviewed after the role of Medical Examiner is defined and implemented in England** |
| Safety Arrangements: | Compliance and effectiveness of this policy will be monitored by Care Organisation Mortality Oversight Groups, which will monitor the numbers of cases reviewed, and that factors contributing to avoidable mortality identified and improvement actions are implemented. This policy will reduce avoidable mortality and lead to a reduction in the trust’s national mortality ratios (HSMR and SHMI). Staff experiencing difficulties with implementing this policy should contact their line manager. |
Who should read this document?

Clinical staff involved in the care and treatment of patients, or those who have managerial responsibility for staff or services which are involved in the care and treatment of patients. This will specifically apply to:

- Medical Consultants and all medical staff
- Registered Nurses (Including Bereavement Nurses)
- Allied Health Professionals
- All managers with responsibility for clinical services

Key Messages

This Policy sets out the standards and roles and responsibilities for the Trust’s...
Mortality Review Process which includes the following:

- How the review process will be conducted
- Who will be involved
- What methodology will be used
- Procedures for the escalation and investigation of any alerts received from the Care Quality Commission (CQC), Coroner, Dr Foster, HES or identified through the internal mortality monitoring information systems e.g. the internal Mortality Review Process (MRP)
- How monitoring of mortality will be undertaken including how assurance will be provided around the process
- Reporting and feedback arrangements within the Care Organisations and to the Board
- How learning will be disseminated

The policy is aligned to, and should be read in conjunction with, the Trust’s Quality Improvement Strategy 2017-20 of which, Aim 1 is that there should be ‘No preventable deaths.’

**Background & Scope**

In March 2017 the National Quality Board published the first edition of the National Guidance on Learning from deaths: A Framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care. Its purpose is to help initiate a standardised approach for learning from deaths across all healthcare organisations and providers and this policy is aligned to the guidance.

Measures of patient mortality are an important indication of the quality of care provided by hospitals and can be viewed by patients, members of the public, and regulators. They provide information on observed deaths, for both inpatients and patients cared for outside of the hospital, and help to measure if a hospital Trust is seeing an average, higher or lower than average number of deaths than expected among patients.

Mortality indicator statistics do not in themselves constitute evidence regarding the standard of care delivered and there is poor correlation with identifying avoidable deaths. It is therefore important to ensure that we can look at any preventable factors that contribute to them and put improvements and learning in place. As well as ensuring there are surveillance processes in place within the Trust to promptly and accurately record deaths, and to interrogate and understand mortality measures (also known as indices*), it is also important to ensure that there are independent clinical reviews of deaths within the Trust to accommodate for the complexity of modern healthcare.

*The mortality indices used within Pennine Acute Hospitals NHS Trust (PAHT) as part of Group are:

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

The Trust Mortality Review Process (MRP) is also aligned to the National Mortality Case Record Review (NMCRR) Programme which is a national collaborative project led by the Royal College of Physicians (RCP) in partnership with Yorkshire and Humber Academic Health Science Network’s (AHSN’s) Improvement Academy. It is commissioned by the Health Quality Improvement Partnership (HQIP).

The aim of the 3-year programme is to introduce a standardised methodology for reviewing case records of adult patients who have died in acute general hospitals in England and Scotland. The primary goal is to improve healthcare quality through qualitative analysis of mortality data using a standardised, validated approach linked to quality improvement activity.

Whilst the work of the NMCRR programme will not cover deaths that occur in other settings outside the Acute Trust at this stage, PAHT will continue to explore how the MSG can be introduced into other Trust services that fall outside this remit.

1. The Mortality Review Process

The Mortality Review Process is described at Appendix 1.

The following stages form the Trust mortality review process:

**Death Summary & Coding Form** - Appendix 2 (currently under development) must be completed by any clinician who treated the deceased within 24 hours of death. The death summary will be modified to help identify harms and problems in healthcare and promote earlier reporting via the existing Trust Datix Incident Reporting system. The Death Summary will be the first opportunity to notify the patient’s consultant via the Care Quality Review Document (see below) of the need for potential SJR review, including:

- registered learning disability
- serious mental illness
- sudden unexpected death (not anticipated in 24 hours preceding death)
- elective admission
- pregnancy (or within 42 days of the end of pregnancy regardless of outcome)
- children and minors under 18 years old
- any known concerns regarding the care of the deceased

The death summary will also include guidance for referral to the Coroner.

This review will also assist the Trust Coding Team to ensure that the most appropriate code is applied to submit this data, prior to uploading to the Secondary Uses Service (SUS), which is used by Dr Foster to determine the Trust’s mortality indices.

**Mortality Review/Screening Tool** – to be replaced by the Care Quality Review Document - Appendix 3 (currently under development to provide a paper based version of the EPR system) must be completed by the patient’s consultant within 7 working days of death. This remains the crucial foundation for all subsequent
learning from mortality within the organisation and ensures that the necessary specialist/departmental context remains at the heart of this process (see Appendix 1 and Appendix 4).

The aim of the tool is to improve the efficacy of mortality review with a strong emphasis on shared learning and improvement. The lead clinician will be informed when the document requires completing, through the mortality review reporting structure. (currently under development) There will be an opportunity to report harms and rate care from very poor (1) to excellent (5) with addition of qualifying statements to justify this conclusion across the patient care pathway which includes:

- Admission and initial management (first 24 hours)
- Ongoing care
- Procedural care (excluding IV cannulation)
- Peri-operative care
- End of life care processes in line with current NICE guidance

This will conclude with an overall care rating and a frontline judgement on whether the death was considered avoidable or not. Please note that this statement will not be final or conclusive at this stage.

If overall care is judged to be very poor or poor (score 1-2) and/ or the death judged as potentially avoidable it must then be reported in the Datix Incident Reporting system and will be forwarded for a second stage, independent Structured Judgement Review. (transitioning from current Mortality Review Process) It must be noted that if there are isolated areas of poor care, the reviewer may wish to report these via the Datix Incident Reporting system, review these with their departmental governance lead and the case be forwarded for SJR.

