Blackpool Teaching Hospitals
NHS Foundation Trust

Responding to Deaths Policy

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Approved by:	Dr Jim Gardner, Medical Director (extension with updates prior to full review)				
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Version Control Sheet

This must be completed and form part of the document appendices each time the document is updated and approved

Date dd/mm/yy	Version	Author	Reason for changes
	3	Principle reviewer - Dr R J M Morgan 1st September 2020	Amendments await outcome of current trust improvement plan in relation to mortality governance

Consultation / Acknowledgements with Stakeholders		
Name	**Designation**	**Date Response Received**
Richard J M Morgan	Intermediate review conducted by Dr Richard Morgan on 1st September in parallel with the formulation and implementation of trust wide improvement plan which has particular focus on mortality governance. Recommend that postponement of follow up detailed policy review for four months' by which time amendments resulting from the trust wide improvement plan will have been implemented.	1st September 2020

CONTENTS

1 Introduction / Purpose

Death is the most easily trackable outcome of care; it is easily counted and occurs predominantly in hospital. Standardised mortality rates (SMR's), as advocated by one section of Dr Foster's intelligence unit, have been equated with quality of care in hospital. There are several different measures of SMR in use nationally. Hospital Standardised Mortality Ratio (HSMR) and Standardised Hospital Mortality Indicator (SHMI) are not, on their own, reliable measures of the quality of hospital care and lack of information regarding the methodology underlying the calculation of SMR's has caused unease amongst care providers. Many deaths are expected and from identifiable causes; there are also preventable deaths.

In line with the Care Quality Commission (CQC) document 'Learning from Deaths' we need to identify preventable or avoidable deaths or serious consequences leading to disability. There is also an opportunity and responsibility for the organisation to identify and disseminate action and learning points as part of the mortality governance process.

The purpose of this policy is to extend our existing work on reducing mortality and to incorporate the national guidance on 'Learning from Deaths'.

The policy describes how we will:

- determine which patients are considered to be under our care and included for case record review if they die;
- report the death within the organisation and to other organisations who may have an interest (including the deceased person's General Practitioner (GP)), including how we determine which other organisations should be informed;
- respond to the death of an individual with a learning disability or mental health needs, an infant or child death (and a stillbirth) or maternal death and our processes to support such deaths;
- review the care provided to patients we do not consider to have been under our 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;
- review the care provided to patients whose death may have been expected, for example those receiving end of life care;
- record the outcome of our decision whether or not to review or investigate the death, which should have been informed by the views of bereaved families and carers;
- engage with bereaved families and carers including informing the family/carers if we intend 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.

In view the persistently elevated HSMR for the trust, in 2009 the then medical director established the trust mortality board, subsequently renamed the trust mortality committee and now known as the Blackpool Teaching Hospitals and Fylde Coast Mortality Governance Committee (MGC).

Our mortality governance work currently includes:

- Bimonthly Mortality Governance Committee (MGC) Meetings
- Bimonthly Trust Mortality Governance Group (TMGG) meetings
- Weekly meetings of the Mortality Reduction Steering Group
- Regular speciality mortality governance meetings
- Identification of opportunities for action and learning for trust wide and within speciality dissemination
- Embracing the principles outlined in 'Learning From Deaths'
- Responding to periodic (CQC) Alerts – (e.g. Stroke / Pneumonia / CAD / Unspecified Chest infection / Fluid and Electrolytes).
- Pathway design, implementation and ongoing refinement for diagnostic groups with high SHMI values (e.g. Sepsis, Stroke, COPD Pneumonia)
- 'End to End' retrospective case records review in conjunction with primary care looking at opportunities for action and learning to improve patient care (e.g. stroke and deaths within 48 hrs of admission to hospital)

2 General Principles / Target Audience

The policy applies to clinicians in all specialties including those with locum or temporary contracts. Implementation of the policy will be supported by administrative staff and managers as required

3 Definitions and Abbreviations

ALL — Action and Learning Points Log

Avoidable / Preventable
These terms are used interchangeably in the NHS and for the purpose of this policy will be used with reference to whether anything could have been done to change the outcome.

Complication
An additional problem that arises following a procedure, treatment or illness and is secondary to it / complicates the situation.

CQC — Care Quality Commission

GP — General Practitioner

Harm — from act of omission (inactions) such as failure to diagnose and treat
from act of commission (affirmative actions) such as incorrect treatment or management
from unintended complications of healthcare
Some further examples are medication errors, IV infection, surgical mistakes and postoperative septicaemia.

