# Learning from Deaths Policy

## Purpose

- To ensure that there is a comprehensive mortality review process using methodology which provides consistency in the depth and quality of individual case note reviews (Structured Judgement Review).
- To clearly define the scope of deaths which require investigation. Critical review of mortality metrics (data sources include CHKS, NHS Digital, NHSI) will identify areas of concern and lead to commissioning of condition-specific reviews.
- To ensure that high priority is given to review deaths in clearly defined categories with links to other policies as appropriate. Specific focus will be on deaths in patients with learning disability and significant mental health issues.
- To outline which deaths require further investigation under the Serious Incident Framework
- To ensure engagement with families and carers in the mortality review process maintaining duty of candour
- To ensure that learning from deaths is shared widely within the organisation highlighting areas for improvement and noting good practice.
- To ensure that learning from deaths is given high focus at Board level and data on avoidable mortality published using an appropriate metric as and when published by NHS Improvement.

## Objectives

To ensure that the Trust has appropriate systems and processes in place for critical review of patient deaths and to identify areas for remedial action. The key objective is to prevent avoidable mortality.

## For Use By

Medical, Nursing & AHP staff; Information Team; Medical Director; Director of Nursing and Patient Services; Divisional Medical/Clinical Directors and Divisional Managers; Clinical Directors.

## Related Policies

- Child Death Overview Process (CDOP). Management of the death of any child (0 – 18) regardless of cause.

## Definitions

- **Crude Mortality**: Number of deaths per 100 patients
### Abbreviations used in policy

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>RAMI</td>
<td>Risk-adjusted Mortality Index</td>
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<td>SHMI</td>
<td>Summary Hospital-level Mortality Indicator</td>
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<td>HSMR</td>
<td>Hospital Standardised Mortality Ratio</td>
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<td>NMCRR</td>
<td>National Mortality Case Record Review</td>
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<td>MRB</td>
<td>Mortality Review Board</td>
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<td>MSG</td>
<td>Mortality Surveillance Group</td>
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### Status / Version Control

**Previous versions of the policy should be stated here with former name if changed along with dates when they were approved.**

- **Version 2.0 (November 2016).** Mortality Review Policy. Amended to reflect divisional structure and change in name from HSCIC to NHS Digital.

### Impact Assessment

To identify the resources necessary to implement, operate and monitor the operation of the policy.

### Equality and Diversity

Linked to the Equality Assessment in section below. This policy applies equally to all deaths in BHT.

### Business

This policy will facilitate consistency in the depth and quality of mortality reviews and allow organisational learning.

### Legal Implications

This policy highlights actions taken in response to the CQC report ‘Learning, candour and accountability. A review of the way NHS Trusts review and investigate deaths of patients in England’ and the requirement by NHS Improvement to report on avoidable mortality.

### Quality

Ensure a robust mortality review process with sharing of learning from deaths; the aim is to reduce avoidable mortality.

### Resources

Within existing resources. Mortality review is an expectation from all Consultants and SAS doctors as per the Job Planning Framework 2017.

### Risk

An avoidable mortality metric has yet to be published and implemented across the NHS. NHSI have indicated that this will not be part of their single oversight framework and will not be used to compare trusts.

### Statutory Compliance

The NHS is committed to reduce avoidable mortality and compliance with the strategy is monitored through NHS Improvement.

### Sustainability

This policy is fully sustainable.
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**Background**

Findings from the 2013 Francis Report (https://www.gov.uk/government/publications/report-of-the-mid-staffordshire-nhs-foundation-trust-public-inquiry) showed that ‘higher than expected’ mortality rates at Mid-Staffordshire Hospital were at worse ignored or manipulated and at best the subject of poorly functioning non-systematic mortality review meetings in which failings in the quality of care were not confronted or corrected. Recommendations from the Francis Report required NHS Trust Boards to be assured that deaths are reviewed and appropriate changes made to ensure that patients are safe.

