



<b>Mortality Management Policy (Learning From Deaths)</b>				
<b>Date Approved:</b>	<b>Approved by:</b>	<b>Date of next review:</b>	<b>Policy Ref:</b>	<b>Issue:</b>
05-07-2017	Patient Safety & Quality Board	January 2019 (ext <sup>1</sup> )	CPG-TW- MMP/LfD	1.0
<b>Division/Department:</b> Trustwide		<b>Policy Category:</b> Clinical Policies & Guidelines		
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## Amendments

Version	Issue Date	Section(s) involved	Amendment
1.0	19-07-2017	• NEW	• Not Applicable
		•	•

## 1 INTRODUCTION

Many patients attend hospitals services every year and are discharged 'well', after effective treatment and care. A proportion of patients admitted to hospital will unfortunately die either because of a new and unexpected illness or the progression of a known or long term condition(s). It is hoped that all patients will have received excellent care and they and those family and friends close and important to them also report a positive experience of care. However some patients experience poor quality care as a result from sometimes single or multiple causal or contributory factors. These factors can include poor leadership, human factors and system-wide failures.

It is now compulsory to review all deaths of patients in the care of the NHS. When mistakes happen or poor care is delivered, it is important to do more to understand the causes and make improvements. The purpose of reviews / investigations into patient deaths where there may have been problems, is to learn from this process, offer explanations to those who are bereaved and prevent recurrence in the future for other patients. Reviews and investigations can only be useful for learning purposes if their findings are valued, shared and acted upon in the positive spirit of transparency and improvement. This process can also support and acknowledge good practice, and provide positive opportunities to share and help other teams.

Healthcare staff responsible for patients must also be "accountable" and this policy supports the operational procedure that clinicians must follow in reviewing and reporting information in clinical governance meetings in their Specialty, Division and to the Trust Mortality Surveillance Group.

This policy is issued and maintained by the Executive Medical Director as the sponsor on behalf of the trust, at the issue defined on the front sheet, which supersedes and replaces all previous versions.

## 2 POLICY STATEMENT

### Equality Impact Assessment

This policy is intended to be applied in a fair and consistent process to all patient deaths in the relevant clinical areas. The policy is expected to have its main impact in adult services and it will enhance existing strategies especially for patients / pathways for specific groups. These are identified in this policy.

The policy will help to identify any possible inequality or inequity of healthcare especially for those perceived to be specific protected characteristics and potential vulnerabilities. The policy promotes listen to and actively supporting bereaved families after death. This policy has been developed in keeping with existing policies in the Trust.

The Trust is committed to ensuring that none of its policies, procedures and guidelines discriminates against individuals directly or indirectly on the basis of gender, colour, race, nationality, ethnic or national origins, age, sexual orientation, marital status, disability, religion, beliefs, political affiliation, trade union membership, and social and employment status.

An EIA of this policy/guideline has been conducted by the author using the EIA tool developed by the Diversity and Inclusivity Committee – See [Appendix D](#).

The correct application of this policy will help to identify patients and those close to them who may have been subjective to discrimination.

### Privacy Impact Assessment (PIA)

The Policy has been subject to a detailed PIA which has been informed and supported by the Information Governance team.

This policy promotes a thorough examination of the patient's treatment and care during their admission. This process may require examination of other information, for example previous admissions or discussions with other health or social care providers.

This policy now requires an active consideration of the necessity to involve the bereaved family (as set in the National Quality Guidance, comply with the statutory requirement of the Duty of Candour and related information sharing procedures) and or those with specific legal / administrative relationships to the deceased. Where necessary and practicable, there will be a specific informed consent / assent with those close to the deceased patient.

## 3 DEFINITIONS AND/ OR ABBREVIATIONS

<b>'The Trust'</b>	Means the Sherwood Forest Hospitals NHS Foundation Trust
<b>'Staff'</b>	Means all employees of the Trust including those managed by a third party organisation on behalf of the Trust.
<b>Case record or Mortality review</b>	The application of a case record/note review to determine whether there were any problems in the care provided to the patient who died in order to learn from what happened, for example Structured Judgement Review delivered by the Royal College of Physicians.
<b>Investigation</b>	The act or process of investigating; a systematic analysis of what happened, how it happened and why. This draws on evidence, including physical evidence, witness accounts, policies, procedures, guidance, good practice and observation - in order to identify the problems in care or service delivery that preceded an incident to understand how and why it occurred. The process aims to identify what may need to change in service provision in order to reduce the risk of future occurrence of similar events.
<b>Death due to a problem in care</b>	A death that has been clinically assessed using a recognised methodology of case record/note review and determined more likely than not to have resulted from problems in healthcare and therefore to have been potentially avoidable

## 4 ROLE AND RESPONSIBILITIES

### The Board of Directors

**1. The Board of Directors** is collectively responsible for ensuring the quality and safety of healthcare services delivered by the Trust, taking into consideration the views of the **Board of Governors**.

**2. The Board of Directors** must ensure robust systems are in place for recognising, reporting, reviewing or investigating deaths and learning from avoidable deaths that are contributed to by lapses in care. The Trust should ensure such activities are adequately resourced. The Board of Directors must ensure the Trust works with commissioners and other providers to develop and implement effective actions to reduce the risk of avoidable deaths, including improvements when problems in the delivery of care within and between providers are identified.

**3. All Trust Directors**, executive and non-executive, have a responsibility to constructively challenge the decisions of the Board and help develop proposals on strategy.