HOD — Heads of the Department

HSMR	Hospital Standardised Mortality Rate
LeDeR	Learning Disabilities Mortality Review
MBBRACE-UK	Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK
Morbidity	This relates to adverse outcomes
Mortality:	Expected Deaths
Mortality:	Unexpected Deaths The patient died of an unexpected illness not suspected by the managing team. The diagnosis was suspected and the patient was treated but died despite not having bad prognostic features associated with that diagnosis/condition. The diagnosis was suspected and the patient was treated, however the treatment was suboptimal.
Mortality Governance Meetings (MGMs)	MGM meeting is where a multi-disciplinary group review and discuss clinical cases, outcome data (clinical and patient reported) and related information (e.g. SUI, complaints, HED or other benchmarking data).
Mortality Governance Committee (MGC)	Bi-monthly meeting including trust, primary care and CCG representation, chaired by the medical director and reporting to the trust quality committee
MGL	Mortality governance Lead
NMCRR	National Mortality Case Record Review
RCOG	Royal College of Obstetricians and Gynaecologists
SAS	Speciality and Associate Specialist
Serious Incident (SI)	Avoidable events Failure to recognise: There was evidence that an intervention could have been made prior to the patient's death that potentially would have impacted the patient's outcome Failure to plan: Diagnosis, investigation, treatment or asking for a rescue team Failure to communicate: Patient to staff, clinician to clinician, inadequate documentation, inadequate supervision, leadership etc
SHMI	Summary Hospital Mortality Indicator
SMGL	Speciality Mortality Governance Leads
SMR	Standardised mortality rate
Trust Mortality Governance Group (TMGG)	Bi-monthly meeting of speciality mortality governance leads, senior nurses and divisional quality managers chaired by trust mortality reduction and governance lead. Reports to the MGC

4 Responsibilities (Ownership and Accountability)

4.1 The Trust Board

- In line with 'Learning From Deaths' The Medical Director shall assume the role of Patient Safety Director, and the non-Executive Director Chair of the Quality Committee shall have oversight of this policy.
- The chair of the Quality Committee shall report on mortality governance to the trust board as informed by the mortality governance committee.
- Mortality reporting in relation to deaths, reviews, investigations and learning shall be provided regularly to the board. The reporting shall be discussed at the public section of the board with data suitably anonymised;
- The Board shall ensure that learning from reviews and investigations is acted on to change sustainably clinical and organisational practice and improve care, and is reported in annual Quality Accounts
- The board ensures that relevant learning is shared across the organisation and with other services where the insight gained could be useful and works with commissioners to review and improve their respective local approaches following the death of people receiving care from their services.

4.2 Medical Director

- Is responsible for the mortality governance process.
- Provides an overarching framework for the Divisions and the Trust.
- Chairs the Mortality Governance Committee

4.3 Trust Mortality Reduction and Governance Lead

- Has an overview of mortality governance activity across the trust.
- Undertakes teaching and training at speciality and trust wide level on matters of mortality governance.
- Ensures that the mortality governance process is informed by regular review and reporting against discrete levels of available information (Appendix 3).
- Collates mortality governance reports on a trust wide basis including ensuring appropriate recording and dissemination of action and learning points.
- Deputises for the Medical Director as directed in matters of mortality governance

4.4 Divisional Directors

- Ensure that resources and facilities are available to hold regular mortality governance meetings.
- Ensure that a consistent, structured process (section 5.2 below) is used for the retrospective review of the case notes of deceased patients.
- Ensure that action points are implemented and learning points are disseminated appropriately and in timely fashion.
- Are responsible and accountable to the Medical Director for information and escalation of issues identified.

4.5 Heads of the Department (HOD)

- Ensure that the speciality takes part in mortality governance meetings on a regular basis.
- Ensure that case notes of deceased patients are reviewed by experienced clinical staff using a consistent, structured process designed to highlight any problems in the health care provided for any given patient, and to identify action and learning points arising from those problems. The structured review process should include a statement of the degree to which each of any identified problems in health care contributed to the death of the patient and should also invite a statement of avoidability of death in the opinion of the reviewer.
- Ensure that records of the structured, consistent review of the case notes of deceased patients are retained for the purpose of retrospective audit and quality control
- Ensure that agreed actions are implemented in timely fashion.
- Ensure that identified learning points are disseminated appropriately.
- Help in organising meetings and supporting the speciality mortality governance leads as required.
- Are responsible and accountable to the Divisional Director for the reporting of speciality mortality governance matters and for the escalation of specific issues as appropriate. (Appendix 5)

4.6 Speciality Mortality Governance Leads (SMGL)

- Organise and chair regular speciality mortality governance meetings.
- Allocate patients for retrospective case record review amongst experienced clinical colleagues
- Identify action points and make assignments for their implementation.
- Identify learning points and assign for dissemination.
- Keep a record of attendance.
- Keep records of the conduct of all meetings.