Bedford Hospital NHS Trust has a well-established mortality review process; the policy was revised in February 2017 following introduction of the Datix mortality review tool. The Mortality Review Group [Appendix 1] reviews mortality metrics and commissions in depth reviews where outliers are identified. Mortality is reported through Quality Board and monthly to Trust Board highlighting areas of concern and actions taken. Critical challenge is provided through the Quality and Clinical Risk Committee. Learning is disseminated through relevant departments and divisions and a mortality spotlight section is featured quarterly in the Trust Quality Improvement newsletter. Significant failings are reported through the Serious Incident process.

Participation in mortality reviews is a requirement for every consultant and has been clearly set out in the 2017 Job Planning Framework. This is a key part of quality improvement work which is a core requirement for medical revalidation for all doctors.

In December 2016, the CQC published the report ‘Learning, candour and accountability. A review of the way NHS Trusts review and investigate the deaths of patients in England’1. This was in response to failings identified at Southern Health NHS Foundation Trust where over a 4 year period only 1% of deaths in patients with learning disability and 0.3% of deaths in patients with mental services for older people were investigated as serious incidents. The report found that although most hospitals in England undertake mortality review, there was considerable variation in terms of methodology, scope, data capture and analysis. It found that learning from deaths was not given sufficient priority in some organisations, with missed opportunities for learning.

In response to this and under the direction of the Secretary of State for Health, the National Quality Board published their report ‘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’2. The aim of the document was to initiate a standardised approach to mortality review and learning from deaths.

The Department of Health commissioned the National Mortality Case Record Review (NMCRR)3 methodology from the Royal College of Physicians in collaboration with HQIP and Datix to assist acute care hospitals to review the safety and quality of care of adults who die in hospital. The Structured Judgement Review allows systematic review of phases of care to identify opportunities for learning. The SJR provides both quantitative and qualitative information on both good and poor care. The methodology has been validated and extensively piloted. The aim is that a care review will provide explicit judgements; scores given are a useful shorthand to assess quality and avoid a prescriptive matrix approach. The methodology is equally applicable to those who are discharged from hospital.

The Learning Disabilities Mortality Review (LeDeR) Programme has also been established as a result of recommendations of the Confidential Inquiry into Premature Deaths of People with Learning Disabilities (CIPOLD). This will support local areas in England to review the deaths of people with learning disabilities and identify avoidable factors that may have contributed to a person’s death and as a consequence guide changes in health and social care services in order to reduce premature deaths. The Associate Director of Nursing for Safeguarding represents Bedford Hospital on the local steering group; staff will be trained in specific root cause analysis.
In summary, this policy aims to standardise the process for mortality review within the Trust and the actions to be taken where areas of poor or inadequate care are identified. It addresses the requirement to report on avoidable mortality and most importantly highlights how the Trust will learn from deaths. The policy also identifies how families and carers should be supported and involved in investigations where appropriate. Learning from deaths will be triangulated with other metrics including length of stay, readmission rates, point of care surveys (e.g. local audits, safety thermometer) and national audits.

Definitions

- **Mortality** - crude mortality relates to any deaths within 30 days of a surgical or other interventional procedure (such as endoscopy) or any in-hospital death for non-surgical specialties. The Summary Hospital-level Mortality Indicator (SHMI) also includes deaths within 30 days of hospital discharge. The mortality review process will therefore involve review of deaths in the community.

- **Morbidity** – this relates to any significant adverse impact on an individual's health status during or following an intervention or treatment. Co-morbidity refers to existing health conditions on admission to hospital.

- **Avoidable/Preventable** – these terms are used interchangeably in the NHS and for the purpose of this policy ‘preventable’ or ‘unpreventable’ will be used with reference to whether anything could have been done to change the outcome. NHSI improvement have indicated that preventable should be considered as a >50% chance that the death could have been prevented.

Roles and Responsibilities

- **Chief Executive** has overall responsibility for the quality of patient care on behalf of the Executive Directors

- **Medical Director** provides assurance to the Board that there is a robust mortality review process in place and that the Trust learns from deaths. Assurance is provided by in depth review of mortality metrics and multidisciplinary case note review. The Medical Director ensures that all relevant clinical staff are engaged with review of deaths.

