Royal Berkshire NHS Foundation Trust

Mortality Policy - Learning from Deaths

CG627

Approval

Approval Group	Job Title, Chair of Committee	Date
Mortality Surveillance Group	Medical Director, Chair of Mortality Surveillance Group	Sept 2017
Clinical Outcomes & Effectiveness Committee	Medical Director, Chair of Clinical Outcomes & Effectiveness Committee	Sept 2017
Policy Approval Group	Chair, Policy Approval Group	24 July 2019

Change History

Version	Date	Author, job title	Reason
1.0	September 2017	Katie Elcock, Head of Governance & Improvement	New Policy – required as part of national guidance on learning from deaths
1.1	June 2019	Katie Elcock, Head of Governance & Improvement	Update to reflect new Medical Examiner System

Contents

Other relevant corporate or procedural documents:

This document must be read in conjunction with:

- Incident Reporting, Investigation & Learning Policy (CG553)
- Duty of Candour, Being Open Policy (CG605)
- Clinical Governance Policy (CG119)
- Bereavement Guidelines (GL111)
- Guideline for Staff Responsible for Care of Adults after Death (GL595)
- Protocol for the care of the child after death (CG544)
- National Best Practice Guidance Implementation Policy (CG543)

1.0 Purpose

Hundreds of patients come through our doors on a daily basis. Most patients receive treatment, get better and are able to return home or go to other care settings. Sadly and inevitably, some patients will die here. While most deaths are unavoidable and would be considered to be "expected", there will be cases where sub-optimal care in hospital may have contributed to the death.

The Royal Berkshire NHS Foundation Trust (hereafter referred to as "the Trust") is committed to continuously monitoring the quality of its care provision in order to identify themes and areas for improvement around mortality, as well as areas of good practice; to undertake thorough reviews where indicated in order to understand contributory factors and root causes; and to draw lessons from these experiences and share learning across the organisation and with the wider healthcare economy where appropriate in order to improve the quality of care for patients.

The purpose of this policy is to demonstrate how the Trust responds to and learns from deaths of patients under its care; and how the Trust responds to and shares learning across organisational boundaries for patients under multi-agency care where appropriate. It provides the framework for undertaking mortality reviews, the processes for specific categories of deaths, the policy for engagement with bereaved families and carers and the collection and publication of data.

Under the *National Guidance on Learning from Deaths*, published by the National Quality Board in March 2017, trusts are required to:

- Publish an updated policy by September 2017 on how their organisation responds to and learns from deaths of patients who die under their management and care, including:
    - how their processes respond to the death of an individual with a learning disability, severe mental illness, an infant or child death, a stillbirth or a maternal death
    - their evidence-based approach to undertaking case record reviews
    - the categories and selection of deaths in scope for case record review (and how the organisation will determine whether a full investigation is needed)
    - how the trust engages with bereaved families and carers, including how the trust supports them and involves them in investigations
    - how staff affected by the deaths of patients will be supported by the trust.

- Collect specific information every quarter on:
    - the total number of inpatient deaths in an organisation's care

- the number of deaths the trust has subjected to case record review
- the number of deaths investigated under the Serious Incident framework (and declared as Serious Incidents)
- of those deaths subject to case record review or investigated, estimates of how many deaths were more likely than not to be due to problems in care
- the themes and issues identified from review and investigation, including examples of good practice
- how the findings from reviews and investigations have been used to inform and support quality improvement activity and any other actions taken, and progress in implementation.

- Publish this information on a quarterly basis from December 2017 by taking a paper to public board meetings.

This policy sets out Trust's approach to meeting these requirements.

2.0 Scope

This policy covers all inpatient and Emergency Department deaths. It also covers the deaths of the specific patient groups: child deaths; mental health deaths; and learning disability deaths.

3.0 Roles and Responsibilities

- **Chief Executive**

  The Chief Executive, so far as it is within their control to do so, has overall responsibility for ensuring the implementation of robust mortality review processes across the Trust.

- **Non-Executive Director – Mortality Lead**

The Mortality Lead Non-Executive Director, so far as it is within their control to do so, is responsible for oversight of the learning from deaths agenda. This includes:

- understanding the review process: ensuring the processes for reviewing and learning from deaths are robust and can withstand external scrutiny
- championing quality improvement that leads to actions that improve patient safety
- assuring published information: that it fairly and accurately reflects the organisation's approach, achievements and challenges.