**Structured Judgement Review** (transitioning from current Mortality Review Process)

The independent Structured Judgement Review method Data collection form must be complete within 21 working days of death for those cases where the need for SJR is confirmed.

**What is the Structured Judgement Review methodology?**

It is a recognised methodology for reviewing casenotes and making explicit qualitative judgements to promote learning through thematic analysis. This approach has been supported by the National Guidance on Learning from deaths: A Framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care. It will use the data entered by specialists providing frontline care to offer an independent assessment on the overall processes of care quality provided. This will aim to be multi-disciplinary as there are multiple overlapping spheres of learning from an individual case.

The Structured Judgement Review tool is aligned to the National Mortality Case Record Review (NMCRR). The approach can be used for any patient pathway that has a defined endpoint or characteristic, e.g. cardiac arrest or end of life care. Therefore, it will be used to learn from mortality.
within the Trust and it can be applied to a number of different pathways if required.

The (SJR) 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 the Trust clinical services and systems of care.

The objective of the review method is to look for strengths and weaknesses in the caring process, to provide information about what can be learnt about the Trust systems where care goes well, and to identify points where there may be gaps, problems or difficulty in the care process. In order to answer these questions, there is a need to look at: the whole range of care provided to an individual; holistic care approaches and the nuances of case management; and the outcomes of interventions.

An important feature of the method is that the quality and safety of care is judged and recorded whatever the outcome of the case and good care is judged and recorded in the same detail as care that has been judged to be problematic.

**Using the Structured Judgement Review methodology**

The Trust will ensure that where a SJR is required a multidisciplinary review of the death will be undertaken using the SJR structured judgement review method Data collection form. Guidance for use of the SJR can be found at the following link: [Using the structured judgement review method - A guide for reviewers](#)

Within each division there will be a cohort of staff trained to undertake SJR. The multi-disciplinary review team will be made up of consultants/senior trainee medical staff, nurses and allied health professionals (AHPs) co-ordinated by the Divisional Clinical Lead for Mortality. Support will be provided where necessary by the Quality Improvement and Clinical Governance Teams.

The SJR provides an opportunity to take a broad look at the processes of care provided by the Trust and to identify defects and examples of excellence to share learning in a drive to relentlessly pursue higher quality care.

The SJR should involve the following people where necessary:

- A consultant with the requisite skill and knowledge, who must not be the named consultant for the patient and must not have been involved in the care or treatment of the patient;
- A lead nurse/ senior nurse who must not have been involved in the care or treatment of the patient; and
- A Care Organisation/Divisional Governance Manager where related adverse incident reports/SI activity
The following staff will be involved when it is has been identified that specialist skills or knowledge are required:

- A consultant anaesthetist for all surgical cases where the patient has been to theatres;
- A consultant intensivist where the patient has been cared for within ICU/ HDU;
- A senior AHP – pharmacist, physiotherapist, occupational therapist, biomedical scientist, etc.;
- A specialist advisor where indicated e.g. Head of Infection Prevention, Lead Nurse for Safeguarding, Resuscitation Officer, etc.

The SJR will conclude with an additional assessment to determine the potential avoidability of the patient’s death. This will include a score assigned for avoidability and a structured judgement comment. See Fig:

Fig.1
‘Avoidability of death scale’

<table>
<thead>
<tr>
<th>Score 1</th>
<th>Definitely avoidable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Score 2</td>
<td>Strong evidence of avoidability</td>
</tr>
<tr>
<td>Score 3</td>
<td>Probably avoidable (more than 50:50)</td>
</tr>
<tr>
<td>Score 4</td>
<td>Possibly avoidable, but not very likely (less than 50:50)</td>
</tr>
<tr>
<td>Score 5</td>
<td>Slight evidence of avoidability</td>
</tr>
<tr>
<td>Score 6</td>
<td>Definitely not avoidable</td>
</tr>
</tbody>
</table>

Example of a structured judgement commentary
Non-invasive ventilation management was sub-optimal, but ultimately it was the patient’s wish not to continue treatment. There may have been an alternative cause of breathlessness that was not fully explored or treated, which is why there may have been some avoidability.

Score 5 – slight evidence of avoidability

If is judged that there is >50% chance that the death was preventable (score of <=3) then this would be classified as a potentially avoidable death and should be subject to further investigation within the SI framework to ascertain degree of preventability and form a necessary action plan. If overall poor care is identified (score 1/2) this should similarly be referred (see Learning from review and investigation, Table 1). Isolated poor care should be reported via Datix Incident Reporting or overall care care score be weighted sufficiently to reflect the need for a 72hour review.

An overview of the mortality review process and reporting timeline is available in Appendix 4.

2. Mortality Governance

Any process that can potentially reveal harm must include integrated governance processes to ensure that appropriate levels of investigation are undertaken and that duplication does not occur i.e. separate reviews or investigations being undertaken for the same patient, but through different processes. This is particularly relevant...
where serious untoward incidents or complaints investigations may need to be undertaken or when an inquest is to take place.

The Mortality Review Process is an integral part of the Trust's clinical governance arrangements. It is therefore, essential that systems are aligned to ensure that staff are clear how the MRP links to other governance processes. The following will apply:

**Incident investigation**

The Trust processes for incident investigation are aligned to the NHS England Serious Incident Framework 2015.

Any death that occurs that has been declared a serious untoward incident (SI) or Serious Incident Action Review Committee Rated Incident (SIARC) must also undergo a SJR. The findings from this review will be used to support the Root Cause Analysis (RCA) investigation and the development of any recommendations and action plan.

Any SJR that is confirmed on the ‘Avoidability of death scale’ to be of a **score of \(<=3\) or overall care score (poor (1)/very poor(2))** must be reported in the Datix Incident Reporting system and escalated to the Head of Risk Management to be investigated as either a SI or SIARC. The SI or SIARC investigation process must then be followed and any findings or learning will be fed back and shared across the specialty as part of this process. The Trust process for investigation can be found in the Trusts Incident Reporting & **Investigation** Policy including Serious Incident Framework & Duty of Candour & Learning from Deaths (EDQ008 v7)

The final report and findings will also be shared with the family in line with the Duty of Candour process. See the Incident Reporting & Investigation Policy including Serious Incident Framework & **Duty of Candour** & Learning from Deaths (EDQ008 v7)

It should be noted that any complaint linked to a patient death must also undergo a SJR and will follow the same investigation process as described above.