- Amend documents / proformas as required in consultation with head of department and/or trust mortality reduction and governance lead.
- Submit action and learning points reports to head of department, divisional director and trust mortality governance lead after each mortality governance meeting (Appendix 5).

4.7 Medical staff (Consultants, Staff and Associate Specialist Doctors (SAS), Trust Doctors, Trainees)

- All Consultants to participate in mortality governance meetings.
- Consultants to ensure that their trainees and other doctors are able to attend mortality governance meetings. This learning opportunity constitutes an important part of junior doctor training.
- All Consultants to support the implementation of agreed actions generated by mortality governance meetings.
- All trainers to provide feedback to their trainees/Trust doctors from mortality governance meetings.

4.8 Nurses, Allied Health Professionals and other Clinical staff

- All healthcare professionals should be involved in the mortality governance process and should attend mortality meetings as far as is practicable.
- This involvement may extend from basic awareness of identified issues and themes to full involvement in gathering data, participating in retrospective case records review, implementing agreed actions and dissemination of identified learning points.

4.9 Quality Managers

- Support the process of retrospective case records review and of holding regular speciality mortality governance meetings.
- Assist in the securing of case notes for divisional speciality teams for retrospective review
- Are responsible and accountable to the Divisional director for the provision of information and for the escalation of relevant issues.
- Ensure that action points are implemented and that learning points are disseminated
- Ensure that the recording and tracking of action point implementation and dissemination of learning points form part of the Divisional performance.

5 Policy

5.1 Introduction

Death is a certainty for all, but we need to ensure that the dying patient is managed with dignity. We also need to ensure that they die in their preferred place. Most importantly we need to identify any preventable (avoidable) deaths or serious consequences / disability of our actions or inactions.

Speciality Mortality Governance meetings (MGM's) are held on a one or two monthly basis depending upon speciality and aim to:

- Identify avoidable deaths.
- Identify any "Near misses" leading to morbidity.
- Implement action plans to address issues contributing to avoidable mortality.
- Discuss the foregoing issues within the division (team / speciality / individuals).
- Review the quality of care provided to dying patients.
- Review the communication with relatives of patients who have died.
- Review the "coding" applied to the cases under review.

5.1.1 Definitions and guidance:

- **Patients considered to be under our care are included for case record review if they die**:

  Any patient who is under active inpatient treatment within any of the Trust's Hospitals or in receipt of active treatment from one of the Trust's community services. Patients who die whilst in receipt of our outpatient services are not included in this definition unless they die during or as a consequence of an out-patient procedure e.g. endoscopy.

- **Reporting the death within the organisation and to other organisations that may have an interest (including the deceased person's GP), including how we determine which other organisations should be informed**:

  Deaths shall be reported within the Trust by means of a cumulative Divisional report to the Mortality Governance Committee. This will include crude mortality rates along with standardised mortality rates and a heat map of high mortality conditions. General practitioners shall be informed by a notification of death notice issued from the Bereavement Office. Other organisations to be informed shall include any that is currently offering health or social care to the patient at the time of death.

- **Response to the death of an individual with a learning disability**:

  This shall be conducted in line with the Learning Disabilities Mortality Review (LeDeR) programme guidance in place at the time of writing as outlined in Annex D of Learning from Deaths.

- **Response to the death of an individual with mental health needs**:

  It is envisaged that this will be a rare occurrence in this Trust. However the deaths of such patients should include input from the lead Mental Health care provider. It may be appropriate for that provider to lead any investigation.

- **Response to the death of an infant or child death**:

  These shall be conducted in line with guidance in Annex F of the Learning from Death document taking account of the differences between child and adult death and the need for cross organisational investigation and use of different documentation. The procedure for these reviews will be updated in line with new guidance from NHS England as and when it becomes available.