**Non-executive directors, in particular**, have a duty to ensure that such challenge is made. They play a crucial role in bringing an independent perspective and should scrutinise the performance of the Trust's management in meeting agreed goals and objectives and monitor the reporting of performance. Non-executive directors should satisfy themselves as to the integrity of financial, clinical and other information, and that clinical quality controls and systems of risk management, for example, are robust and defensible.

### Learning from Deaths

Executive and non-executive directors have a key role in ensuring their Trust is learning from problems in healthcare identified through reviewing or investigating deaths by ensuring that:

- the processes are in place are robust, focus 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
- the information the Trust publishes is a fair and accurate reflection of its achievements and challenges.
- must ensure that there is a system to collect, publish and learn from new data to monitor trends in deaths. Board oversight of this process is as important as board oversight of the data itself. As a critical friend, non-executive directors should hold the Trust to account particularly those deaths assessed as having been avoidable.

**The roles and responsibilities of non-executive directors (as set out by the National Quality Board) include:**

- 1. "Understand the process: ensure the processes in place are robust and can withstand external scrutiny, by providing challenge and support.** This includes:
  - being curious about the accuracy of data and understand how it is generated; who is generating it, how are they doing this, is the approach consistent across the Trust, are they sufficiently senior/experienced/trained?

- seek similar data and trend information from peer providers, to help challenge potential for improvements in your own organisation's processes, but understand limitations of any direct comparisons;
- ensure timely reviews/investigations (what is the interval between death and review or investigation?), calibre of reviewer/investigator and quality of the review or investigation;
- is the Care Record Review process objective, conducted by clinicians not directly involved in the care of the deceased?
- how was the case-record review selection done? For example, does selection reflect the evidence base which suggests older patients who die or those where death may be expected are no less likely to have experienced problems in healthcare that are associated with potentially preventable death? Does it ensure all vulnerable patient groups (not just those with learning disabilities or mental health needs) are not disadvantaged?
- are deaths of people with learning disabilities reviewed according to the LeDeR methodology?
- for coordination of responses to reviews/investigations through the provider's clinical governance processes, who is responsible for preparing the report, do problems in care identified as being likely to have contributed to a death feed into the organisation's Serious Incident processes?"

**2. "Champion and support learning and quality improvement" such as:**

- ensuring the organisation has a long-term vision and strategy for learning and improvement and is actively working towards this;
- understanding the learning being generated, including from where deaths may be expected but the quality of care could have been better;
- understanding how the learning from things going wrong is translated into sustainable effective action that measurably reduces the risks to patients - ensuring that learning and improvements are reported to the board and relevant providers;
- supporting any changes in clinical practice that are needed to improve care resulting from this learning;
- ensuring families and carers are involved reviews and investigations, and that nominated staff have adequate training and protected time to undertake these processes;
- paying attention to the provision of best practice and how the learning from this can be more broadly implemented.
- iii. Assure published information; ensure that information published is a fair and accurate reflection of the provider's achievements and challenges, such as:
  - ensuring that information presented in board papers is fit for publication i.e. it is meaningful, accurate, timely, proportionate and supports improvement;
  - checking that relevant team are working towards a timely quarterly publication, in line with the Quality Accounts regulations and guidance;
  - checking that arrangements are in place to invite, gather and act on stakeholder feedback on a quarter by quarter basis;
  - ensuring the organisation can demonstrate to stakeholders that "this is what we said we would do, and this is what we did" (learning and action), and explain the impact of the quality improvement actions."

### **Doctors must**

#### Consultant staff must

- ensure all patients that have died in their care have the standard of the treatment and care and the mechanism of their death reviewed (as set out in the relevant standard procedure)
- offer support to non-consultant medical / healthcare staff to complete this process in a timely and accurate manner complying to the information standards set out in the mortality reporting systems
- correctly identify deaths that need to be subject to the different steps of review as set in the procedure and where relevant escalate cases quickly where serious failings have been identified (complying with the NHS Serious Incident Reporting Framework)

### **Nurses, Allied Healthcare and other registered clinical staff are responsible for:**

- contributing to the process of care after death, the support for the bereaved and the timely involvement of other key groups or specific groups where relevant e.g. if there was a concern or complaint about the standard of care
- being involved in working with the medical staff to offer information to support the review and report of a death (as set out in the procedure) as part of a multi-professional approach
- and be accountable for the standard of treatment they administer and the care they provide

### **Specialty and Divisional Clinical / Governance Leads are responsible for:**

- ensuring that there is a system in place to deliver the clinical governance process as set in the
- policy and procedure
- supporting these staff to perform and report reviews
- facilitating multi-professional forums to allow reviews and performance to be discussed and the lessons learned and shared in a confidential and professional manner
- working with other professional groups e.g. matrons, clinical nurse specialist / teams or specialty teams or services to ensure reviews and discussions are adequately supported, information is shared and the quality of learning outcomes is optimised.

### **Service Directors and Heads of Nursing (supported by General and Senior Management) are responsible for:**

- ensuring the policy and procedure is implemented
- meeting the performance requirements set out in the policy and procedure and where there are system problems they are addressed.
- addressing any individual or professional under-performance or lack of competency, and where relevant any serious breaches of professional standards

## 5 SCOPE OF POLICY

This clinical document applies to:

### Staff group(s)

- This is a Trustwide clinical policy, which focuses on those staff directly or indirectly providing a clinical service to the patients. It also applies to service managers, administrative and governance staff in the Trust. Specific responsibilities are identified in this policy.

### Clinical area(s) and Patient group(s)

- This policy is intended to be applied in a fair and consistent process to all patient deaths in all clinical areas. The policy is expected to have its main impact in adult services; there are clear and existing patients / pathways patient for specific groups.