**Inquests**

Any SJR linked to an inquest that is confirmed on the ‘Avoidability of death scale’ to be a **score of \(<=3\) (more than 50:50) or overall care quality score of 1-2** must be reported in the Datix Incident Reporting system and escalated via the 72 hour review process to be investigated through the Serious Incident (SI) framework. The Group Associate Director of Patient Safety must be informed where a patient death is being investigated as an SI or SIARC.

The final RCA report and findings will be shared with the family and HM Coroner.

It is recommended in the National Guidance on Learning from Deaths that providers should undertake a case record review following any linked inquest and issue of a “Regulation 28 Report on Action to Prevent Future Deaths” in order to examine the effectiveness of their own review process.
The inquest process is managed by the Group Associate Director of Patient Safety and all reports and information from the MRP must be submitted to them and the Legal Team prior to submission to the family and the coroner’s office, in order to support the preparation for inquest.

Clinical audit

Any audit that identifies concerns with patient outcomes resulting in death must be escalated to the Clinical Effectiveness Lead and Associate Director of QI. This will be escalated to the MSG for further scrutiny and to decide if further investigation using the SJR is required.

Learning from review and investigation

Table 1 below describes the process for investigation and sharing learning based on the outcomes from the MRP:

<table>
<thead>
<tr>
<th>Review Score</th>
<th>Action and Learning</th>
</tr>
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<tbody>
<tr>
<td>Avoidability Score 1 Definitely avoidable</td>
<td>• Division to consider whether to submit through 72 hour review process to determine type of SI investigation required.</td>
</tr>
<tr>
<td>Avoidability Score 2 Strong evidence of avoidability and/or Overall Care Score 1-2 Very Poor/Poor</td>
<td>• SI investigation process commences. See Incident Reporting &amp; Investigation Policy including Serious Incident Framework &amp; Duty of Candour &amp; Learning from Deaths (EDQ008 v7)</td>
</tr>
<tr>
<td>Avoidability Score 3 Probably avoidable (more than 50:50) and/or Overall Care Score 1-2 Very Poor/Poor</td>
<td>• Duty of Candour process commences. See Incident Reporting &amp; Investigation Policy including Serious Incident Framework &amp; Duty of Candour &amp; Learning from Deaths (EDQ008 v7)</td>
</tr>
<tr>
<td></td>
<td>• Learning presented to ward/department/specialty/Mortality Surveillance Group (MSG) and the Divisional Assurance &amp; Risk Committee and to be included in the ‘Lessons Learned’ newsletter.</td>
</tr>
<tr>
<td></td>
<td>• Submit through 72 hour review process to determine type of SI investigation required.</td>
</tr>
<tr>
<td></td>
<td>• SI investigation process commences. See Incident Reporting &amp; Investigation Policy including Serious Incident</td>
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Framework & Duty of Candour & Learning from Deaths (EDQ008 v7)

- Duty of Candour process commences. See Incident Reporting & Investigation Policy including Serious Incident Framework & Duty of Candour & Learning from Deaths (EDQ008 v7)
- Learning presented to ward/department/specialty/MSG and the Divisional Assurance & Risk Committee and to be included in the ‘Lessons Learned’ newsletter.

<table>
<thead>
<tr>
<th>Score 4</th>
<th>Possibly avoidable, but not very likely (less than 50:50)</th>
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<tbody>
<tr>
<td></td>
<td>Review forwarded to the specialty for consideration of findings, development of recommendations and action planning where necessary. Any learning identified presented to MSG and Divisional Assurance &amp; Risk Committee</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Score 5</th>
<th>Slight evidence of avoidability</th>
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</table>

<table>
<thead>
<tr>
<th>Score 6</th>
<th>Definitely not avoidable</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>If any learning is identified, to be shared via MSG/DARC with ward/department/consultant.</td>
</tr>
<tr>
<td></td>
<td>Isolated poor care to be</td>
</tr>
</tbody>
</table>

Isolated phases of poor care may be referred via the Datix Incident Reporting system for review and action-planning or reflected in sufficient weighting of the overall care score at any stage to trigger a 72 hour review.

Learning and feedback from outcomes of mortality reviews and related investigations will also occur through the following:

- Discussion at Specialty Mortality & Morbidity Meetings (See Appendix 5 for guidance)
- Monthly reporting of all SJRs to the Mortality Surveillance Group
- Quarterly reports to the Pennine Acute Clinical Effectiveness Committee and similarly quarterly to the Committees in Common Board from PAHT CEC
- Care Organisation Governance meetings/forums
- Development of quality & service improvement initiatives
- Clinical Coding Group
- Shared learning with external bodies for e.g. Coroner and CCG

It should be recognised that learning from the mortality review process will also have many positive elements relating to the quality and standard of care provided to the patient and it is equally important that this is also shared with staff across the wider organisation.
3. Bereaved Families and Carers

The Trust Bereavement Service will provide guidance and support for the Trust MRP. Further detailed guidance can be found within the Bereavement Policy.

The National Guidance on Learning from deaths highlights that providers should 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 principles described below:

- bereaved families and carers should be treated as equal partners following a bereavement;
- bereaved families and carers must always receive a clear, honest, compassionate and sensitive response in a sympathetic environment;
- bereaved families and carers should 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;
- bereaved families and carers should be informed of their right to raise concerns about the quality of care provided to their loved one;
- bereaved families’ and carers’ views should help to inform decisions about whether a review or investigation is needed;
- bereaved families and carers should receive timely, responsive contact and support in all aspects of an investigation process, with a single point of contact and liaison;
- bereaved families and carers should 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;
- bereaved families and carers who have experienced the investigation process should be supported to work in partnership with Trusts in delivering training for staff in supporting family and carer involvement where they want to.