- **Response to a stillbirth or maternal death**:

  Stillbirths and maternal deaths are all reviewed in depth locally and records of these reviews are stored electronically.

  Maternal deaths are all reported externally to Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBBRACE-UK).

  Stillbirths are all reported externally to the Royal College of Obstetricians and Gynaecologists (RCOG) in support of the 'Each Baby Counts' project

- **Review of the care provided to patients we do not consider to have been under our 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 may require the participation of the Trust in another organisation's investigation in which case appropriate staff will offer necessary assistance. Alternatively there may be the need for a separate review of care through the trust's governance mechanism. If this is the case a Serious Incident (SI) investigation shall be convened and its outcome reported to the Patient Safety Panel. This panel shall refer any relevant concerns to the Mortality Governance Committee for information, to appropriate external agencies and to the relevant Divisions for action.

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

  A proportion of deaths of patients in receipt of end of life care is audited annually. This shall continue.

- **Engagement with bereaved families and carers**:

  This includes the informing of family / carers if we intend 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

  As part of the Duty of Candour and as a matter of course on the death of a patient in our care (as defined above) families and carers will be asked if they have any concern regarding the care received by the deceased. Any concern should form part

of the terms of reference for review of the death and may be grounds for initiating an SI investigation

- **Recording the outcome of our decision whether or not to review or investigate the death, which should have been informed by the views of bereaved families and carers**:

  This will form part of the data set collected after the first stage review of all deaths conducted at Divisional level. These data will be reported bi-monthly to the Mortality governance Committee

- **Lessons Learned**:

  The Mortality governance team will produce a report to submit regularly to a public part of the Trust Board meeting detailing the numbers of cases reviewed in the preceding period and the learning from those deaths.

5.2 Process for Speciality Review Meetings

- Mortality governance meetings to be held on a monthly or bi-monthly basis depending upon absolute numbers of deaths by speciality.
- Ideally a dedicated day and time to be allocated for mortality governance meetings.
- Mortality governance to be addressed by individual teams /specialities on a regular basis.
- The case notes of all deceased patients to be screened at least against the basic trust assessment proforma (appendix 4).
- A structured consistent data collection proforma, such as that issued from the Royal College of Physicians of London (appendices 1 and 2), is to be used for detailed retrospective review of the case records of selected deceased patients, customised by speciality as required.
- The outcomes of these speciality mortality governance meetings to be recorded.
- Implementation of action points to be agreed upon with a realistic time scale.
- Any serious concerns or themes identified to be notified to the (Medical Director) via the trust Mortality Reduction & Governance Lead.
- Any serious concerns or themes identified, along with the appropriate plan of action to be discussed in the mortality governance committee meeting and/or trust board meeting at the discretion of the Medical Director.
- Mortality governance meetings to be conducted within the relevant team/speciality in the first instance. Cross speciality multidisciplinary and multi-professionals meetings to be scheduled periodically.

5.3 Case Record Review Proformas

The standard screening basic proforma for application in the case of all deaths is attached (Appendix 4).

The core proforma for detailed retrospective case record review published by the National Mortality Case Record Review Program (NMCRR - Appendices 1 and 2) is included as an example of a review tool that generates all of the information upon which the trust is required to report and is accordingly recommended for use across the trust. This core proforma is based upon the structured judgement review method and may be customised by speciality. It is anticipated that modification to this core proforma may be required in light of further experience with trust wide reviews and mortality governance meetings. Whatever review tool is chosen at speciality level it must be capable of generating the outcomes listed in 3.2.5 above and must be retained for audit and quality control purposes.

5.4 Checklist for Review

The Trust aspiration is that all deaths will be reviewed, at least at basic level (trust basic screening proforma), in order to identify opportunities for action and learning thereby enabling continuous quality improvement. In addition, the case notes of patients whose death(s) are considered partially or entirely avoidable or for whom more detailed investigation is considered to be appropriate and potentially productive, will be reviewed in greater detail (e.g. using the Structured Judgement Review (SJR) method data collection proforma as published by the NMCRR program – appendices 1 and 2)

5.5 Checklist of Case Selection for Detailed Retrospective Review

- All deaths where bereaved families and carers, or staff, have raised a significant concern about the quality of care provision;
- All in-patient, out-patient and community patient deaths of those with learning disabilities and with severe mental illness;
- All deaths in a service specialty, particular diagnosis or treatment group where an ‘alarm’ has been raised with the provider through whatever means
- All deaths in areas where people are not expected to die, for example in relevant elective procedures;
- All deaths where learning will inform the provider’s existing or planned improvement work, for example if work is planned on improving sepsis care, relevant deaths should be reviewed, as determined by the provider. To maximise learning, such deaths could be reviewed thematically;

A further sample of other deaths that do not fit the foregoing categories will enable providers to take an overview of where learning and improvement are most needed across the organisation.