- **Executive Lead for Mortality - Medical Director**

  The Medical Director, so far as it is within their control to do so, is responsible for ensuring the learning from deaths agenda is implemented across the Trust.

- **Lead Medical Examiner**

  The Lead Medical Examiner, so far as it is within their control to do so, is responsible for the implementation of the Medical Examiner System in the Trust and ensuring that it meets national guidelines and standards. They have responsibility for oversight of the Medical Examiners and ensuring the scrutiny they are providing is robust and impartial.

- **Medical Examiners**

  The Medical Examiners, so far as it is within their control to do so, are responsible for providing scrutiny for the death certification process and ensuring appropriate referrals are made to the coroner for further investigation.

- **Trust Board**

  The Trust Board, so far as it is within its control to do so, has responsibility for ensuring the Trust has robust systems for recognising, reporting and reviewing or investigating deaths where appropriate. It also has a responsibility to ensure the Trust has appropriate processes in place to learn from problems in healthcare identified by reviews or investigations. The Trust Board will receive assurance around the Trust's mortality review processes via a quarterly report giving data on mortality reviews, themes and issues identified from review, and actions taken in response.

- **Quality Committee**

  The Quality Committee, so far as it is within its control to do so, is responsible for ensuring the delivery of safe, high quality patient care across the Trust. It does this by ensuring that there are appropriate structures, processes and controls in place to assure quality in clinical care and the patient experience, including thorough and appropriate review of in-hospital deaths; and that the key risks to safety and quality of clinical services are recognised and are being addressed, including analysis of themes and learning from mortality reviews and the implementation of appropriate actions to address any issues.

- **Head of Governance & Improvement**

  The Head of Governance & Improvement, so far as it is within their control to do so, is responsible for supporting the implementation of the Learning from Deaths agenda across the Trust as part of the effective running of the Trust's clinical governance framework.

- **Child Death Overview Panel (CDOP) Coordinator**

  The CDOP Co-ordinator is responsible for overseeing the process of the notification of child death to the CDOP. The CDOP Co-ordinator is responsible for managing the information gathering and collation with all professionals involved in the child's care prior to review.

- **The Associate Director of Safeguarding & Mental Health**

  The Associate Director of Safeguarding & Mental Health, so far as it is within their control to do so, is responsible for ensuring the implementation of mortality review processes in relation to learning disability and mental health deaths within the Trust.

- **Designated Professional for Child Death**

  The Designated Professional for Child Death is a CCG appointment to ensure that the Local Safeguarding Children Board (LSCB), through the child death overview panel has access to a healthcare professional whose role is to provide advice on the commissioning of the paediatric services needed to undertake enquiries into unexpected child deaths, the relevant medical investigation services and the organisation of those services. The Designated Professional is responsible for co-ordinating the multiagency response to all child deaths in a LSCB area which are unexpected or where the cause of the death is uncertain

- **Medical Examiner Office**

  The Bereavement Office, as far as it is within its control to do so, is responsible for liaising with and advising families on what happens after death; co-ordinating the Medical Examiner Service; providing the death certificate collection service; and informing GPs about patient deaths.

- **Clinical Outcomes & Effectiveness Committee (COEC)**

  The COEC, so far as it is within its control to do so, is responsible for reviewing, the benchmarked mortality rates of the Trust; clinically investigating any mortality alerts referred from the Clinical Data Quality Group; and overseeing the Mortality Surveillance Group.

- **Mortality Surveillance Group (MSG)**

  The MSG, so far as it is within its control to do so, is responsible for the implementation and monitoring of standardised mortality review processes across the Trust; for the identification of themes and dissemination of learning coming from mortality reviews.

- **Clinical Data Quality (CDQ)**

  The CDQ Group, so far as it is within its control to do so, is responsible for the scrutiny of Trust mortality trends; for investigating nationally benchmarked mortality

data for data quality issues, specifically clinical coding; and for referring areas which warrant further clinical review to the COEC.