Any mortality review or investigation linked to a patient death, where support and communication is required for bereaved families and carers, will be managed in line with the Trust Incident Reporting & Investigation Policy including Serious Incident Framework & Duty of Candour & Learning from Deaths (EDQ008 v7)

The Trust will be working with the Greater Manchester Health & Social Care Partnership as they establish a process for the city wide review of deaths related to patients with Learning Disabilities, in line with the University of Bristol Learning Disabilities Mortality Review Programme.

All deaths of people with a learning disability are expected to be notified to the programme as it rolls out across England in 2017. All deaths of people with a learning disability, that meet the programme criteria, will receive an initial review by a trained reviewer. Where it is felt that further learning about a death could contribute to improved service provision, that death will receive a full multi-agency review.

The main purpose of the LeDeR reviews is to identify any potentially avoidable factors that may have contributed to the person’s death, and to then develop action plans that, either individually or in combination, will guide changes needed in health and social care services to and to then develop action plans that, either individually or in combination, will guide changes needed in health and social care services to an initial review by a trained reviewer. Where it is felt that further learning about a death could contribute to improved service provision, that death will receive a full multi-agency review.

The main purpose of the LeDeR reviews is to identify any potentially avoidable factors that may have contributed to the person’s death, and to then develop action plans that, either individually or in combination, will guide changes needed in health and social care services to reduce premature deaths of people with a learning disability. The Trust mortality review process for LeDeR will be supported by the Named Nurse for Adult Safeguarding and the Trust liaison to support any multi-disciplinary review will be the nominated Clinical Lead for Mortality. Further information can be found at NHS England Roll out of the Learning Disabilities Mortality Review programme (LeDeR) Important information for Acute General and Specialist Hospitals.

Should any concerns arise during the mortality review that could be considered a Safeguarding issue then this should be reported through the appropriate safeguarding channels and a discussion should be held with a member of the Trust Safeguarding Team. See the Safeguarding webpage for further advice and information.

5. End of Life Care

The provision of high quality end of life care is a priority for all patients and as such, it is intended that the mortality review process should include evaluation of the quality of care in the last days of life. Clinical teams will be supported to make sustainable improvements to end of life care where areas for development are identified. Evaluation of care in the last days of life will be underpinned by use of the End of Life Care Quality Markers when indicated. The review of expected deaths (including a supplemental SJR validation dataset) will be co-ordinated with the End of Life Care Steering Group.

1 Learning, candour and accountability - A review of the way NHS trusts review and investigate the deaths of patients in England http://www.cqc.org.uk/content/learning-candour-and-accountability
6. Reporting and Monitoring of Mortality

From April 2017, Trusts are now required to collect and publish on a quarterly basis specified information on deaths. This should be through a paper and an agenda item to a public Board meeting in each quarter to set out the Trust’s policy and approach (by the end of Q2) and publication of the data and learning points (from Q3 onwards). This data should include the total number of the Trust’s in-patient deaths (including Emergency Department deaths for acute Trusts) and those deaths that the Trust has subjected to case record review. Of these deaths subjected to review, Trusts will need to provide estimates of how many deaths were judged more likely than not to have been due to problems in care. The dashboard provided with the national guidance shows what data needs to be collected and a suggested format for publishing the information, accompanied by relevant qualitative information and interpretation.

Changes to the Quality Accounts regulations will require that the data providers publish be summarised in Quality Accounts from June 2018, including evidence of learning and action as a result of this information and an assessment of the impact of actions that a provider has taken.

The MRP is overseen and managed by the MSG which is chaired by the NMGH Medical Director. The MSG will report to the PAHT Clinical Effectiveness Committee (CEC) which is chaired by the Group Medical Director. CEC reports to the Committees in Common and a quarterly dashboard and report outlining information on avoidable deaths, learning from these, themes/trends and family/carers’ engagement with the process will be provided. (commencing December 2017)

At departmental level, there are Mortality & Morbidity (M&M) meetings, reporting to directorate governance meetings. The role of M&M meetings within the Trust is to reflect and to enable learning from outcomes to make improvements in treatment and care. All deaths reviewed locally at departmental M&M meetings must be completed within 30 working days of the patient death.

7. Mortality Indices Alerts

On a monthly basis, the Information Team will analyse mortality data (HSMR and SHMI) and this will be presented to the monthly Operations Board and to the Board of Directors via the Performance Report. The statistical analysis is reported monthly to the Operational Board and looks at trends in HSMR, SHMI, crude mortality, weekend mortality, mortality by site and palliative care.

In addition, the MSG reviews in-depth mortality analysis reviewing cumulative sum (CUSUM) mortality alerts. A cumulative sum (CUSUM) statistical process control chart plots patients’ actual outcomes against their expected outcomes sequentially over time. The chart has upper and lower thresholds and breaching this threshold triggers an alert. If patients repeatedly have negative or unexpected outcomes, the chart will continue to rise until an alert is triggered. The Trust investigates all negative alerts at 95% detection, as when the detection reaches 99.9% this triggers to the Care Quality Commission, and is raised as part of the Trust’s Intelligent Monitoring Report (IMR). When a CUSUM alert is brought to the attention of the MSG and the Chief Medical Officer a deep dive investigation may be required,
following an initial discussion and review, via the speciality M&M meetings and by using the SJR method. If the M&M meeting identifies any risks these will be escalated to MSG, and by CEC to the Board of Directors.

8. Training

A regular programme of training on the Mortality Review Process and the SJR Methodology will be led by the Trust Clinical. Specific staff in each speciality will be designated to attend by each Clinical Director/Associate Director of Nursing. This will include consultants, medical staff, senior nurses, AHPs and key advisors. These staff will be expected to provide cascade mortality review training other staff within their specialty.

Standards

The Trust uses the SJR review methodology (England) to support the Mortality Review Process.