- All deaths with unspecified diagnosis;
- All deaths from a Low “predicted mortality”;

- Patients coded as “Misadventure”;
- Patients coded as “Complications”;
- Discrepancy between Initial diagnosis and cause of death;
- Death within 30 days of discharge;
- Readmission and death within 30 days;
- Deaths within 30 days of Chemotherapy;
- Patients with No significant co-morbidity;
- All cases subject to a Serious Incident (SI) investigation– as soon as possible after registering and ideally before the SI investigation begins;
- All cases subject to HM Coroner’s Inquest – after investigations and action by the Trust;
- Cases where other data on mortality governance by diagnostic group is found in the benchmarking systems;
- Any other significant, unexpected morbidity or concerns identified by any member of the team / speciality;
- All paediatric and neonatal deaths;
- All maternal deaths;
- Responses to diagnosis specific CQC Alerts;

Review of mortality data may identify other deaths for case review.

This is not an exhaustive list and not necessarily applicable to all teams.

5.6 The Divisional Mortality Review Process

5.6.1 Step 1

- Identification all deaths occurring in the preceding month by speciality;
- Mortality governance Lead (MGL) and Head of Department (HOD) to be informed of the case record numbers of all deaths in the preceding month;
- Case notes for review to be distributed between experienced clinicians within the team/speciality along with appropriate proformas;
- Case notes for SI patients to be reviewed as a matter of priority.

5.6.2 Step 2

- Monthly/two monthly speciality MG meetings;
- Team / speciality presentations and discussion;
- Action points to be agreed upon including time scales for implementation etc.;
- Learning points to be agreed upon including details of dissemination process.

5.6.3 Step 3

- The Medical Director to be advised of identified issues / themes;
- The Medical Director to be provided with evidence of issues/themes;
- The Medical Director to be appraised of appropriate action plans and the schedule for their implementation.

5.6.4 Step 4

- Dissemination of Action and Learning points to all relevant staff;
- Within speciality action and learning points (SMGL),
- Trust wide action and learning points (SMGL),
- Trust Action and Learning Points Log (ALL),
- 'Lessons Learned' Newsletter (Risk department),
- 'Learn and Let Live' column in Pulse (Staff magazine),
- Quarterly report to the board by way of assurance regarding the mortality governance process.

5.7 Outcomes

5.7.1 Medical Director to be advised of:

- Issues and themes with evidence;
- Appropriate action plans and implementation of the same;
- Disseminate of learning points to all relevant staff.

5.7.2 In specific circumstances the Medical Director will forward:

- Details of issues/themes to be presented at the mortality governance committee;
- Details of issues/themes to be presented at the clinical policy forum;
- Details of issues/themes to be presented at the trust board meeting.

5.8 Monitoring Compliance with Policy

- The divisional quality managers will oversee the monitoring of this policy through the periodic organising of comparative reviews of the case notes of a sample of deaths already reviewed at speciality level.
- Each division will generate a cumulative annual report for the Mortality Governance Committee and the Quality Committee comprising a compilation of the bi-monthly divisional reports to the MGC augmented by an executive summary cover sheet.

5.9 Legal Liability Statement

The Trust will generally assume vicarious liability for the acts of its staff, including those on honorary contract. However, it is incumbent on staff to ensure that they:

- Have undergone any suitable training identified as necessary under the terms of this policy or otherwise.
- have been fully authorised by their line manager and their Directorate to undertake the activity.
- Fully comply with the terms of any relevant trust policies and procedures at all times.

It is recommended that staff have Professional Indemnity Insurance cover in place for their own protection in respect of those circumstances where the Trust does not automatically assume vicarious liability and where Trust support is not generally available. Such circumstances will include Samaritan acts and criminal investigations against the staff member concerned.

Suitable Professional Indemnity Insurance Cover is generally available from the various Royal Colleges and Professional Institutions and Bodies.

6 References and Associated Documents

National Quality Board. 2017. 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. [Online] 03 2017. [Cited: 11 09 2020.] https://www.england.nhs.uk/wp-content/uploads/2017/03/nqb-national-guidance-learning-from-deaths.pdf.