- **Specialty Clinical Governance Leads**

  The Specialty Clinical Governance Leads, so far as it is within their control to do so, are responsible for ensuring the effective operation of mortality review processes within their specialties as part of the specialty clinical governance processes.

- **All Consultants**

  All consultants have a responsibility to take part in systems of quality assurance and quality improvement to promote patient safety as part of their General Medical Council registration. In the context of this policy this includes undertaking mortality reviews when requested to do so, responding constructively to the outcomes, taking steps to address any problems and carrying out further training where necessary

4.0 Definitions

Death certification

The process of certifying, recording and registering death, the causes of death and any concerns about the care provided. This process includes identifying deaths for referral to the coroner.

Case record review

A structured desktop review of a case record/note, carried out by clinicians, to determine whether there were any problems in the care provided to a patient. Case record review is undertaken routinely to learn and improve in the absence of any particular concerns about care. This is because it can help find problems where there is no initial suggestion anything has gone wrong. It can also be done where concerns exist, such as when bereaved families or staff raise concerns about care.

Mortality review

A systematic exercise to review a series of individual case records using a structured methodology to identify any problems in care and to draw learning or conclusions to inform any further action that is needed to improve care within a setting or for a particular group of patients.

Serious Incident

Serious Incidents in healthcare are adverse events, where the consequences to patients, families and carers, staff or organisations are so significant, or the potential for learning is so great, that a heightened level of response is justified. Serious Incidents include acts or omissions in care that result in unexpected or avoidable death, unexpected or avoidable injury resulting in serious harm – including those where the injury required treatment to

prevent death or serious harm – abuse, Never Events, incidents that prevent (or threaten to prevent) an organisation's ability to continue to deliver an acceptable quality of healthcare services, and incidents that cause widespread public concern resulting in a loss of confidence in healthcare services. See the Serious Incident framework for further information.

Investigation

A systematic analysis of what happened, how it happened and why, usually following an adverse event when significant concerns exist about the care provided. Investigations draw on evidence, including physical evidence, witness accounts, organisational policies, procedures, guidance, good practice and observation, to identify problems in care or service delivery that preceded an incident and to understand how and why those problems occurred. The process aims to identify what may need to change in service provision or care delivery to reduce the risk of similar events in the future. Investigation can be triggered by, and follow, case record review, or may be initiated without a case record review happening first.

Death due to a problem in care

A death that has been clinically assessed using a recognised method of case record review, where the reviewers feel that the death is more likely than not to have resulted from problems in care delivery/service provision. (Note, this is not a legal term and is not the same as 'cause of death'). The term 'avoidable mortality' should not be used, as this has a specific meaning in public health that is distinct from 'death due to problems in care'.

Quality improvement

A systematic approach to achieving better patient outcomes and system performance by using defined change methodologies and strategies to alter provider behaviour, systems, processes and/or structures.

Patient safety incident

A patient safety incident is any unintended or unexpected incident which could have led or did lead to harm for one or more patients receiving NHS care.

Summary Hospital-level Mortality Indicator (SHMI): An indicator which reports on mortality at trust level across the NHS in England. It is the ratio between the actual number of patients who die following hospitalisation at the Trust (including 30-day post discharge deaths) and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there.

5.0 Mortality Review Processes

5.1 Non-Executive / Executive Director Mortality Lead

The Trust has an identified Non-Executive Director and an Executive Director Lead for mortality. Their roles and responsibilities are set out above.

5.2 Engagement with Bereaved Families and Carers

The Trust believes it is essential to engage meaningfully and compassionately with bereaved families and carers at all stages of responding to a death. The Trust subscribes to the eight guiding principles laid out by the National Quality Board (2018) that set out what bereaved families and carers can expect:

1. Being treated as equal partners
2. Receiving clear, honest, compassionate and sensitive response in a sympathetic environment
3. Receiving a high standard of bereavement care including being offered appropriate support
4. Being informed of their rights to raise concerns
5. Helping to inform decisions about whether a review or investigation is needed
6. Receiving timely, responsive contact and support in all aspects of an investigation process with a single point of contact and liaison
7. Being partners in an investigation as they offer a unique and equally valid source of information and evidence
8. Being supported to work in partnership with trusts in delivering training for staff in supporting family and carer involvement where they want to.