- **Deputy Medical Director** leads on the mortality review process, ensuring that procedures and processes are in place to identify all deaths subject to case note review. Where case note review identifies deaths which were by balance of probability preventable, the Deputy Medical Director will ensure these are reported on Datix and considered by the executive-led review group under the Serious Incident Framework.

- **Director of Nursing and Patient Services** along with the Medical Director will ensure that families and carers are treated sensitively, with empathy and have the opportunity to be involved in investigation of any deaths deemed potentially preventable.

- **Divisional Medical/Clinical Directors and Divisional Directors** ensure that multi-disciplinary mortality reviews at specialty are upward reported through divisional quality groups to Quality Board. **Clinical Directors** are responsible for ensuring engagement with the mortality review process at individual and specialty level.

- **Deputy Director of Clinical Governance** proactively monitors reported Datix incidents to ensure that any patient deaths where areas of concern have been reported are managed according to the Incident Reporting Policy. Under supervision of the Deputy Director of
Clinical Governance, the clinical governance team facilitate the process for case note review and produce the Datix dashboard. The Clinical Governance team in conjunction with the Medical Director and Director of Nursing and Patient Services will ensure dissemination of learning from deaths to clinical staff.

- **Medical Staff** are expected to participate fully in the mortality review process undertaking case note reviews and participating in specialty-level mortality meetings.

- **Nurses, allied health professionals and other clinical staff.** All healthcare professionals should have awareness of mortality outliers within their area of clinical practice and more widely in the Trust. Senior clinicians will be trained in the structured judgement review methodology. Clinicians will have responsibility to ensure that any learning from deaths is cascaded down to staff at all levels.

- **Head of Clinical Information** is responsible for ensuring that clinical coders work with consultants to ensure that all deaths are coded correctly; that accurate SUS information is submitted to allow analysis by CHKS; that information is provided to support condition-specific mortality reviews commissioned by the Mortality Review Board; to highlight any deaths in patients who die with a diagnosis of learning disability.

### POLICY

#### Section 1: Mortality Review Process

The Clinical Governance team will request the clinical notes of all patient deaths under scope for investigation (there will be an initial screen to exclude patients with learning disabilities, severe mental health problems, maternal deaths and children under the age of 18 years (see below)). They will enter patient demographics and clinical coding information on admission and death onto the Datix reporting module. The case will be assigned to an independent reviewer and notes sent. An automated Datix notification email sent to the relevant clinician.

The reviewer will use the Structured Judgement Review (SJR) methodology\(^3\) to undertake case note review using the electronic version of the data collection form (Datix). Initial screening questions will exclude deaths in patients with learning disabilities, severe mental health problems, maternal deaths and deaths in children which are subject to separate review processes. These deaths will be recorded on Datix but these reviews will all report directly into the Mortality Review Board.

Reviews will be carried out using explicit judgements on the quality of care received in accordance with good practice during phases of care: admission and initial management (first 24 hours); ongoing care; care during a procedure; peri-operative care; end of life care. Each phase of care is scored from 1 (very poor care) to 5 (excellent care); an overall assessment of quality of care is then made.

Outputs from individual case note reviews will be assessed by the Deputy Medical Director. Where the reviewer has indicated an overall quality of care as 2 (poor care) or 1 (very poor care) then a second stage review will be undertaken by the Mortality Surveillance Group. This group consists of a group of senior clinical staff who meet on a monthly basis to review results of case note reviews and also to agree themes arising that can be shared through the CQP and QI newsletters and provide an upward report to the MRB. An avoidability of death judgement score will then be agreed:

- Score 1. Definitely avoidable.
- Score 2. Strong evidence of avoidability.
- Score 3. Probably avoidable (more than 50:50)
- Score 4. Possibly avoidable (less than 50:50)
• Score 5. Slight evidence of avoidability.
• Score 6. Definitely not avoidable.