Explanation of Terms & Definitions

For the purpose of this Policy, the Trust has adopted the following definitions:

- **Avoidable death** - ‘Avoidability of death scale’ to be a score of \( \leq 3 \) (more than 50:50)
- **Mortality** In relation to this policy Mortality relates to any inpatient-hospital deaths.
- **Hospital Standardised Mortality Ratio (HSMR)**. The HSMR is calculated each month for each hospital in England. It looks at deaths in the most common conditions in hospital which account for around 80% of deaths in hospital.
- **Summary Hospital-level Mortality Indicator (SHMI)**. The SHMI score looks at all deaths in hospital and within 30 days of discharge from hospital.
  - A (CUSUM) cumulative sum is a statistical process control chart plotting patients’ actual outcomes against their expected outcomes sequentially over time. The chart has upper and lower thresholds and breaching this threshold triggers an alert. If patients repeatedly have negative or unexpected outcomes, the chart will continue to rise until an alert is triggered.
  - **Structured judgement review method**. 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.
References and Supporting Documents

- Gibson A. Using the structured judgment review method – A clinical Governance guide to mortality case record reviews, Royal College of Physicians; 2016


- Hogan H, The Scale and Scope of Preventable Hospital Deaths. Doctoral thesis, London School of Hygiene Tropical Medicine; 2014


- Hutchison A. Using the structured judgement review method - A guide for reviewers (England), Royal College of Physicians: 2016

- Learning, candour and accountability - A review of the way NHS trusts review and investigate the deaths of patients in England. Care Quality Commission; December 2016

- National Guidance on Learning from deaths: A Framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care; March 2017

- Serious Incident Framework 2015.

Roles and Responsibilities (for process see Appendix 1)

- Chief Medical Officer is the Lead Executive for the Mortality Review Process within the Trust, and as such, must ensure that appropriate mechanisms are in place to review mortality data and learning, monitor this within the Trust’s governance structures, identify any potential areas for further investigation and ensure appropriate mitigation is in place where risks are identified relating to mortality.

- The Responsible Officer for the PAHT must ensure that all consultants must have an appraisal and that mortality data, where available and appropriate, is part of this appraisal.

Executive and Non-Executive Directors

- Executive and non-executive directors will have a key role in ensuring that their provider is learning from problems in healthcare identified through reviewing or investigating deaths. There will be a nominated non-
executive director for mortality who will ensure:

- the processes the organisation has in place is robust, focused on learning and can withstand external scrutiny, by providing challenge and support;
- quality improvement becomes and remains the purpose of the exercise, by championing and supporting learning, leading to meaningful and effective actions that improve patient safety and experience, and supporting cultural change; and
- the information the organisation publishes is a fair and accurate reflection of its achievements and challenges.

**Associate Director of Governance**

- Will ensure, that this policy is implemented, monitored and aligned to the other clinical governance processes within the Trust.

- Responsible for ensuring that there is a process for capturing and disseminating learning from the MRP across the organisation.

**Group Associate Director of Patient Safety**

- To be notified when avoidable death identified and have oversight of communication with coroners and family where applicable.

**Care Organisation Clinical Leads for Mortality**

- Will have responsibility for ensuring that the Mortality Review Process including the SJR is understood and embedded across the organisation.

- Will act as a point of contact for specialties in relation to the Mortality Review Process and will offer expert advice and support when required.

- Will develop and support the delivery of a programme of mortality training (including SJR) across the organisation.

- Will act as a point of contact for Greater Manchester Health & Social Care Partnership as they establish a process for the city wide review of deaths related to patients with Learning Disabilities.

- Cascade alerts from Datix Incident Reporting system for SJR where necessary.

**Care Organisation Managing Directors**

- Ensure that Mortality Review processes are in place at a directorate/speciality level and report into the Care Organisation Assurance & Risk Committee, as well as flagging any risks to the Mortality Surveillance Group.

- Ensure that there are mechanisms at a directorate/speciality level to ensure that mortality alerts are investigated and any action taken as appropriate.
• Monthly review of ongoing Care Organisation investigations into patient deaths.

• Provide annual summary of Care Organisation deaths, cases reviewed, summary of learning outcomes and actions.

• Support CDs/Nurse managers in reviewing the commitments of individuals to the Mortality Review Process where necessary.

Care Organisation Clinical Lead for Mortality

• Liaise between Mortality Surveillance Group and Divisional Assurance and Risk Committee.

• Co-ordinate Care Organisation SJR review process.

• Provide steer for the MSG, assurance of Trust review process and when necessary and able, assist in determination of avoidability of death supported by the mechanisms outlined in this policy.

Departmental Governance/Mortality Lead (See Appendix 5)

• Will co-ordinate the mortality review process at local level ensuring reviews are completed by the named specialty consultant and presented at a regularly scheduled multi-disciplinary forum (e.g. M&M meeting). This should be a minuted meeting.

• Direct colleagues where necessary to report problems in healthcare or concerns around care via the Datix Incident Reporting system.

• Convey cascaded learning points to departmental team for reflection and actions where necessary.

• Provide a quarterly report to divisional assurance and risk committee summarising local learning, process engagement/performance and forwarding any relevant issues identified by relevant specialty-specific local/national mortality surveillance.

Clinical Directors/ Care Organisation Nurse Managers (See Appendix 5)

• Support the role of those engaged in the Mortality Review Process through regular job-planning.

• Ensure that multi-disciplinary Mortality & Morbidity meetings are in place within the directorate /speciality, with an appointed chair and report to DARC on a quarterly basis.

• Ensure that any Cumulative Sum (CUSUM) mortality alerts within the directorate/ speciality are investigated and reported to the Care Organisation Clinical Director / MSG.

• Ensure that any learning from the Trust Mortality Review audits are shared individually and collectively, with improvements implemented where applicable.
Consultants
• Ensure that when a patient, for whom they are the named consultant, dies, the appropriate mortality review is completed within 7 working days.
• Ensure that where applicable the deceased is referred to the necessary body for further investigation (e.g. Safeguarding, MBRRACE-UK).
• Reflect and act on learning from the Trust Mortality Review Process that links to their own and team’s practice via. audit, appraisal and other governance activity.

Head of Clinically Coded Data and Standards Assurance
• Responsibility for the initial investigation of Alerts raised using the Standardised Mortality Ratio (SMR) Methodology, SHMI and Dr Foster Early Warning Mortality (EVM) tool to identify clinical coding errors.
• Make recommendations to the clinical coding team and Mortality Review Committee.
• Provide Clinical Coding expertise and support when required.