Throughout the mortality review process, bereaved families and carers are treated as equal partners and given opportunities to raise concerns about a patient's death. For every inpatient and ED death, a Medical Examiner will attempt to contact the NoK to discuss the MCCD and ask if they have any concerns about the death. Any clinical concerns raised would be a prompt for the ME to request a mortality review. When the NoK pick up the death certificates from the Bereavement Office, they will again have the opportunity to express any concerns about the care given. The NoK will be given the bereavement information leaflet which gives the contact details of the Patient Relations team if they wish to raise any queries or concerns at a later date. A bereavement survey will also be given to all bereaved families and carers to complete if they wish. Clinical concerns raised by families and carers via any of these routes would be considered as a trigger for a full mortality review of the patient.

If the patient death is identified as a reportable SIRI, the family/ carer of the deceased would be automatically contacted in line with the Trust's "Duty of Candour" Policy. Families and carers are given the opportunity to feed into the investigation process and to ask any questions they would like answers to. The final report would be given to the family/ carer and explained to them via a face-to-face meeting if that is the wish of the relative/ carer.

Where family/carers notify the investigating officer that they intend to seek legal advice or instruct solicitors, the investigating officer will notify the Trust's Head of Legal Services so that prompt and efficient liaison and communication can take place.

5.3 Inpatient Mortality Review Procedure

After an inpatient dies, the next of kin (NoK) will be informed and given the bereavement information by the ward staff. The death will be recorded on EPR. The Qualified Attending Practitioner (QAP) will complete a brief summary of the case including proposed cause of death on the mortality IT system "CORS", in discussion with the deceased's consultant. The Medical Examiner Officer (MEO) will contact the QAP to arrange an appointment for them to meet with the Medical Examiner (ME).

The ME for that day will undertake appropriate scrutiny of the death to include:

- review of patient's notes on EPR;
- discussion with the QAP;
- and discussion with the NoK to advise about the cause of death and ask if the NoK have any concerns they want to raise.

The ME will either agree a consensual cause of death with the QAP and the Medical Certificate of Cause of Death (MCCD) will be completed; or, agree the death requires referral to the Coroner. Occasionally, it may be appropriate for the ME to ask the QAP to go to their clinical team to request further information before a decision can be reached about the cause of death.

The QAP will complete the electronic discharge letter (EDL) whilst in the Bereavement Office if not already completed. The MEO will contact the patient's GP and arrange for the NoK to pick up the MCCD.

The ME will also consider whether the death requires a full mortality review and which specialty would be based placed to review the death, based on the *Learning from Deaths* criteria:

- Learning disability patient
- Severe mental health illness patient
- Elective admission
- Death within 30 days of chemotherapy
- NoK concerns about death
- Other concerns which warrant further review [*ME clinical judgement*]

The Quality Governance Team will notify the clinical teams when a review is required in their specialty. The Reviews will be completed on the CORS system using the Structured Judgement Review (SJR) methodology. The reviews will be completed by a consultant from the relevant specialty (who has not been involved in the care of the patient). The SJR review should be completed within 6 weeks of the date of death and presented to the specialty clinical governance (CG) or mortality & morbidity (M&M) meeting.

If the SJR review identifies "Very Poor" or "Poor" care overall then a stage 2 SJR review is required. The Quality Governance Team will allocate a stage 2 reviewer (a consultant independent of the specialty).

If the (stage 1 or stage 2) mortality review is given an overall avoidability score of Grade 0, 1, or 2 these will be reported via the Mortality Surveillance Group monthly thematic report and no further action will be necessary. If the SJR review comes back with an overall

avoidability score of Grade 3, these cases will be presented by the reviewer to the Mortality Surveillance Group and they will be considered for potential Serious Incident Requiring Investigation scoping.

Learning points and themes from the Mortality Surveillance Group will be reported to the Clinical Outcomes & Effectiveness Committee, and disseminated as applicable to the specialty clinical governance meetings.

See flow chart – Appendix 1

5.4 Patients identified for mortality review

All inpatient and ED deaths are required to be scrutinized by the Medical Examiner process and assessed to decide if a full mortality review is required. All inpatient deaths which are identified as requiring review will be reviewed using the SJR form on the electronic CORS system. All ED deaths will be reviewed by the mortality lead for ED using an amended version of the SJR form which has been agreed by the Mortality Surveillance Group.