### Related Trust policies and guidelines and/or other Trust documents

- Incident Reporting Policy, Procedures and Toolkit
- Risk Management Policy
- Last Days of Life for Adults Policy
- Verification of an Expected Adult Death by Registered Nurses Policy
- Emergency Department Record Sharing – ‘share in’ implied consent policy

## 6 CONSULTATION

The following individuals, groups of staff and Trust group(s)/ committee(s) have been consulted in the development/ update of this document:

<b>Contributors:</b>	<b>Communication Channel: e.g.</b> • Email • 1:1 meeting/ phone • Group/ committee meeting	<b>Date:</b>
Kim Kirk, Head of Patient Experience	Email	05-05-2017
Jacque Widdowson, Information Governance Manager	Email; meeting with IG representative	05-05-2017
Dr Colin Dunkley, Childrens and Women’s Division Governance lead	email	12-05-17
Shared to all MSG meeting recipients	Email	June 2017
Feedback from Dr S Foley	Email	June 2017
Feedback from Dr Clements (Womens/Childrens Division) and Jackie Briggs (Child Death Review Team)	Email Telephone	June 2017
Mortality Surveillance Group	Group meeting	July 2017

## 7 NARRATIVE

The introduction to this policy sets out the national mandate and how the NHS requirement to ensure all patient deaths are reviewed. This helps to identify good care as well as what could have been improved. This policy reflects the guidance set out by the National Quality Board which has been driven by the collected learning from national reviews and through inspection and regulation by the Care Quality Commission.

**This policy and the standard procedure ([Appendix A](#)) sets out how the Trust and its staff must:**

- determine which patients are considered to be under their care and included for case record review if they die
- respond to the death of an individual using the established and where required specific mechanisms with a learning disability; or mental health needs; an infant or child death and a stillbirth or maternal death and the Trust's processes to support such deaths; report the death within the organisation

Further information regarding infant, child, stillbirth, newborn and maternal deaths can be found in [Appendix B](#). In addition, more detailed information can be found in the following associated trust procedures and guidelines/ documentation:

- [Procedure for the reporting of perinatal deaths](#)
- [Maternal death – standard operating procedure](#)
- [Sudden Unexpected Death in Children up to the age of 11 years](#) (guideline/ documentation)
- [Sudden Unexpected Death in Young People between the ages of 12-18 years](#) (guideline/ documentation)

A summary chart regarding deaths in people who have a learning disability can be found in [Appendix C](#). The previous CIPOLD reporting system (Confidential Enquiry into Premature Deaths of People with Learning Disabilities) has recently stopped and the new LeDeR system (Learning Disabilities Mortality Review) programme is not yet fully embedded. The Trust anticipates this system will be live in Nottinghamshire during this (2017-18) year. Local information will be collated and any LeDeR outcomes be also considered by the Safeguarding Steering Group. Current case reviews are reported to this Trust group.

**This policy requires careful consideration of any staff in the review and discussion of any death where there is potential need for information sharing:**

- to other organisations who may have an interest (including the deceased person's GP), including how they determine which other organisations should be informed
- review the care provided to patients who they do not consider to have been under their care at the time of death but where another organisation suggests that the Trust should review the care provided to the patient in the past

**This policy and the review procedures (which include specific information about the quality of palliative and end of life care) ensures there is a**

- review of the care provided to patients whose death may have been expected, for example those receiving end of life care

**This policy requires sensitive and meaningful engagement with bereaved families and carers. This must**

- record the outcome of the review / investigation process of all cases identified and informed by the views of bereaved families and carers (where these people have significant concerns or complaints)
- To appoint a member of the Patient Experience Team (and /or Bereavement Centre) to be the initial and the on-going contact with the bereaved families and carer
- to facilitate listening and recording of any concerns or complaints
- to ensure the family/carers are informed if the Trust intends to review or investigate the care provided to the patient. In the case of an investigation, this should include details of how families/carers will be involved to the extent that they wish to be involved
- to manage the involvement and discussions between the clinicians responsible for the care of the patient with the bereaved families and carers
- to offer guidance, where appropriate, on obtaining advocacy, legal advice for families carers or staff. This should include clear expectations that the reasons, purpose and involvement of any lawyers by the Trust will be communicated clearly from the outset.

## 8 EVIDENCE BASE

- **CQC report: Learning, Candour and Accountability – a review of the way NHS Trusts review and investigate the deaths of patients in England (Dec 2016)**
- **Royal College of Physicians: National Mortality Case Record Review Programme**  
<https://www.rcplondon.ac.uk/projects/national-mortality-case-record-review-programme>
- **National Quality Board: National Guidance on Mortality Reporting (March 2017)**  
<https://www.england.nhs.uk/wp-content/uploads/2017/03/ngb-learning-from-deaths-dashboard.xlsx>
- Working together to safeguard children (2010)

## 9 MONITORING COMPLIANCE

The Trust has developed an electronic reporting tool for all deaths.

- [Appendix A](#) sets out the standard procedure requirements for adults for timely reviews and reporting of adult deaths in the Trust.
- [Appendix B](#) sets the procedure for ‘Maternal, Infant, Child and Young People’ deaths;
- [Appendix C](#): sets out the Learning Disabilities (LeDeR) Programme Review.

Data will be collated, checked and analysed at each stage of the procedure, and where necessary corrected in the electronic review / reporting tool. This electronic tool, the Mortality Reporting Tool, will provide summary reports for the data to achieve the requirements set out in the national Framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care set out below in the Department for Health dashboard. More detailed information from the electronic tool will also be available to start to provide clinical accountability, service level information, trends and themes.