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National Mortality Case Records Review program – Spring 2017. HQUIP commissioned program endorsed by Royal College of Physicians and developed by Yorkshire & Humber AHSN

Structured Judgement Review Method – Royal College of Physicians 2016. Last accessed July 2017

Letter to all medical directors from Sir Bruce Keogh & Dr Mike Durkin regarding Mortality Governance December 2015. - Mortality governance guidance & trust mortality calculator. Last accessed May 2017

Appendix 1: Structured Judgement Review Method – A Guide For Reviewers
Royal College of Physicians and National Mortality Case Record Review Programme (NMCRR). https://www.rcplondon.ac.uk/sites/default/files/media/Documents/NMCRR%20guide%20England_0.pdf

Appendix 2: Structured Judgement Review Method – Data Collection Form
Royal College of Physicians & National Mortality Case Record Review Programme (NMCRR). https://www.rcplondon.ac.uk/file/5065/download?token=ad_j5n6M

Appendix 3: Reportable Levels of Mortality Governance Information	
Level	**Descriptive**
1	Crude mortality information, HSMR, SHMI and speciality heat maps
2	Outcomes of serious incident reviews and speciality mortality governance meetings
3	Trust Responses to CQC alerts
4	Trust responses to mortality related national audits etc
5	Trust responses to regulation 28 communications
6	Dissemination of action and learning points arising from 1-5 above

Appendix 4: Basic Case Records Review Screening Proforma

Reviewer's Projected Outcome at Patient Admission
(As judged from information available during the patient's first 24 hrs in hospital)

Hospital Number: Date of review: Name of Reviewer: (Please Print)

Gender M/F Age: Parent Speciality:

Projected Outcome (please circle – also see page 2)

Likelihood of Death - as assessed from presenting problem, age, dependence, BMI, EOL status, co-morbidities, worst SpO2, worst EWS, worst blood results and any other significant diagnostic or clinical information relating to the first 24 hours of inpatient care available at the time of level 1 review**.**	**Grade 1** Death Inevitable	**Grade 2** Death Probable	**Grade 3** Death Possible	**Grade 4** Survival Probable	**Grade 5** Survival Expected	**Needs NMCRR** Y/N

- DNACPR pre-admission? Y/N
- Evidence of end of life care planning? Y/N
- Evidence of pre-admission end stage organ failure? Y/N
- Pre-admission multiple comorbidity? Y/N

In your opinion, and subject to the patient's expressed wishes, do you feel that hospital admission could have been avoided through the satisfactory provision of end of life care in the community (given the availability of appropriate resources)? Yes / No / Possibly

- Please record any further comments below:

If you as the reviewer are experiencing difficulty in deciding on the patient's probable outcome at admission consideration of the following factors might be of assistance:
Presenting problem or diagnosis: Dependence:
Robust/Frail/Very Frail/Cachexic (please circle if recorded) BMI:
Worst EWS in first 24 hrs: Worst SpO2 in first 24 hrs (state if ABG result):

Oxygen Supplement: VPFM, FPFM, NRFM Litres/min: Intermittent/Continuous/Ventilated

Worst blood results in first 24 hrs:
Hb: Wbc: Platelets: INR: APTT: Creatinine: Urea: TNI :
Chest X Ray: Lactate (either arterial or venous):
ECG:

Appendix 4: Basic Case Records Review Screening Proforma		
Comorbidities		
Condition	**Tick**	**Comment**
Hypertension		
Ischaemic Heart Disease (including angina)		
Peripheral Vascular Disease		
Congestive Cardiac Failure		
Chronic Obstructive Pulmonary Disease		
Asthma		
Chronic Renal failure		
Cerebrovascular Disease (Stroke)		
Other Chronic Neurological Disease		
Alcohol Excess		
Drug Dependence		
Smoking History		
Metabolic Disorder (e.g. Diabetes Mellitus)		
Known Malignancy		
Other (specify)		

Functional Impact of Co-existing Disease (From NCEPOD)	**Tick**
Normal healthy patient	
Patient with mild systemic disease	
Patient with severe systemic disease that limits activity but is not incapacitating	
Patient with incapacitating systemic disease that is a constant threat to life	
RNMM August 2017	

Appendix 5: Mortality Meeting – Action and Learning Points Report	
Speciality	
Chairman	
Date, Time & Place	