In addition, a random sample of adult inpatient deaths which have not triggered will be selected for full review.

Where the Trust is undertaking specific quality improvement work mortality reviews may be requested for certain clinical categories of deaths. This will provide useful data to identify issues and focus the quality improvement effort.

Patients who have died outside of the Trust, but had previously been under the Trust's care, may also be flagged by local healthcare providers to the RBFT Quality Governance Team, to seek input into their mortality review processes, or to share learning. When this happens, a relevant consultant would be asked to complete a review of the patient's care in hospital and this would be shared via the Quality Governance Team with the external healthcare provider. Likewise, if it was identified that a patient who had died in the RBFT had been under the care of another healthcare provider prior to death, and queries were raised about the pre-hospital part of the patient's pathway, these would be raised via the Quality Governance Team with those external providers.

Whilst this policy sets out the minimum requirements for undertaking mortality reviews, it is noted that some specialties may wish to undertake full reviews on all of their deceased patients to draw out all possible learning and to provide full assurance around the care being provided to patients. This is an approach encouraged by the Trust.

Additional processes for specific categories of patients are set out in section 5.8.

5.5 Mortality Review Methodology

Case record review is a method used to determine whether there were any problems in the care provided to a patient within a particular service. It is undertaken routinely to learn and improve in the absence of any particular concerns about care. This is because it can help identify problems where there is no initial suggestion anything has gone wrong. It can also

be done where concerns exist, such as when bereaved families/carers or staff raise concerns about care.

The Trust uses the Structured Judgement Review methodology (SJR) for its mortality reviews. This template must be used for all adult inpatient mortality reviews. Paediatric deaths are mandatory and should be undertaken in accordance with Working together to safeguard children (2015) and the current child death overview panel processes. Perinatal death reviews are also mandatory and will be reviewed, using the bespoke perinatal mortality review tool, by the Perinatal Mortality Review Group.

Full reviews should be undertaken by a consultant level doctor with knowledge of the specialty under which the patient died, but not directly involved in the care of the patient to maintain objectivity. Discussion of the mortality review in a multi-disciplinary forum is encouraged to broaden the scope and learning from the review.

5.6 Potential Reportable Serious Incidents Requiring Investigation (SIRI)

At any point, if a serious concern is identified about the care that has been given to a patient which may have led to significant harm or contributed to death, the incident should be reported on the Trust incident reporting system (Datix) and immediately referred to the Patient Safety Team for potential SIRI scoping. If it is agreed that the case is a reportable SIRI, or that a local root cause analysis (RCA) investigation needs to take place, this process (as set out in the Incident Reporting, Investigation and Learning Policy) will take precedence over the standard mortality review process. Therefore, a mortality review will not be required as it is superseded by the more thorough RCA investigation.

Once the SIRI or local RCA investigation report is completed it should be presented to the Mortality Surveillance Group (MSG) and learning shared. All SIRI or local RCA investigations will be graded by the MSG in accordance with the mortality review grading system.

5.7 Audit and Assurance

Assurance that the mortality review process is being undertaken in a fair, unbiased and objective manner will be provided by:

- Scrutiny of the random sample reviews to assess whether or not these were appropriately triaged by the MEs
- An annual review of a sample of mortality reviews that have been graded as 0 – ‘no suboptimal care’.

In addition, all grade 1 and 2 reviews are scrutinised at the Mortality Surveillance Group on a monthly basis and any queries about the grading would be re-reviewed by a member of the Group.

In order to ensure all deaths are included in the review process, a monthly reconciliation of the ME reviewed deaths will be undertaken against the deaths recorded on EPR.

5.8 Processes for Specific Categories of Mortality Reviews

a) Deaths of patients with learning disabilities

Patients with learning disabilities would be flagged by the ME on the CORS system. These cases are notified to the Learning Disability Coordinator by the Quality Governance Team. The Learning Disability Coordinator will notify these deaths to the national Learning Disabilities Mortality Review Programme (LeDeR) and undertake the initial review as per the process mandated by this programme (flowchart given in Appendix 2).