There are existing frameworks and national audit processes for specific deaths of patients:

- Learning Disabilities
- Patients in Detention (which now excludes DOLS orders)
- Mental Health (and subject to specific detention under this Act)
- Maternal, Infant, Child and Young People

Specific other requirements set out in coronial and criminal statutory law remain the same. For most patients this relates to the reporting of a death to the coroner. There are established procedures in place for this, already subject to monitoring and audit.



*"This suggested dashboard is a tool to aid the systematic recording of deaths and learning from the care provided by NHS Trusts. Trusts may use this to record relevant incidents of mortality, deaths reviewed and lessons learnt to encourage future learning and the improvement of care.*

*Guidance on what should be recorded in individual fields is provided below, alongside instructions for completing and updating the dashboard. This guidance on individual fields complements the wider guidance provided in the National Framework on Learning From Deaths and separate methodology guidance on the Structured Judgement Review (SJR) as developed by the Royal College of Physicians (RCP). The dashboard is not prescriptive and Trusts may set their own definitions according to local goals and data availability, although minimum requirements are set out in the framework"*

Field No.	Field	Description of Field
<b>Recording data on structured judgement reviews:</b>		
1	<b>Total Number of Deaths in scope</b>	This must as a minimum include all adult inpatient deaths excluding maternity services. Where additional deaths are included (for example maternal deaths, deaths post-discharge or deaths of outpatients etc) the inclusion criteria should be made clear in this field, which can vary by trust. The total number of deaths in scope defined in this field must be used in all subsequent relevant fields in this work book. If a post-discharge period is being included in scope, (eg deaths within 30 days of discharge) then the death should be counted in the month where the death actually occurred rather than time of admittance or discharge.  Note that where it has been identified that a patient has a learning disability the death should be recorded separately (see Data item 6, below).
2	<b>Total Number of Deaths Reviewed under the SJR methodology</b>	This is the total number of deaths for which the care provided to the patient has been reviewed by your Trust. This may be a combination of deaths reviewed under national and local minimum requirements and random sampling of all other deaths in scope.
3	<b>Total number of deaths considered to have more than a 50% chance of having been avoidable</b>	The Structured Judgement Review methodology, for use in relation to adult acute inpatient deaths, allows for reviewers to score a death as having a more than 50% chance of having been avoidable when this judgement is made in relation to the care provided by the trust conducting the review. This is the equivalent of a score of 3 or less. If using the RCP SJR then the number of such deaths scored in this way is equivalent to this field  If not using RCP SJR, then the method used to judge whether a death was more likely than not to have been avoidable in relation to the care provided by the trust conducting the review (or another provider if appropriate) should be stated here including any definitions used. Note that if you are applying other methodologies to specific groups, such as learning disabilities patients, those methodologies may require a degree of judgement to determine whether the death was more likely than not to be avoidable. It may be appropriate to cross-reference those outputs with the processes for assessing structured judgement reviews, and if appropriate to include those outputs here.  If the RCP SJR methodology is being used for structured judgement reviews Trusts are able to include monthly totals of reviewed deaths that were in each category 1 to 6. If the Trust is not using this methodology these fields can be either left blank or edited as appropriate.
<b>Recording data on LeDeR reviews:</b>		
4	<b>Total Number of Deaths in scope</b>	This must include all adult inpatient deaths for patients with identified learning disabilities. The total number of deaths in scope defined in this field must be used in all subsequent relevant fields. If a post-discharge period is being included in scope, (eg deaths within 30 days of discharge) then the death should be counted in the month where the death actually occurred rather than time of admittance or discharge.
5	<b>Total Deaths Reviewed Through the LeDeR Methodology</b>	Formally, the LeDeR review methodology should be applied to all of the deaths shown as 'in scope'. You should record the total number of deaths reviewed here.
6	<b>Total Number of deaths considered to have been potentially avoidable</b>	Record the total number of deaths for which review evidence leads to a conclusion that it is more likely than not that the death was potentially avoidable. This will require that a degree of judgement is applied to the outputs of the LeDeR review, and it may be appropriate to cross-reference these outputs with the processes for assessing structured judgement reviews

This policy and the quality of the outcomes will be subject to clinical audit and independent audit as part of the Trustwide clinical audit plan. Information will be presented through the quality dashboard and be supported by detailed quarterly reports to the Board of Directors and delegated sub-groups.

<b>WHO</b> is going to monitor this element (job title of person/ group responsible)	<b>WHAT</b> element of compliance or effectiveness within the procedural document will be monitored	<b>HOW</b> will this element be monitored (method used)	<b>WHEN</b> will this element be monitored (frequency/ how often)	<b>REPORTING</b> Which committee/ group will the resultant report and action plan be reported to and monitored by (report should include any areas of good practice/ organisational learning)
Specialty Governance Lead	See dash board. Also trends and themes and changes as a result of review must be reported.		monthly	Specialty reporting to Division
Divisional Governance Leads			monthly	Division reporting to Mortality Surveillance Group
Chair of the Mortality Surveillance Group			Monthly, Offering quarterly Board reports Mortality Surveillance Group	

## 10 TRAINING REQUIREMENTS

An educational framework with supporting resources has been developed to support the implementation of this policy. The training is not mandatory training but must be seen as important in the competency of staff, especially all medical consultant staff.

The initial awareness raising and training has been advertised and attendance recorded and where possible added to the OLM Administration Officer: Training, Education and Development Department, King's Mill Hospital.

## 11 DISTRIBUTION

This policy will be distributed through the divisions and specialty teams in the Trust and will be identified and located on the Trust intranet.