Named Nurse for Adult Safeguarding
• Will provide advice and support to help establish the Trust mortality process for the review of patients who have died with a diagnosis of Learning Disability.
• Will provide leadership for the Learning Disabilities Mortality Review (LeDeR) programme, ensuring that lessons learned and feedback from this process is provided across the Trust.

Bereavement Services Team
• Will provide expertise and advice on the development of systems and processes for the support and engagement of families and carers as part of the MRP.

Assistant Director of Nursing, Palliative & End of Life Care and Consultant in Palliative Medicine
• Will provide advice and support to help establish the use of the Trust End of Life Care Quality Markers within the structured judgement review process (widening the scope beyond DNA-CPR).
• Support the establishment of Mortality Review as a multidisciplinary process with specific reference to end of life care.
• Support the establishment of staff engagement in Mortality Review into the NAAS End of Life Care Standard.
• Support the establishment of local (i.e. Directorate and Care Organisation) end of life care quality improvement initiatives against the outcomes of mortality reviews.

Legal Services
• Notify Associate Director of Governance and Group Associate Director of Patient Safety where a Regulation 28 Report on Action to Prevent Future Deaths is issued by the Coroner.
• Support liaison with pathology department to provide post-mortem reports (where available) to identified individuals on written request.

• Provide records to the appropriate national bodies when requested to assist in external investigation of a death (e.g. MBRRACE-UK).

**Mortality Surveillance Group**

- To act as the strategic Trust mortality overview group with senior leadership and support to ensure the alignment of the Trust departments for the purpose of reducing avoidable deaths.
- Consult with local departmental and Care Organisation mortality groups and review their current processes to generate a unified Trust approach to mortality & morbidity that will enable shared learning and improve practice.
- Provide Strategic oversight of existing Mortality Surveillance Group(s) such as mortality & morbidity meetings and Divisional Assurance & Risk Committee (DARC).
- To produce a Mortality Policy that supports the work plan described within the Trust Quality Improvement (QI) Strategy and that aligns to hospital systems such as audit, incident reporting, information services, training and clinical directorates.
- Sign off of action plans and methodologies that are designed to reduce morbidity and mortality across the Trust.
- Sign off of all regulatory mortality responses /alerts from the CQC, CCG, NHS Improvement, etc.
- To report on mortality performance to the Board including qualitative thematic evidence linked to learning and improvement strategies.
- Implement and provide feedback on the developing National Framework for mortality review.
- To ensure that Trust Mortality Review incorporates systems and processes that support implementation of NICE Guidance for Care of Dying Adults in the Last Days of Life (NG31, 2015)
- To ensure that the Trust Mortality Review process incorporates the care and treatment of patients with learning disabilities and mental health diagnosis.
- To ensure that family and carer engagement is prioritised and embedded within the mortality review process.
- Review the Mortality Policy and associated procedures and systems on an annual basis.
Appendix 1: Mortality Review Process

**THE BOARD**
- Be accountable for mortality outcomes.
- Receive and scrutinise mortality data via the Performance Dashboard Report on a monthly basis, seeking assurance and identification of any potential risks that need further investigation.
- Receive and scrutinise learning from the Trust’s review of deaths on a quarterly basis, seeking assurance that this learning is being implemented.

**CLINICAL EFFECTIVENESS COMMITTEE (CEC)**
- Receive and scrutinise assurance from the Mortality Surveillance Group (MSG) monthly in relation to mortality.
- Receive and scrutinise mortality data via the Performance Dashboard Report on a monthly basis, seeking assurance and identification of any potential risks that need further investigation to inform the Board discussions.
- Receive and scrutinise learning relate to the SJR from the MSG on a quarterly basis, seeking assurance that this learning is being implemented, to inform Board assurance.
- Receive and scrutinise annual Care Organisation mortality and learning assurance report.

**MORTALITY SURVEILLANCE GROUP (MSG)**
- Oversee overall mortality outcomes and the effectiveness of the review of mortality at Trust level
- Be able to explain and justify any residual gaps in control and variance from peer, identifying areas for further ‘deep delves’ (CUSUM alerts triggering 95% detection)
- Satisfy itself that the mortality review process is operating consistently across all Directorates and Divisions and Care Organisations
- Satisfy itself that any actions are in place to sufficiently rectify any underlying care or data management problems
- Ensure that independent auditing of mortality (SJR) is in place within the Trust for a determined sample of deaths, reported on a quarterly basis.

**MORTALITY & MORBIDITY (M&M) MEETINGS**
(SEE APPENDIX 5)
- Receive mortality indices data, trend issues for specialty and benchmark with peers
- Ensure any deep dives are overseen where mortality has triggered (CUSUM alert 95% detection)
- Receive and review Trust mortality audit quarterly reports (independent mortality review)
- Ensure that the Consultant mortality screening tool is being completed consistently
- Develop clear action plans and commence implementation of those actions including necessary Governance reporting via Datix
- Quarterly report of local delivery, performance and learning via Divisional Assurance & Risk Meetings

**DIVISIONAL ASSURANCE & RISK COMMITTEE (DARC) MEETING**
- Oversee delivery of action plans at specialty level
- Explain and justify any gaps in control and variance from peer
- Identify any areas of risk and ensure that this is logged as a risk in Datix, mitigated and/or escalated appropriately
- Submit annual summary of divisional mortality figures, process performance and learning to MRC

**INDIVIDUAL CONSULTANT VALIDATION & MORTALITY REVIEW**
- Care Quality Review Document to be completed within 7 working days of the death occurring by named lead Consultant. (under development) If the death meets the inclusion criteria for SJR, the death will be undergo an independent SJR review.
- Problems in healthcare and/or major care concerns should be reported immediately via the Datix Incident Reporting system
- Where relevant the patient should be referred to the necessary body for further investigation (Safeguarding etc.)