All reviews scoring \( \leq 3 \) will be tabled at Mortality Review Board and reported on the Datix incident reporting system, to be considered under the Serious Incident Framework.

**Divisional processes**
A report for each Division will be compiled by the Mortality Surveillance Group and reported through the monthly Clinical Quality Portfolio. Divisions are required to ensure that outputs from case note reviews are reviewed at divisional quality groups and at specialty level, and learning disseminated (Appendix 4).

**Reporting within organisation and to GP**
Outputs from mortality reviews should be widely shared within the organisation:
- at divisional and specialty level as outlined above
- reporting from Mortality Board to the executive-led Quality Board
- upward reporting of specific thematic reviews/ mortality spotlights to Quality and Clinical Risk Committee
- quarterly report on avoidable mortality to trust board using an agreed dashboard. This will be reported in the mortality section of the Integrated Performance Report
- Quality Improvement newsletter
- reporting through the Serious Incident framework where appropriate (see below)

General Practitioners should be informed where investigation has indicated that the death is by balance of probability avoidable; this is important as bereaved families and carers may wish to discuss concerns arising with an informed and independent clinician.

**Interim process pending availability of Datix SJR module**
The previous Mortality Review Policy (v2.1) outlined use of the existing Datix mortality reporting module. This uses the NCEPOD Classification of Care and a preventability score ranging from 0 (unavoidable death, no suboptimal care) to 3 (suboptimal care. Different care would reasonably be expected to have prevented death).

<table>
<thead>
<tr>
<th></th>
<th>A</th>
<th>Good Practice</th>
<th>A standard that you accept for yourself, your trainees and your institution</th>
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<td></td>
<td>B</td>
<td>Room for Improvement</td>
<td>Aspects of <strong>clinical</strong> care that could have been better</td>
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<td></td>
<td>C</td>
<td>Room for Improvement</td>
<td>Aspects of <strong>organisational</strong> care that could have been better</td>
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<td></td>
<td>D</td>
<td>Room for Improvement</td>
<td>Aspects of both <strong>clinical</strong> and <strong>organisational</strong> care that could have been better</td>
</tr>
<tr>
<td></td>
<td>E</td>
<td>Less than Satisfactory</td>
<td>Several aspects of <strong>clinical</strong> and/or <strong>organisational</strong> care that were well below satisfactory</td>
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</tbody>
</table>

**PLEASE REPORT A CLINICAL ADVERSE EVENT**
Section 2: Categories of deaths which require investigation and links to external agencies and processes

Scope of deaths to be reviewed and exclusions
The following deaths will automatically be sent for case note review:
- deaths in patients with learning disability\(^a\)
- deaths in patients with severe mental health problems (psychoses)\(^b\)
- infant and child deaths\(^c\)
- stillbirths, neonatal and maternal deaths\(^d\)
- deaths where other external agencies have requested review (e.g. other acute Trusts, CCGs etc)
- deaths where bereaved families or carers or staff have raised concerns\(^e\)
- elective deaths
- emergency admissions (see exclusions below)
- deaths where mortality outliers have been identified through surveillance of metrics

Deaths within 30 days of discharge from hospital are also within scope for review; it is recognised that there are difficulties in robustly identifying these patients in real time. SHMI data is reviewed quarterly and reviews of outlier diagnostic groups commissioned; this includes out of hospital deaths which are available through NHS Digital.

\(^a\) **Learning disability**
Deaths in patients with learning disabilities will be investigated using the SJR but will automatically trigger a multidisciplinary second stage review led by the Deputy Medical Director and involving the Lead Disability Liaison Nurse. Reporting and multiagency review will then be undertaken through the Learning Disabilities Mortality Review (LeDeR) Programme which is currently under development. Outcomes from investigations will be reported through Mortality Review Board.