Learning and themes coming from the LeDeR reviews will be shared at the Safeguarding Adults Committee and the Mortality Surveillance Group.

b) Deaths of patients with mental health issues

Patients who have a severe mental illness would be flagged by the ME on the CORS system. These cases would be flagged to the Trust Mental Health Co-ordinator as well as the specialty consultant mortality lead for review. These cases must also be referred to the Coroner.

c) Child Deaths

All child deaths (excluding those babies who are stillborn and planned terminations of pregnancy carried out within the law) are notified to the Designated Person who is the Pan Berkshire Child Death Overview Panel (CDOP) Coordinator. Following notification the CDOP Coordinator manages the information gathering and collation with all professionals who have been involved with the child or family prior the child's death. The Sudden Unexpected Death in Childhood (SUDIC) process involves early notification of the unexpected death of a child and a prompt process of investigation led by the Designated Healthcare Professional. A report into the circumstances of the child's death is produced, which is shared with the Coroner, and with the CDOP. CDOP meets quarterly and during this meeting reviews the death of every Berkshire resident child aged under 18 years. This is in line with the Child Death Overview Process as described in Working Together to Safeguard Children (2015).

Learning and themes coming from child death reviews will be shared via a quarterly report with the Mortality Surveillance Group.

d) Maternal, Perinatal & Neonatal Deaths

Any perinatal, neonatal or maternal death should be notified to the local MBRRACE co-ordinator (Bereavement Specialist Midwife) and they should notify the death to the national "Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK" (MBRRACE-UK) Programme. Reviews are undertaken of all of these deaths in line with the MBRRACE-UK methodology. All maternal and neonatal deaths must be referred to the Coroner; stillbirths are not required to be reported to the Coroner.

Learning and themes coming from the maternal, perinatal and neonatal death reviews will be shared via a quarterly report with the Mortality Surveillance Group.

e) Emergency Department (ED) Deaths

Deaths of patients within the Emergency Department are not considered 'inpatient' deaths (n.b. ED 'Obs bay' deaths should be considered as inpatient deaths and reviewed in accordance with inpatient processes). However, all deaths within the ED will be subject to review using the Trust standardised ED Mortality Review template. These reviews will be undertaken be the designated ED mortality consultant lead and presented to the ED clinical governance for discussion and shared learning within the team. All reviews will be submitted to the Quality Governance Team (QGT) and included as relevant in monthly reporting to the Mortality Surveillance Group.

5.9 Data Collection and Reporting

Data will be collected by the Trust, on a continuous basis, on: the number of deaths in hospital, the number of deaths subject to case record review; the number of deaths investigated under the Serious Incident framework (and declared as serious incidents); the number of deaths that were reviewed/investigated and as a result considered more likely than not to be due to problems in care; themes and issues identified from review and investigation (including examples of good practice); actions taken in response, actions planned and an assessment of the impact of actions taken.

A monthly report detailing the numbers of deaths reviewed, the outcome of the reviews, and thematic analysis and learning points will be shared with the Mortality Surveillance Group. All grade 3 (probable avoidable) deaths will be presented to the Mortality Surveillance Group by the clinical reviewer.

A summary report of the Mortality Surveillance Group will be presented to the Clinical Outcomes & Effectiveness Committee highlighting any key concerns or points of learning.

A mortality dashboard containing summary SHMI data as well as numbers of reviews completed with review outcomes and key learning points will be presented to Board on a quarterly basis. A summarised version of the quarterly Board reports will be published in the Trust Quality Accounts including evidence of learning and action as a result of this information and an assessment of the impact of actions that have been taken.

Performance reports will be produced for the Care Group Performance meetings on a monthly basis, detailing the outstanding mortality reviews and mortality review outcomes for each area.

5.10 Shared Learning

It is essential that the learning coming from mortality reviews and serious incident investigations (examples of excellence in care as well as areas where care could have been better) is shared as widely as possible across the organisation, and with local healthcare providers if applicable. Sharing learning will help to prevent recurrence of suboptimal care, lead to quality improvements and help to drive up standards of care for our patients.

All mortality reviews should be presented at specialty clinical governance or mortality & morbidity meetings for discussion of cases and to share learning amongst the clinical team.

