South London and Maudsley NHS Foundation Trust

MORTALITY REVIEW POLICY

Version:	2.1
Ratified By:	Clinical Policy Working Group
Date Ratified:	4th June 2019
Date Policy Comes into Effect:	17th June 2020
Author:	Dr Michael Holland, Medical Director and Simon Sherring, Deputy Director of Nursing
Responsible Director:	Dr Michael Holland, Medical Director
Responsible Committee:	Mortality Review Group
Responsible Committee Approval Date:	25th April 2019
Target Audience:	Clinical Staff
Review Date:	April 2021

Equality Impact Assessment	Assessor: Simon Sherring	Date: 09/05/2019
HRA Impact Assessment	Assessor: Simon Sherring	Date: 09/05/2019

Document History

Version Control

Version No.	Date	Summary of Changes	Major (must go to an exec meeting) or minor changes	Author
1.0	June – Sept 2017	N/A	New Policy	Lucy Stubbings/Mary O'Donovan
2.0	March 2019	Revision of the policy in light of the Royal College of Psychiatrists guidance	Major	Simon Sherring/ Michael Holland
2.1	Nov 2019	Addition of LeDeR flowchart to appendices, and text in policy referring to this.	Minor	Stefanos Maltezos /Simon Sherring

Consultation

Stakeholder/Committee/ Group Consulted	Date	Changes Made as a Result of Consultation
Mortality Review Group	15/06/17	Clarification of internal and Trust processes including roles and responsibilities
Clinical Directors, Governance Teams, Legal Services and QI	16/08/2017	Updates to wording and links to other policies made
Mortality Review Group	2019	Consultation occurred in the March and April 2019 MRG meetings, and via emails sent to MRG members in March 2019.
Proposed changes discussed at the Mortality Review Group	2019	Minor changes as above.

Service Users/Carers consulted	Date	Changes Made as a Result of Consultation

Plan for Dissemination of Policy

Audience(s)	Dissemination Method	Paper or Electronic	Person Responsible
Mortality Review Group, Clinical Directors and Service Directors	Circulated by email	Electronic	
All staff	Trust intranet	Electronic	Policy co-ordinator

Key changes to policy:
Policy changed to reflect the implementation of the Royal College of Psychiatrists Care Review Tool.

Plan for Implementation of Policy

Details on Implementation	Person Responsible
Directorate Clinical Directors will ensure policy implementation within monthly MRG forums, with oversight from the Trust MRG who will monitor implementation and efficacy of the policy through its quarterly	Medical Director/ Directorate Clinical Directors

CONTENTS

1 Introduction

This policy outlines the procedures and guidance around mortality governance in support of both the Trust's local Incident Policy and Investigation Policy. This policy should also be read in conjunction with the NHS England Serious Incident Framework (2015) and the National Quality Board National Guidance on Learning from Deaths (March 2017).

2 Background

2.1 This policy is produced in the context of national concerns regarding mortality rates, and the reporting and investigation of tragic deaths of patients in the care of NHS services.

2.2 The purpose of Mortality Review is to establish whether aspect of care provision may have contributed to the death of our patients, in order to learn from these to prevent recurrence. This learning will be used to improve the way the Trust's services are delivered as well as working with partner organisations to reduce avoidable or premature death.

3 Definitions

3.1 Patient

The term 'patient' will be used to describe all patients and services users who are currently or have previously been under the care of the Trust.

3.2 Incident

An event or circumstance which could have resulted, or did result, in damage, loss or harm to patients, staff, visitors or members of the public.

3.3 Mortality Review

A process undertaken after the death of a patient who was in receipt of SLAM services or after discharge from services which aims to identify, understand and learn from any problems identified with the quality of care delivered.

3.4 Datix

Datix is the electronic database used within SLaM to help monitor and evaluate issues which impact on the safety of patients, healthcare workers, visitors and contractors. Incidents, complaints, concerns, risks and claims/inquests are reported on the system enabling robust management whilst contributing to the safety culture and learning of the entire Trust.

3.5 Clinical Records/ Notes

SLaM services use a number of 'clinical notes' systems e.g. ePJS and IAPTUS. The terms clinical notes will refer to all electronic patient records systems are used within SLaM to document all patient interactions and care provided.