\(^b\) **Mental health**
As a general acute Trust, deaths in patients with severe mental health problems (predominantly psychoses) will be investigated using the SJR. Where external agencies are involved (e.g. the Essex Partnership University Trust, current mental health provider) this will be reported through the Datix incident reporting system and shared externally.

\(^c\) **Infant or child death**
Deaths are investigated through the Child Death Overview Process (CDOP). An unexpected death is defined as the death of an infant or child (aged under 18 years) where there is no prior condition that might be expected to cause the death at that time, and the child dies either immediately or subsequently from the consequences of the precipitating event or collapse. This includes Sudden Unexpected Death of an Infant (SUDI) where babies are born in a good condition but suddenly deteriorate; these deaths are reported to the Coroner and to the police. Unexpected deaths are also logged on the Datix incident reporting system.

The CDOP manager at Bedfordshire CCG is notified of any deaths applicable to the CDOP process and they will liaise with the lead paediatrician. The Trust’s internal governance systems mean that these will be reported on Datix.

\(^d\) **Stillbirths, neonatal and maternal deaths**
These are reported and investigated through MBRRACE-UK (Mothers and Babies: Reducing the Risk through Audits and Confidential Enquiries across the UK). This includes stillbirths (deaths before or during birth once the pregnancy has reached 24 weeks gestation), perinatal deaths (at any viability), neonatal deaths (within 28 days) and maternal deaths.

For maternal deaths, ICD-10 defines these as pregnancy-related deaths (deaths during pregnancy or within 42 days from all causes i.e. including coincidental causes e.g. RTA) or late maternal deaths (42
days to 1 year) from either direct (related to the pregnancy) or indirect (aggravated by the physiological effects of pregnancy).

When available, the Perinatal Mortality Review Tool (currently piloted nationally) will be used for relevant deaths.

   e) Concerns raised by bereaved families or carers and staff
A mortality administrator will screen all deaths and triangulate information from PALS, complaints and the Datix reporting system to ensure that any cases where concerns have been raised by either staff or families and carers will automatically trigger a SJR.

Exclusions including end of life.
Patients where death is expected e.g. admissions for end of life care, admissions where patients are deemed unfit for treatment, deaths where during the admission patients have deteriorated and a decision is made for end of life care (Treatment Escalation Plan) will be screened to ensure there are no trigger factors (e.g. learning disability) that mandate in depth review. A decision that a review is not required will be logged by the Mortality Surveillance Group. However a sample of these patients (5 per month) will undergo SJR.

Section 3: Deaths to be investigated under the Serious Incident Framework
Deaths where a second stage review have indicated an avoidability of death judgement score of <3 will be highlighted by the Mortality Surveillance Group and reviewed against the Serious Incident Framework. SI review meetings take place three times per week with cases presented by the clinical governance team to the Chief Executive, Medical Director and Director of Nursing and Patient Services. Cases declared as serious incidents are processed according to the Incident Reporting Policy and reported to Trust Board.

Section 4: Engagement with bereaved families and carers
The Bereavement Services will sensitively liaise with bereaved relatives and carers, providing information on relevant processes in a clear and honest approach. There should be a single point of contact. Where families and carers have raised concerns around care prior to death they will be assured that the death will be reviewed as part of the SJR process. Where families have not previously raised concerns they should, as part of bereavement processes, be informed that the Trust has a policy of reviewing deaths of patients within its care, given the opportunity to raise any concerns and asked if they wish to be approached for their involvement in the review. Families should have an opportunity to be involved in learning and quality improvement work arising from the review.

Where families wish to seek legal advice, information should be provided by the Bereavement team with access to PALS should they wish any further advice.

NHS England is undertaking work to determine what support bereaved relatives should expect from Trusts and this is expected to be published in 2018.
Figure 1: Mortality Review Process

Quality Board
Receives monthly Mortality Reports

Mortality Review Board
Meets monthly
Reports back to Divisional Quality Groups

Divisional Quality Group
and
Specialty Mortality meetings
Ensures that mortality reviews are happening
Ensures that themes are collated
Ensures that actions are implemented

Independent Consultant
reviews every death using Trust wide Mortality Datix Module

Coding Review of each patient’s death
By the patients consultant and the specialty coder
Appendix 1: Structured Judgement Review data collection form
(electronic collection on Datix module)
Appendix 2: Datix Mortality Review Module

Users Guide to Electronic Mortality Module

Initial data from the patient’s hospital admission will be entered onto the Electronic Module by the information department.