Individual and thematic learning points arising from the Mortality Surveillance Group will be shared via a monthly shared learning slide to all specialty clinical governance meetings and published on the Trust intranet. Themes coming from the Mortality Surveillance Group will be considered to inform the Trust's Clinical Audit & Quality Improvement Annual Programme, its annual Quality Priorities, and any ad-hoc projects as felt necessary throughout the year.

5.11 National Benchmarking Review

In addition to the individual review of mortality through the mortality review processes described above, the Trust seeks assurance on its mortality rates through national benchmarking of SHMI data. The Trust employs standardised clinical data benchmarking tools in order to interrogate the quality of its clinical data quality, to compare mortality performance against other healthcare providers, and to identify any outlier alerts.

The Trust's SHMI data as well as any outlier alerts will be reviewed on a monthly basis through the Clinical Data Quality Review Group, and any clinical concerns will be escalated to the Clinical Outcomes and Effectiveness Committee for clinical case note review. The Trust's SHMI rates are also reported to the Board on a monthly basis as described in section 5.9 above.

5.12 Supporting and Involving Staff

When staff are involved in difficult situations relating to the death of a patient they are offered support from the Medical lead / Matron. Junior Doctors are supported by their Educational supervisors and student Midwives and Nurses are offered support from Assistant Director of Nursing.

Debriefing sessions are offered to staff on a group or 1:1 basis as and when required

6.0 Consultation Undertaken

- Clinical Outcomes & Effectiveness Committee
- Mortality Surveillance Group
- Clinical Data Quality Group
- Head of Patient Safety
- Head of Legal Services
- Director of Midwifery
- Associate Director of Safeguarding and Designated Professional for Child Death
- Bereavement Team

7.0 Dissemination/Circulation/Archiving

This policy will be circulated to all clinical governance leads, clinical directors, care group directors, directors of nursing, and informatics lead for dissemination amongst their teams.

The policy will be available online via the Trust Policies Hub. In line with national guidance, this policy will also be made available to the public on the Trust internet site.

The Trust Secretary will be responsible for archiving old versions of this document.

8.0 Implementation

All specialty clinical governance leads will be expected to ensure this policy is fully implemented within their specialties. The implementation of the policy will be monitored by the Mortality Surveillance Group

9.0 Training

There is no mandatory training associated with this procedure. Training in mortality review methodology will be available to clinical staff as required.

10.0 Monitoring of Compliance

Aspect of compliance or effectiveness being monitored	Monitoring method	Individual or dept. responsible for the monitoring	Frequency of the monitoring activity	Group/committee which will receive the findings/ monitoring report	Committee/ individual responsible for ensuring that the actions are completed
Accuracy of mortality review grading	'Grade 0' Audit of mortality reviews Review of 'Grade 1' deaths with re-reviews as required	Mortality Surveillance Group	Annually Monthly	Mortality Surveillance Group	Mortality Surveillance Group
Ensuring all relevant deaths are included in the mortality review process	Reconciliation of mortality app records against Bereavement records	Head of Governance & Improvement	Monthly	Mortality Surveillance Group	Mortality Surveillance Group

The Trust reserves the right to amend its monitoring requirements in order to meet the changing needs of the organisation.

11.0 Supporting Documentation and References

- National Guidance on Learning from Deaths, National Quality Board (March 2017)
- Working Together to Safeguard Children (2015).

- Pan Berkshire Child Death Overview Panel webpage, http://www.westberkslscb.org.uk/professionals-volunteers/cdop/#, accessed: 6/09/2017 – for rapid response to child death procedures

12.0 Equality Impact Assessment

Stage 1: Screening

Part 1: Initial Scoping
For each of the nine protected groups identified in the table below, respond to the identified questions with a Yes (Y); No (N); or Unclear (U)

	Age	Sex	Disability	Race	Gender Reassignment	Religion or Belief	Sexual Orientation	Marriage and Civil Partnership	Pregnancy and Maternity
Do different groups have different needs, experiences, issues and priorities in relation to the proposed policy/change proposal?	N	N	N	N	N	N	N	N	N
Is there potential for or evidence that the proposed policy/change will not promote equality of opportunity for all and promote good relations between different groups?	N	N	N	N	N	N	N	N	N
Is there potential for or evidence that the proposed policy will affect different population groups differently (including unintended discrimination against certain groups)?	N	N	N	N	N	N	N	N	N
Is there public concern (including media, academic, voluntary or sector specific interest) in potential discrimination against a particular population group or groups?	N	N	N	N	N	N	N	N	N