## 12 COMMUNICATION

This policy will be included

- in the Trust/ local induction of new staff
- in the monthly team brief for dissemination through the organisational structures
- in the staff bulletin
- in designated communication tools e.g. (i)care2, patient safety bulletin, medications newsletter
- Email sent by the author to key stakeholders

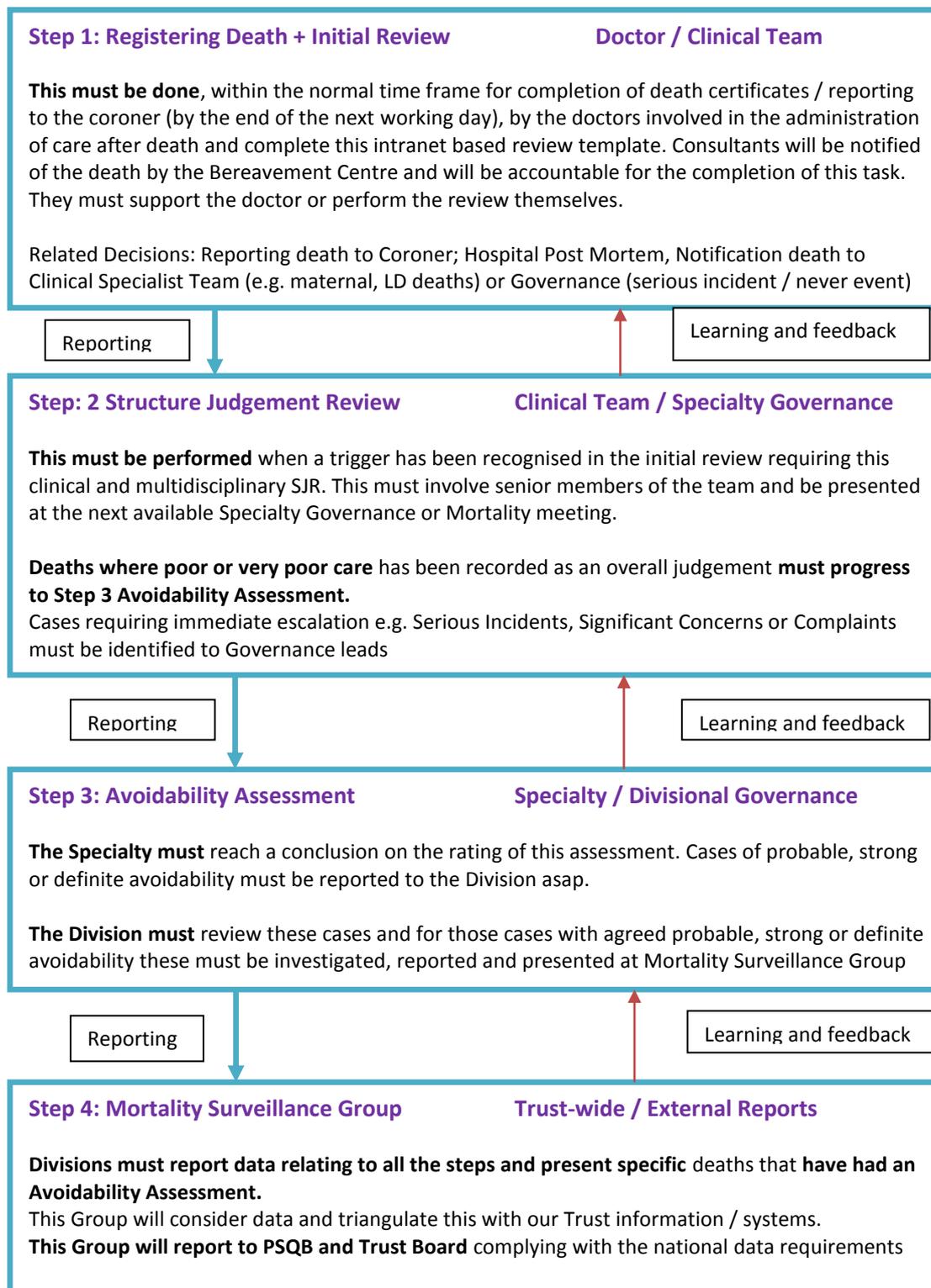
### 13 AUTHOR AND REVIEW DETAILS

<b>Issue/ Version:</b>	v1.0
<b>Date issued:</b>	19 <sup>th</sup> July 2017
<b>Date to be reviewed by:</b>	January 2019 (ext <sup>1</sup> )
<b>To be reviewed by:</b>	Dr Ben Lobo, Consultant Physician / Geriatrician
<b>Executive Sponsor:</b>	Executive Medical Director
<b>Supersedes:</b> (Ref No., Version number, previous title if changed, date issued – review date).	NEW POLICY – Not Applicable but supersedes the current stand-alone document as this is now incorporated as an appendix of the Policy: Standard procedure for the review and reporting of adult deaths (v1.0, issued May 2017 to RV May 2018)

### 14 APPENDICES

- [Appendix A](#) – Standard Procedure for the Review and Reporting of Adult Deaths
- [Appendix B](#) – Reporting Still Births, Newborn, Infant, Child and Maternal Deaths
- [Appendix C](#) – Summary Chart for Learning Disabilities Mortality Review Programme
- [Appendix D](#) – Equality Impact Assessment (EqIA) Form

## Appendix A – Standard Procedure for the Review and Reporting of Adult Deaths



## Appendix B: Reporting Still Births, Newborn, Infant, Child and Maternal Deaths

SFH contributes to the national system of the reporting of these deaths and the information can be found at <https://www.npeu.ox.ac.uk/mbrpace-uk>.