Once the initial information is entered onto Datix, a message will be sent informing the clinician that they have been allocated the case record for review.

This will indicate the Datix code which is the means of identification of the case for review.

Clinical notes will be sent to clinician for review

Once notes are available the following steps should be taken:
1. Log onto Datix
2. Select PALS module
3. In ‘New Search’ field enter Datix code number
4. Select case for review by clicking on the case
5. Enter details as requested
6. Save
7. Change status of review from being reviewed to awaiting final approval
8. Save

Clinicians should aim to respond to a request for case note review within 14 days of receipt.

Email reminders will be sent for outstanding reviews.
Appendix 3: Mortality Review Board Terms of Reference

MEMBERSHIP
Chair – Medical Director
Deputy Medical Directors
Divisional Medical/Clinical Directors
Clinical Directors
Head of Clinical Information or representative
Director of Nursing and Patient Services or deputy
Lead Disability Liaison Nurse
Deputy Director Clinical Governance or representative
Divisional Lead Nurse – Planned Care
Divisional Lead Nurse – Integrated Medicine
Head of Midwifery
Lead Nurse Cardiac Arrest Prevention
Ward Manager (in rotation)
Consultant Palliative Care or representative
Junior Doctor representative (Chief Resident and one other)
CHKS analyst

QUORUM
Four members plus the Chair (one nurse, two doctors, clinical governance: all Divisions to be represented).

FREQUENCY OF MEETINGS
The Board will meet monthly.

TERMS OF REFERENCE

Operational functions:

1. To work towards the elimination of avoidable in-hospital and out of hospital mortality related to the index admission.
2. To review monthly mortality metrics benchmarked against relevant peer groups (crude mortality, RAMI and in-hospital SHMI) and quarterly SHMI data.
3. To consider mortality metrics in conjunction with other qualitative clinical data and commission condition-specific in depth reviews. To facilitate the increased use of outcomes from national clinical audits and registries, led by professional bodies in the fuller assessment of in-hospital mortality.
4. To investigate any alerts received from the Care Quality Commission (CQC) or identified by the mortality monitoring information systems e.g. CHKS.
5. To develop data collection systems to ensure the Trust’s mortality data is timely, robust and in line with national and international best practice.
6. To ensure mortality information linked to consultant appraisals is accurate, contextual and engenders a culture of clinical excellence.
7. To produce an annual mortality clinical coding improvement plan and receive regular reports on its implementation.
8. To assign clinical leads to address raised mortality in particular clinical areas by the deployment of strong evidence based interventions such as care bundles. The Mortality Review Board will receive regular reports on implementation and the measurable impact of these interventions on hospital mortality.
9. To work with established groups to ensure each junior doctor intake receives the latest guidelines on care protocol implementation and clinical coding best practice.
10. To review and monitor compliance with other hospital policies including DNAR/TEP and Death Certification Policy.

11. To monitor and consider the information from the electronic review of all in hospital deaths.

12. Oversee any publication of information on deaths including learning and actions taken.

**Strategic functions:**

a) To act as the strategic hospital mortality overview group with senior leadership and support to ensure the alignment of the hospital departments for the purpose of reducing all avoidable deaths.

b) Strategic oversight of extant mortality review(s).

c) To develop a mortality reduction strategy that aligns hospital systems such as audit, information services, training and clinical directorates. This strategy will be reviewed by the Medical Director and an annual report produced.

d) Sign off of action plans and methodologies that are designed to reduce morbidity and mortality across the trust.

e) Sign off of all regulatory mortality responses.

f) Liaise, through the MRB Chair, with the Non-Executive Director responsible for ensuring progress on implementation of the national framework.