**PATIENT DEATH**

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**Issue 1**
**Sept 2017**
**Mortality Review Policy**
**Current Version is held on the Intranet**
**Check with Intranet that this printed copy is the latest issue**
**Page 21 of 32**
Step 1 Document version of this Allscripts EPR system to be developed for PAHT and implemented.

<table>
<thead>
<tr>
<th>DATE AND TIME OF DEATH</th>
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</thead>
<tbody>
<tr>
<td>Date and time of Death</td>
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<table>
<thead>
<tr>
<th>CAUSE OF DEATH</th>
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</thead>
<tbody>
<tr>
<td>1a</td>
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<td>1b</td>
</tr>
<tr>
<td>1c</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>PRESENTING CONDITION &amp; INITIAL DIAGNOSIS</th>
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</thead>
<tbody>
<tr>
<td>Presenting Condition &amp; Initial Diagnosis</td>
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</table>

<table>
<thead>
<tr>
<th>COMPLICATIONS DURING ADMISSION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complications:</td>
</tr>
<tr>
<td>C. None</td>
</tr>
<tr>
<td>C. Anastomotic Leak</td>
</tr>
<tr>
<td>C. Cardiac Failure</td>
</tr>
<tr>
<td>C. Chest Infection</td>
</tr>
<tr>
<td>C. CVA</td>
</tr>
<tr>
<td>C. Failure to Fix/Maintain Fracture</td>
</tr>
<tr>
<td>C. Failure to Reduce Fracture</td>
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<tr>
<td>C. Haematoma</td>
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<td>C. Haemorrhage</td>
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<td>C. MI</td>
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<td>C. MRSA</td>
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<td>C. MRSA-</td>
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<tr>
<td>C. Nerve/Vessel Injury</td>
</tr>
<tr>
<td>C. PE</td>
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<tr>
<td>C. Pneumothorax</td>
</tr>
<tr>
<td>C. Pressure Sores</td>
</tr>
<tr>
<td>C. Prosthesis Infection</td>
</tr>
<tr>
<td>C. Prosthetic Joint Dislocation</td>
</tr>
<tr>
<td>C. Renal Failure</td>
</tr>
<tr>
<td>C. Resp. Failure</td>
</tr>
<tr>
<td>C. Resp. Infection</td>
</tr>
<tr>
<td>C. Septicaemia</td>
</tr>
<tr>
<td>C. Urinary Retention</td>
</tr>
<tr>
<td>C. UTI</td>
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<tr>
<td>C. Wound Dehiscence</td>
</tr>
<tr>
<td>C. Wound Infection</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>END OF LIFE CARE PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did the patient have an end of life care plan</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DEPRIVATION OF LIBERTY SAFEGUARDS (DoLS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Important</td>
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</table>

<table>
<thead>
<tr>
<th>POST-MORTEM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital PM requested (Coroner's PM determined by HM Coroner following referral)</td>
</tr>
<tr>
<td>Full post-mortem required</td>
</tr>
<tr>
<td>Post-mortem limited to ABDOMEN</td>
</tr>
<tr>
<td>Post-mortem limited to CHEST</td>
</tr>
<tr>
<td>Post-mortem limited to HEAD</td>
</tr>
<tr>
<td>Type of post mortem required (Details included on Consent Form)</td>
</tr>
</tbody>
</table>
Appendix 3: Care Quality Review Document

Document in development to reproduce Care Quality Review paper based version of this Allscripts EPR system document for PAHT.

Reported Episode

<table>
<thead>
<tr>
<th>Event(s) occurred during this reported episode</th>
</tr>
</thead>
<tbody>
<tr>
<td>☑ Mortality  ☐ Cardiac arrest</td>
</tr>
</tbody>
</table>

Below shows the cause of death recorded in the death summary document, this is for reference only.
If this is blank or unknown obtain the post mortem report (email to legal.services@sft.nhs.uk) stating in title: 'Post Mortem Request hospital number and patients initials' Specify your name, role / involvement and secure contact email address.

Cause of Death Reference

Case Summary Details
### Problems in healthcare

**Problems with care of the patient**
- Yes
- No

**Problems details**
- Assessment, investigation or diagnosis (including assessment of falls, VTE, pressure ulcer risk)
- Medication/Fluid/electrolyte/oxygen delivery (excluding anaesthetic)
- Treatment/Management plan (including falls, VTE, pressure ulcer prevention)
- Infection control and management (including sepsis care, HAIs and barrier/prevention)
- Operative/procedural problem or complication
- Clinical monitoring (including failure to plan, undertake, recognise and respond appropriately)
- Resuscitation related to cardiorespiratory arrest (including review of resus status, care planning, response, performance and equipment)
- Other (Specify)

### Problem

<table>
<thead>
<tr>
<th>Problem</th>
<th>Harm Due to This Problem</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessment, Investigation or diagnosis</td>
<td>Yes (Specify), No, Uncertain</td>
</tr>
<tr>
<td>Treatment/Management plan</td>
<td>Yes (Specify), No, Uncertain</td>
</tr>
</tbody>
</table>

**Test harm details**

**Mortality triggers for SJR**

- Possibility of a learning disability
- Recorded serious mental illness
- Death was expected in the 24 hours preceding
- Pregnant or within 42 days of pregnancy and regardless of outcome
- Death within 30 days of discharge or during elective admission
- Patient was under 18 years old
- Any concerns you know of / have regarding the care of the dece...

**Details of concerns**

Test concerns
### Core Quality Review

Please rate the quality of care provided where applicable. If care was particularly good or bad please offer a short supporting statement for learning.