'MBRRACE-UK' is the collaboration appointed by the Healthcare Quality Improvement Partnership (HQIP) to run the national Maternal, Newborn and Infant clinical Outcome Review Programme (MNI-CORP) which continues the national programme of work conducting surveillance and investigating the causes of maternal deaths, stillbirths and infant deaths.

**The aim** of the MNI-CORP MBRRACE-UK programme is to provide robust national information to support the delivery of safe, equitable, high quality, patient-centred maternal, newborn and infant health services.

**MBRRACE-UK achieves this by:**

- Surveillance of all maternal deaths
- Confidential enquiries into maternal deaths during and up to one year after the end of the pregnancy
- Confidential enquiries into cases of serious maternal morbidity on a rolling basis
- Surveillance of perinatal deaths including late fetal losses (22-23 weeks gestation), stillbirths and neonatal deaths

Confidential enquiries into stillbirths, infant deaths and cases of serious infant morbidity on a rolling basis

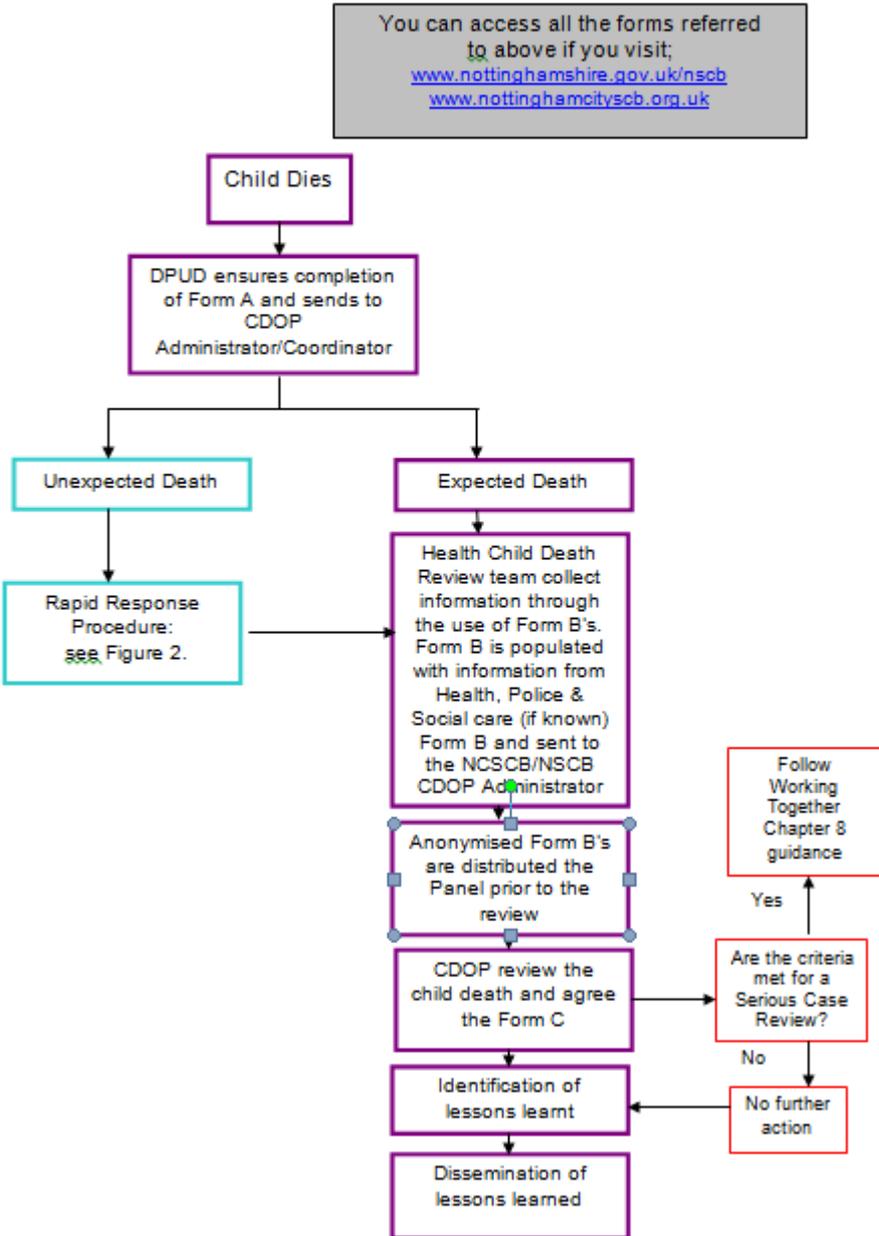
The Trust has a detailed and robust reporting and review system for deaths of children through the Nottinghamshire Safeguarding system, a summary of the process is included in figure 1 and 2 which set out the processes to be followed when a child dies in the Nottingham City and Nottinghamshire Local Authority areas as set out in Working Together to Safeguard Children (2010). There are two interrelated processes for reviewing child deaths (either of which can trigger a Serious Case Review (Chapter 8 in Working Together):

- a. rapid response by a group of key professionals who come together for the purpose of enquiring into and evaluating each unexpected death of a child
- b. an overview of all child deaths up to the age of 18 years (excluding both those babies who are stillborn and planned terminations of pregnancy carried out within the law) in the LSCB area(s) undertaken by a panel.