Progress with Action and/or Learning Points Arising from Last Mortality Review Meeting Dated:

Case No.	Case Summary	Action Points	Assigned to	Completed	Learning Points	Assigned to	Completed

Summary of Deaths in Month(s) Under Review

Total Deaths in Review Period	Number Reviewed	Death Inevitable	Death Probable	Death Possible	Survival Probable	Survival Expected	Number of Level 2 Reviews

Potential Cases for Discussion at This Meeting

Case No.	Level 1 or 2	Summary of Case Details	Avoidability Grade (1-6)	Action Points	Learning Points	Assigned To

Appendix 6: Equality Impact Assessment Form

Department	Mortality	**Service or Policy**	CORP/POL/189	**Date Completed:**	

GROUPS TO BE CONSIDERED

Deprived communities, homeless, substance misusers, people who have a disability, learning disability, older people, children and families, young people, Lesbian Gay Bi-sexual or Transgender, minority ethnic communities, Gypsy/Roma/Travellers, women/men, parents, carers, staff, wider community, offenders.

EQUALITY PROTECTED CHARACTERISTICS TO BE CONSIDERED

Age, gender, disability, race, sexual orientation, gender identity (or reassignment), religion and belief, carers, Human Rights and social economic / deprivation.

QUESTION	**RESPONSE**		**IMPACT**	
	Issue	Action	Positive	Negative
What is the service, leaflet or policy development? What are its aims, who are the target audience?	The Mortality and Morbidity policy is to ensure that the Trust systematically and continuously reviews patient outcomes and especially mortality and morbidity.	Raise awareness to staff of the requirement of staff to participate in Mortality and Morbidity Meetings.	Yes – Participation in Mortality and Morbidity meetings will enable lessons to be learned and disseminated throughout the Divisions.	
Does the service, leaflet or policy/ development impact on community safety • Crime • Community cohesion	No			
Is there any evidence that groups who should benefit do not? i.e. equal opportunity monitoring of service users and/or staff. If none/insufficient local or national data available consider what information you need.	No. This policy should ensure a positive impact across all groups of staff working for the Trust.	This policy is to raise awareness of the processes in place to systematically and continuously review patient outcomes, especially mortality and morbidity.	Yes	
Does the service, leaflet or development/ policy have a negative impact on any geographical or sub group of the population?	No			
How does the service, leaflet or policy/ development promote equality and diversity?	Ensures a standard approach to the review of mortality and morbidity within the Trust.		Yes	
Does the service, leaflet or policy/ development explicitly include a commitment to equality and diversity and meeting needs? How does it demonstrate its impact?	The Policy includes a completed EA which provides the opportunity to highlight any potential for a negative / adverse impact.		Yes	
Does the Organisation or service workforce reflect the local population? Do we employ people from disadvantaged groups	Our workforce is reflective of the local population.		Yes	
Will the service, leaflet or policy/ development i. Improve economic social conditions in deprived areas ii. Use brown field sites iii. Improve public spaces including creation of green spaces?	No	N/A	N/A	
Does the service, leaflet or policy/ development promote equity of lifelong learning?	No	N/A	N/A	
Does the service, leaflet or policy/ development encourage healthy lifestyles and reduce risks to health?	No	N/A	N/A	
Does the service, leaflet or policy/ development impact on transport? What are the implications of this?	No	N/A	N/A	
Does the service, leaflet or policy/development impact on housing, housing needs, homelessness, or a person's ability to remain at home?	No	N/A		
Are there any groups for whom this policy/ service/leaflet would have an impact? Is it an adverse/negative impact? Does it or could it (or is the perception that it could exclude disadvantaged or marginalised groups?	No	N/A		
Does the policy/development promote access to services and facilities for any group in particular?	The Policy promotes access to information for all members of staff involved in the Mortality and Morbidity Review meetings.	Lessons learned will be disseminated throughout the Divisions.	Yes	

Appendix 6: Equality Impact Assessment Form

Does the service, leaflet or policy/development impact on the environment • During development • At implementation?	No	N/A	N/A	

ACTION:			
Please identify if you are now required to carry out a Full Equality Analysis	**~~Yes~~**	**No**	**(Please delete as appropriate)**

Name of Author: **Signature of Author:**		**Date Signed:**	
Name of Lead Person: **Signature of Lead Person:**		**Date Signed:**	
Name of Manager: **Signature of Manager**		**Date Signed:**	