<table>
<thead>
<tr>
<th>Care provided</th>
<th>Quality rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admission and Initial management (first 24 hours)</td>
<td></td>
</tr>
<tr>
<td>Supporting information</td>
<td></td>
</tr>
<tr>
<td>Ongoing care</td>
<td></td>
</tr>
<tr>
<td>Supporting information</td>
<td></td>
</tr>
<tr>
<td>Procedural care (excluding IV cannulation)</td>
<td></td>
</tr>
<tr>
<td>Supporting information</td>
<td></td>
</tr>
<tr>
<td>Peri-operative care</td>
<td></td>
</tr>
<tr>
<td>Supporting information</td>
<td></td>
</tr>
<tr>
<td>End of life care - (see reference information below)</td>
<td></td>
</tr>
<tr>
<td>Supporting information</td>
<td></td>
</tr>
</tbody>
</table>
Appendix 4: Mortality Review Flowchart & Reporting Timeline

To be implemented

Step 1:
(Under development)
Death Summary and Coding Form
1 working day from death

Step 2:
Named Consultant Care Quality Review Tool
(under development)
7 working days from death

Step 3:
Independent Structured Judgement Review
(Datix)
• Learning Disability/Severe Mental Illness
• Expressed care concerns
• Dr Foster alerts/inquests
• SI investigation
• Uncertain/potentially avoidable death identified in Step 2
• Poor care identified in Step 2
• Selected case/assurance
21 working days from death

Step 4:
SI Framework/Investigation
(Duty of Candour)
• Avoidable death score <=3
• Overall care quality score 1-2 (poor/very poor)
60 working days from death

Any isolated poor care to be considered in context of overall care quality and reported via Datix reporting system and/or overall care score weighted for escalation and further review where necessary.

Outcomes presented to Trust Board and published in Learning from Deaths Dashboard with Thematic Learning Points

Review in conjunction with Learning from review and investigation, table 1 (page 10)
Appendix 5: Core dataset for review at M&M meetings

1. Number of deaths in specialty (available currently from weekly datawarehouse report).

2. Number of mortality reviews completed (report to be generated and circulated to departmental mortality leads).

3. Review of cases including those where:
   - Identified problems in healthcare: actions taken including reporting where necessary;
   - Care quality and safety judged as very poor/poor or excellent;
   - Death considered potentially preventable or there is uncertainty;
   - Local/National alerts triggered by audit data/HES data etc.

4. Reflection on feedback and implementation of action-plan/QI activity from:
   - Completed SJRs;
   - Investigation findings through SI process;
   - Local audits related to mortality.

Note that meetings should be minuted and retained by the departmental mortality/governance lead. If required there is a free-text box within the Care Quality Document for time-stamped entries from this forum.
Policy Implementation Plan

The policy will be cascaded to all clinical specialties including clinical directors, all consultants, lead nurses / AHPs and governance managers / leads.

A programme of training through bespoke workshops will be delivered for all clinical staff who will be involved in the SJR mortality review process and this will be accompanied by a guidance document. Training will be cascaded to all consultants through the Care Organisations.

An implementation timeline for Steps 1 and 2 of the Mortality Review Process and the transition to SJR Methodology will be developed within the Mortality Improvement Plan.

Monitoring and Review

This is described within Appendix 1 of the Policy.

Endorsement

This table summarises the document ratification process.

Before submission of the document to a governance committee for final approval, endorsement by relevant stakeholders should be sought via a consultation process. This process should involve as many potential policy users as possible.

Once the appropriate endorsements have been received and noted in the table below, the draft document should be sent to the appropriate committee’s administrator to be added to the agenda for document approval.

All documents which have a Trust-wide or multi-Care Organisation involvement must be ratified at Executive Governance level. There are several Executive Governance Committees – the most appropriate one will be determined by the nature of the document.

Endorsed by:

<table>
<thead>
<tr>
<th>Name of Lead Clinician/Manager or Committee Chair</th>
<th>Position of Endorser or Name of Endorsing Committee</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executive Medical Director for SRFT &amp; PAHT</td>
<td>Clinical Effectiveness Committee</td>
<td>18th September 2017</td>
</tr>
<tr>
<td>Medical Director NMGH &amp; Chair MSG</td>
<td>Mortality Surveillance Group</td>
<td>17th September 2017</td>
</tr>
</tbody>
</table>

Equality Analysis

Current Version is held on the Intranet
Check with Intranet that this printed copy is the latest issue

Appendix 1 – Equality Impact Assessment

This form should be completed in liaison with your Equality Champion as per the ‘Equality Impact Assessment Guidelines’ (EDH062).

Equality Impact Assessment for …Mortality Review Policy…

To be completed by the Lead Author (or a delegated staff member)

<table>
<thead>
<tr>
<th>Protected Characteristics &amp; equality &amp; diversity streams</th>
<th>Age</th>
<th>Disability</th>
<th>Ethnicity / Race</th>
<th>Gender</th>
<th>Reassignment &amp; Civil Partnership</th>
<th>Pregnancy &amp; Maternity</th>
<th>Religion/belief</th>
<th>Sexual orientation</th>
<th>Human Rights</th>
<th>Carers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Example</td>
<td>N</td>
<td>Y</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
</tr>
</tbody>
</table>

A variety of methods will be made available to minimise barriers to communication such as provision of easy read formats, advocacy services, translation into other languages and braille as required.

1. Does the practice covered have the potential to affect individuals or communities differently or disproportionately, either positively or negatively (including discrimination)?

   | Y |

   All deaths will be treated the same, however, some mortality reviews will be triggered immediately as per the national guidance e.g. learning disabilities, elective patients, Maternal or neonatal deaths.

2. Is there potential for, or evidence that, the proposed practice will promote equality of opportunity for all and promote good relations with different groups?

   | Y |

   The Mortality Review Policy provides a single pathway for all mortality reviews therefore treats all groups equally and promotes good practice for all.

3. Is there public concern (including media, academic, voluntary or sector specific interest) in the document about actual, perceived or potential discrimination about a particular community?

   | N |

   The Mortality Review Policy provides a review process for all patients who die in hospital therefore the public should have no concern over discrimination.

Your Name: Beverley Cook

Signed*: [Signature]

Date: 28/09/2017

To be completed by the relevant Equality Champion following satisfactory completion & discussion of answers above with author

<table>
<thead>
<tr>
<th>Equality Champion: Joe McMahon</th>
<th>Directorate: Organisational Development</th>
</tr>
</thead>
<tbody>
<tr>
<td>Signed*: [Signature]</td>
<td>Date: 03/10/2017</td>
</tr>
</tbody>
</table>

*Please scan or insert electronic signature