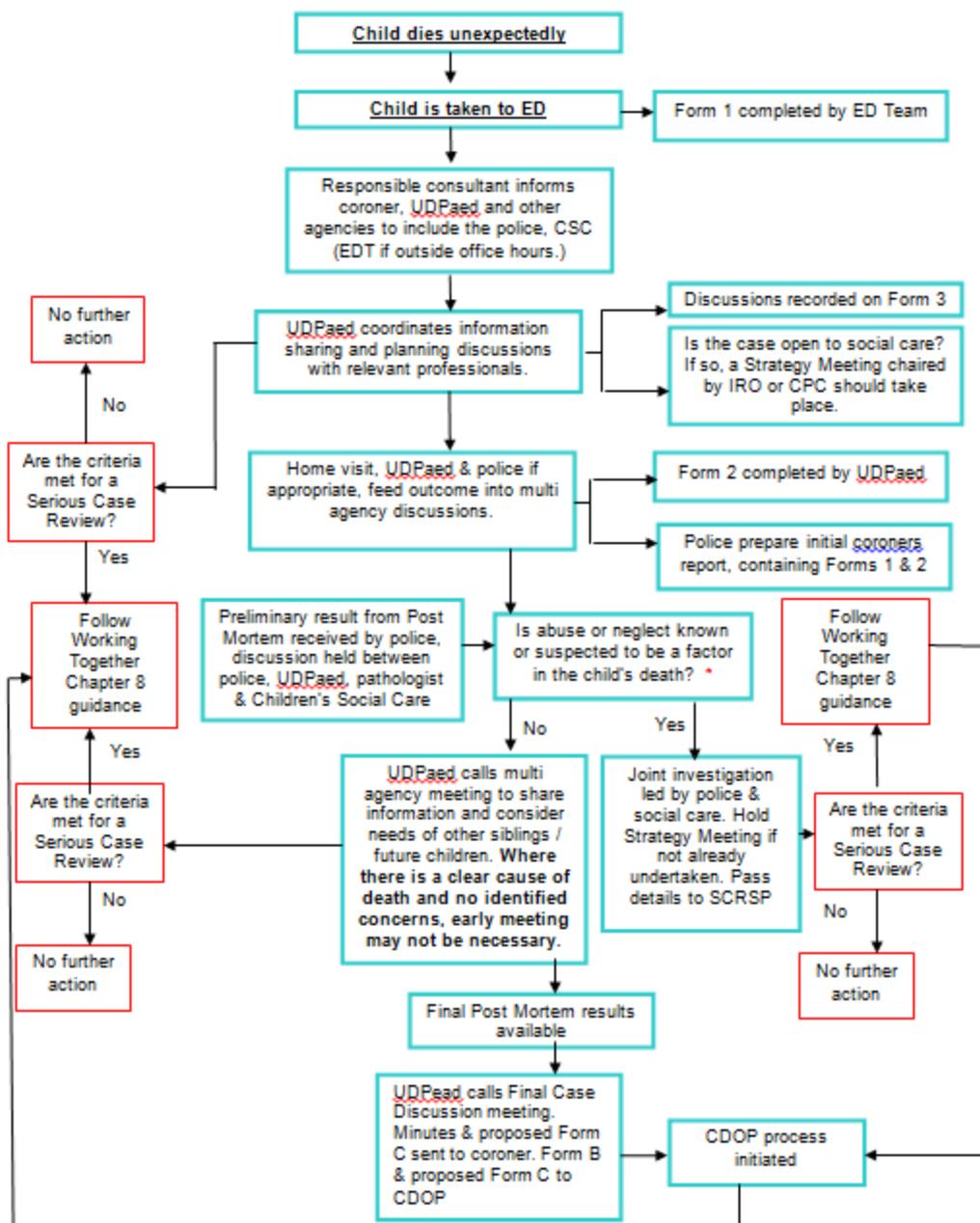
The deaths are reported to the Coroner and supported by the Child Death Review Team. The deaths are reported to the Child Death Overview Panel a multi-agency group (for the appropriate local authority area) that informs reports to the Safeguarding Childrens Board.

Monthly mortality review meetings occur in the women and children's division (appropriately supported by other clinical team representatives) to ensure all cases are reviewed and understand and act upon any learning from any of the local or statutory review processes.