**ACCOUNTABILITY**

The Mortality Review Board is formally accountable to the Quality Board and will report its key actions through the Quality Report monthly as well as through the Divisions’ exception reports. The Medical Director / Deputy Medical Director will on behalf of the Mortality Review Board report to the Quality and Clinical Risk Committee twice yearly and Trust Board as necessary.
Appendix 4: Bedford Hospital Trust Mortality Surveillance Group Summary

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<tr>
<th>HOSPITAL NUMBER</th>
<th>LEARNING POINT(S)</th>
<th>ACTION(S)</th>
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<td>SJR Outcome Summary</td>
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<td>Excellent care</td>
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References
i.e. NICE guidance, externally recognised reports or research

4. Implementing the Learning from Deaths framework: key requirements for trust boards. [https://improvement.nhs.uk/resources/learning-deaths-nhs/#resources].

Staff Involved In Development

Mr Paul Tisi, Medical Director
Dr Jacquelyn Harvey, Deputy Medical Director

Monitoring / Audit Criteria

<table>
<thead>
<tr>
<th>Aspect</th>
<th>Method</th>
<th>Frequency</th>
<th>Responsibility</th>
<th>Reporting Arrangements</th>
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<td>Review of mortality metrics</td>
<td>Quality report</td>
<td>Monthly</td>
<td>Medical Director</td>
<td>Quality Board</td>
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<td>Integrated Performance Report</td>
<td>Bimonthly</td>
<td>Medical Director</td>
<td>Quality and Clinical Risk Committee</td>
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<td>Monthly</td>
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<td>Trust Board</td>
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<tr>
<td>Reporting of avoidable mortality and learning</td>
<td>Integrated Performance Report</td>
<td>Quarterly</td>
<td>Medical Director</td>
<td>Trust Board</td>
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### Equality Impact Assessment Screening Tool for Policies

<table>
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<th>NEGATIVE IMPACT</th>
<th>SIGNIFICANT Y/N?</th>
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<tbody>
<tr>
<td></td>
<td>Y ✓</td>
<td>N ×</td>
</tr>
<tr>
<td>1. Gender</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>2. Religion/ belief</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>3. Age</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>4. Disability (includes: mental health, learning disability,</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>physical, sensory</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Ethnicity (includes: travellers and gypsies)</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>6. Sexual Orientation (includes: gay, lesbian, bisexual)</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>7. Social / Economic</td>
<td>✓</td>
<td>✓</td>
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For any boxes marked as ‘yes’ above please complete details below

<table>
<thead>
<tr>
<th>Area</th>
<th>Issue</th>
<th>Further Steps to be Taken</th>
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<tbody>
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</table>

**Negative Impact**

1. Will the policy create any problems or barriers to any community or group? Y/N ✓
2. Will any group be excluded because of the policy? Y/N ✓
3. Will the policy have a negative impact on community relations? Y/N ✓

If yes, a full equality assessment must be done.

**WILL THE POLICY PROMOTE**

<table>
<thead>
<tr>
<th>POSITIVE IMPACT</th>
<th>State how, i.e. evidence used to reach this decision</th>
</tr>
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<tbody>
<tr>
<td>Y ✓</td>
<td>Applicable to all</td>
</tr>
<tr>
<td>N ×</td>
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</tbody>
</table>

1. Equal Opportunities
2. Get rid of discrimination
3. Get rid of harassment
4. Promote good community relations
5. Promote positive attitude to disabled people
6. Encourage participation by disabled people
7. Consider more favourable treatment of disabled people
8. Promote and protect human rights

Assessed by (Name/s)  Mr Paul Tisi

Signed  Post:  Medical Director  Date:  07/08/17

Signed  Post:  Date:  

---

FINAL (September 2019 Review: )
Ref No 02807803  -  Learning From Deaths
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### Approving Signatories