Part 2: Evidence and Feedback that has informed your analysis

Please identify below the data, information or feedback that you have drawn on to reach the conclusions above. This will be information that has enabled you to assess the actual or potential impacts in the context of the key needs to **eliminate unlawful discrimination**, **advance equality of opportunity** and **foster good relations** with respect to the characteristics protected by equality law. These sources could include:

- Equalities monitoring information of staff/service users affected by the identified provision/policy etc.

- Engagement (internal/external or both) with or feedback from relevant stakeholders e.g. staff; patient groups, commissioners, external agencies.
- Staff Survey Data; Patient Survey Data etc.
- Research or information available relative to the identified protected group.
- Project leads professional knowledge of the issues the policy/change is seeking to enact.

- National guidance on learning from deaths - Engagement with relevant stakeholders

If the analysis under Part 1 has concluded that there are equality impacts or that the impacts are unclear (i.e. you responded 'Yes' or 'Unclear' in Part 1), **please move on to Part 4 of the assessment**. If no equality impacts are identified, **please move on to Part 3 below** to conclude the assessment

Part 3: Narrative

If you have concluded there are no equality impacts related to the policy/provision, please provide a brief narrative to explain why you have come to this conclusion:

The mortality review process applies equally to all patients and is a requirement for all consultant staff to engage with. Patients with learning disabilities, mental health issues and under the age of 18 have strengthened measures in place to ensure that these deaths are thoroughly reviewed to prevent any discrimination and to protect the most vulnerable.

If no equality impacts have been identified, this concludes the equality impact assessment. Please complete the declaration below:

Based on the information set out above I have decided that a full equality impact assessment is (please delete as appropriate):

Not necessary.

Appendix 1: Mortality Review Process

TRUST GUIDELINES / POLICIES TO FOLLOW

- **"Guideline for Staff Responsible for Care after Death" (GL595)**
- **"Protocol for Care of the Child after Death" (CG544)**
- **"Bereavement Guidelines" (GL111)**
- **"Berkshire Protocol, Health-Led Rapid Response for Unexpected Child Death" (GL111)**
- **"National Best Practice Clinical Guidance Implementation Policy" (CG543)**
- **"Clinical Governance Policy" (CG119)**
- **"Incident Reporting, Investigation and Learning Policy" (CG553)**
- **"Duty of Candour, Being Open Policy" (CG605)**

Inpatient RIP

- NoK informed; given bereavement info
- EPR updated

- Qualified Attending Practitioner (QAP) completes summary of care on CORS in discussion with consultant
- Bereavement Team contact QAP to arrange an appointment to see ME
- ME completes scrutiny of death (review of patient notes; discussion with QAP; telephone call to NoK)
- ME undertakes triage to decide if full SJR review is indicated
- Coronial referral made if required; if not, death certificate completed
- Electronic discharge letter (EDL) completed
- Bereavement Team contact GP & arrange for family to pick up death certificate

Child Death: notify the named nurse for child protection, and the Child Death Overview Panel Co-ordinator.

Learning Disability Death: notify LD Co-ordinator

Maternal/ perinatal death: notify the Bereavement Specialist Midwife

Death does not Trigger Review

No further action required

Death Triggers Review

Specialty lead sent request for SJR by QGT

SJR review completed on CORS, presented at specialty CG or M&M

Learning shared within specialty

Overall "Very poor" or "Poor" care identified

Stage 2 SJR completed

Grade 0 / 1 / 2

Reported to MSG **No further action required**

Grade 3

Presentation to MSG; consider for potential SIRI scoping*

Learning shared across the Trust

*At any point after death if a serious concern is identified about the care that has been given to a patient which may have led to significant harm or contributed to the death the incident should be reported on Datix and referred immediately to the Patient Safety Team for potential SIRI scoping.

Appendix 2: LeDeR Process Flowchart