Figure 1: Child Death Review Process



**Figure 2: Rapid Response Process**



Appendix C Summary Chart for Learning Disabilities Mortality Review Programme

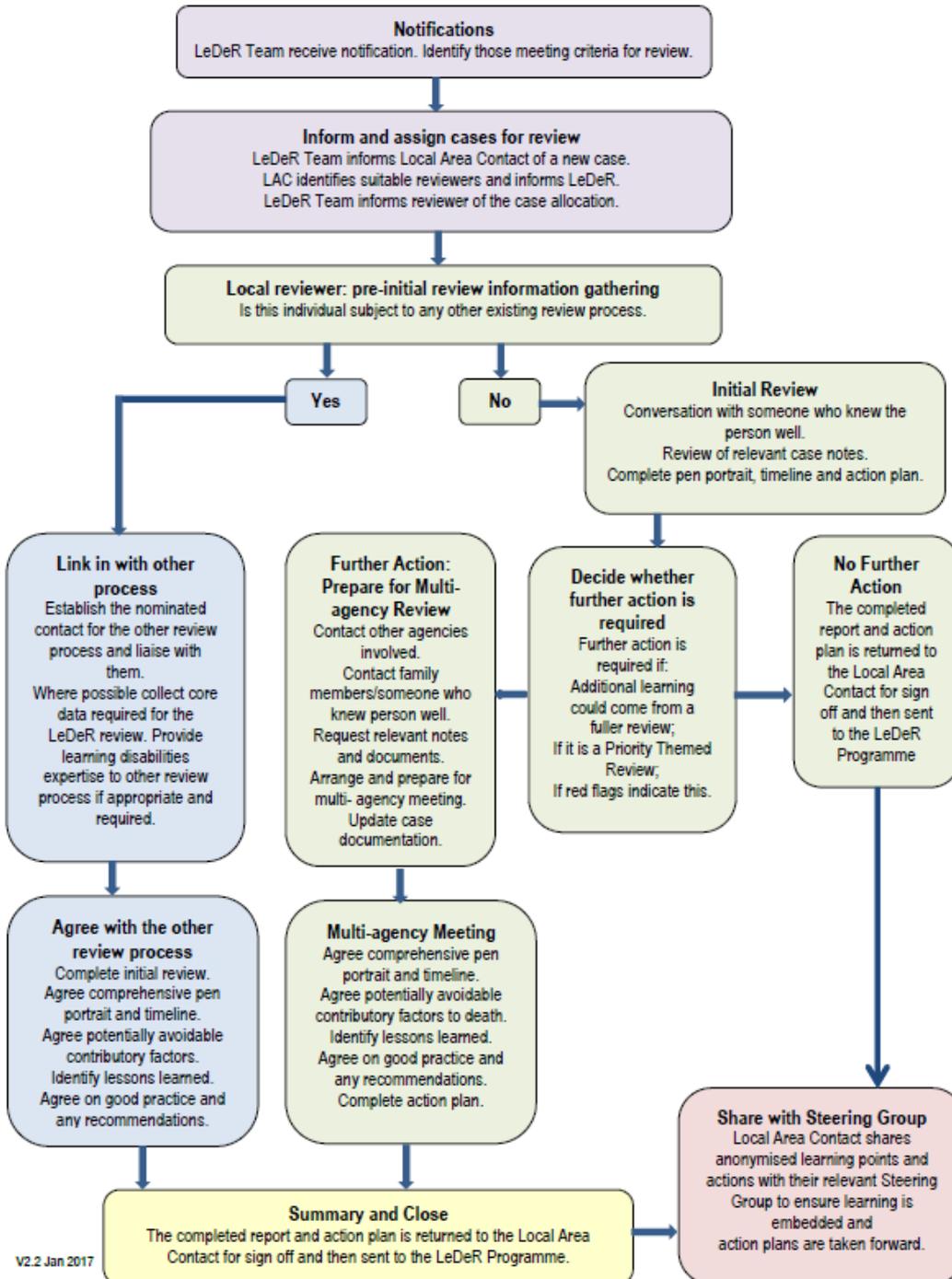


Learning Disabilities Mortality Review (LeDeR) Programme



The Learning Disabilities Mortality Review (LeDeR) Programme is commissioned by the Healthcare Quality Improvement Partnership (HQIP), on behalf of NHS England.

LeDeR Process Flowchart



v2.2 Jan 2017

**Appendix D – Equality Impact Assessment (EqIA) Form** (please complete all sections)

Name of service/policy/procedure being reviewed:			
New or existing service/policy/procedure:			
Date of Assessment:			
<i>For the service/policy/procedure and its implementation answer the questions a – c below against each characteristic (if relevant consider breaking the policy or implementation down into areas)</i>			
Protected Characteristic	a) Using data and supporting information, what issues, needs or barriers could the protected characteristic groups' experience? For example, are there any known health inequality or access issues to consider?	b) What is already in place in the policy or its implementation to address any inequalities or barriers to access including under representation at clinics, screening?	c) Please state any barriers that still need to be addressed and any proposed actions to eliminate inequality
The area of policy or its implementation being assessed:			
<b>This is a policy that looks at the standards and outcomes of treatment and care of patients that have died in this Trust. It does not directly affect these deceased patients and any impact on those important to the deceased patient (the bereaved) will be offered support by the patient experience team. This does not affect the legal or human rights of the deceased or those people close to them. This statement applies to all people with protected characteristics.</b>			
Race and Ethnicity:	Please see other statements. Low impact policy with safeguards and controls in place.		
Gender:			
Age:			
Religion:			
Disability:			<b>LeDer (national Learning Disabilities Mortality Review) systems are not fully established in this locality</b>
Sexuality:			
Pregnancy and Maternity:			
Gender Reassignment:			
Marriage and Civil Partnership:			
Socio-Economic Factors (i.e. living in a poorer neighbourhood / social deprivation):			

**The implementation of this policy, data collection and analysis will help identify any potential inequality especially those who may have a protected characteristic. The establishment of a baseline of information will provide a comparison for trends and themes. This will be supported by information and reports for and by the Trust e.g. Dr Foster; Nottinghamshire Safeguarding and Childrens Board.**

<p>What consultation with protected characteristic groups including patient groups have you carried out?  <b>There has been no external or public consultation at local level. Internal consultation is described in section 6 of this document.</b>  <b>The national guidance which has been, to a greater extent prescriptive, has been through a formal route.</b></p> <p>What data or information did you use in support of this EqIA?  <b>Please see above.</b></p>
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As far as you are aware are there any Human Rights issues be taken into account such as arising from surveys, questionnaires, comments, concerns, complaints or compliments?

**This is a positive policy approach to the national CQC report: Learning, Candour and Accountability – a review of the way NHS Trusts review and investigate the deaths of patients in England (Dec 2016)**

Level of impact

From the information provided above and following EqIA guidance document ([insert link](#)), please indicate the perceived level of impact:

**Low Level of Impact**

For high or medium levels of impact, please forward a copy of this form to the HR Secretaries for inclusion at the next Diversity and Inclusivity meeting.

Name of Responsible Person undertaking this assessment:

Signature:  
Dr Ben Lobo

Date: 28<sup>th</sup> June 2017, Updated 19/07/17