<table>
<thead>
<tr>
<th>Name of Sub-Committee / Business Unit:</th>
<th>Mortality Review Board</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date:</td>
<td>Date:</td>
</tr>
<tr>
<td>Signature:</td>
<td>Signature:</td>
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</tbody>
</table>

**Print Name:** Mr Paul Tisi

(Chairperson of Board or Committee indicated above)

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### Approved by

- Trust Board
- IM&T Strategy Group
- Information Governance Committee
- Audit Committee
- Human Resources and Organisational Development Committee
- Quality Board
- Executive Management Board
- Health and Safety Committee
- Safeguarding Committee
- Other – Please Specify [ ]

<table>
<thead>
<tr>
<th>Date: 18th Sep 2017</th>
<th>Date: 18/9/17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Signature: [ Signature:</td>
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</tbody>
</table>

(Chairperson of Board or Committee indicated above)

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### Responsible Executive Director Signature

<table>
<thead>
<tr>
<th>Signature:</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Print Name</td>
<td>Mr Paul Tisi</td>
</tr>
<tr>
<td>Job Title</td>
<td>Medical Director</td>
</tr>
<tr>
<td>Name of Person</td>
<td>Department or Committee</td>
</tr>
<tr>
<td>------------------------</td>
<td>-------------------------------------------------------------</td>
</tr>
<tr>
<td>Mr Paul Tisi</td>
<td>Medical Director</td>
</tr>
<tr>
<td>Dr Jackie Harvey</td>
<td>Deputy Medical Director</td>
</tr>
<tr>
<td>Dr John McNamara</td>
<td>Deputy Medical Director</td>
</tr>
<tr>
<td>Dr Mohammed Azher</td>
<td>Divisional Medical Director - Integrated Medicine</td>
</tr>
<tr>
<td>Mr Kandarp Thakkar</td>
<td>Divisional Medical Director – Planned Care and Womens’ and Children</td>
</tr>
<tr>
<td>Dr Stuart Lloyd</td>
<td>Clinical Director</td>
</tr>
<tr>
<td>Dr Rajeev Kumar</td>
<td>Clinical Director</td>
</tr>
<tr>
<td>Dr Sarah Smith</td>
<td>Clinical Director</td>
</tr>
<tr>
<td>Mr Mike Simpson</td>
<td>Clinical Director</td>
</tr>
<tr>
<td>Dr Pallab Rudra</td>
<td>Clinical Director</td>
</tr>
<tr>
<td>Mr Ed Neale</td>
<td>Clinical Director</td>
</tr>
<tr>
<td>Dr Jeremy Sizer</td>
<td>Clinical Director</td>
</tr>
<tr>
<td>Name</td>
<td>Position</td>
</tr>
<tr>
<td>--------------------</td>
<td>-----------------------------------------------</td>
</tr>
<tr>
<td>Dr Penny McNamara</td>
<td>Consultant Palliative Care</td>
</tr>
<tr>
<td>Dr Charlotte Oliver</td>
<td>Chief Resident</td>
</tr>
<tr>
<td>Tracey Brigstock</td>
<td>Acting Director Nursing</td>
</tr>
<tr>
<td>Belinda Wood</td>
<td>Acting Deputy Director of Nursing</td>
</tr>
<tr>
<td>Nichola Keer</td>
<td>Associate Director of Nursing - Safeguarding</td>
</tr>
<tr>
<td>Helen Friend</td>
<td>Associate Director of Nursing - QI</td>
</tr>
<tr>
<td>Toni McLaughlin</td>
<td>Lead Disability Liaison Nurse</td>
</tr>
<tr>
<td>Aidan Vaughan</td>
<td>Deputy Director Clinical Governance</td>
</tr>
<tr>
<td>Ann Buck</td>
<td>Head of Clinical Information</td>
</tr>
<tr>
<td>Emma Hutt</td>
<td>Lead Nurse Cardiac Arrest Prevention</td>
</tr>
<tr>
<td>Brian Courtney</td>
<td>Interim Director of Corporate Affairs</td>
</tr>
</tbody>
</table>