4 Purpose and Scope

This policy will provide guidance to staff on which deaths should be reported on Datix, outline the process of Mortality Review and the Trust's governance structures to support the Mortality Review Process. The policy should be read in conjunction with the Incident Policy, Policy of Investigation of Incidents, Complaints and Claims, Policy for Supporting Staff involved in incidents, complaints or claims, Being Open and Duty of Candour Policy

5 Roles and Responsibilities

5.1 All Trust Staff

All Trust staff have a responsibility to ensure patient deaths are recorded in the clinical notes and reported on Datix. Although it is preferable that reporting is completed by a

member of the patient's clinical team, any member of staff informed of the death can report. The incident policy states that this should be the most senior person on duty. Further information can be found in the incident policy.

5.2 Trust Medical Director

The Trust Medical Director is the executive lead for Mortality Review and is responsible for ensuring the systems within the Trust are fit to provide a review of mortality and learning from the findings of Mortality Reviews is embedded and disseminated.

5.3 Directorate Clinical Directors

The clinical directors are responsible for ensuring their Directorate has an appropriate system for the review of reported deaths by a senior doctor. The Clinical Director is responsible for ensuring Directorate medical and nursing attendance at the Trust's Mortality Review Group (MRG) and timely reports are submitted to the MRG.

5.4 Non-Executive Directors

The Board of Directors are collectively responsible for ensuring the quality and safety of healthcare services provided by the Trust. The Mortality Review group and policy will be overseen by the Quality Sub Committee which is chaired and attended by Non- Executive Directors, thereby providing assurance that the processes in place are robust.

5.5 Mortality Review Group (MRG)

The MRG is responsible for monitoring the number of patient deaths and themes arising from Mortality Reviews across the Trust. The MRG is chaired by the Medical Director with oversight by the Trust Board and attendance from each of the Directorates. The terms of reference are found in Appendix 1.

5.6 Learning Disability Mortality Review Programme (LeDeR) lead for Mortality

The Learning Disability Mortality Review Programme (LeDeR) lead for Mortality is the Behaviour and Developmental Psychiatry Clinical Director for Neurodevelopmental Services. The Mental Health Learning Disabilities (MHLD) team has developed its own flow chart (Appendix 4) to show the process MHLD staff should follow when reporting a death. It shows key stages of where LEDER feedback is provided to the MHLD Mortality Review meeting and then cascaded to the MHLD teams.

6 Bereaved Family and Carers

6.1 When a patient in receipt of care from the Trust dies, within an inpatient setting, bereaved families and carers should be informed immediately. In all circumstances of a death, contact should be made to offer support to the family in a clear, honest and compassionate way.

6.2 Bereaved families and carers have a right to raise concerns about the quality of care and thereby help to inform decisions about whether a review or investigation needed. Bereaved families and carers are partners in an investigation and should receive a timely, responsive contact in all aspects of the investigation process.

6.3 Duty of Candour should always be followed when a patient dies, as it is unclear if any aspects of care provided may have led to the harm of the patient. Further information can be found in the Trust's Being Open and Duty of Candour Policy.

6.4 A condolence letter should be sent to bereaved family and carers to

- Offer support and condolences for the death of the patient
- Inform them of the Mortality Review and any other investigative processes
- Invite them to contribute their views on the patient's care
- Provide details of a named contact who can be a resource for them during the review process investigation process or who can be contacted at a later stage
- Signpost them to organisations who can provide them with further support

7 Process for reporting deaths

7.1 All deaths of patients who currently receive care from SLaM services, including where the patient is in receipt of palliative care and instances of expected death are reportable. Additionally deaths of patients up to 12 months post discharge are reportable (with the exception of those with Learning Disability, see below). The level of review will be defined following the initial review and completion of the Care Review Tool form (See Appendix 2).

7.2 In instances where a patient with has an apparent or secondary diagnosis Learning Disability has accessed any SLaM service all deaths should be reported within 12 months of their last contact. The Trust has a Learning Disability Mortality Review Programme (LeDeR) lead for Mortality. See National guidance flow chart (Appendix 3).

7.3 Deaths which must be reported on Datix within the Trust and will require the completion of a Care Review Tool Form are outlined below in Table 1.

	Deaths which must be reported on Datix	Mortality Review
All Directorates	All patients who are **open** to a service or were discharged in the **12** months preceding their death	***Open*** *to service or within* ***1*** *month of discharge* Complete Care Review Tool - ***2- 6*** *months post discharge* Admin to contact GP to ascertain any concerns about care
Diagnosis of Learning Disability	All patients who are **open** to a service or were discharged in the **12** months preceding their death	Full Mortality Review section 1 and section 2

Table 1: Trust criteria for reporting deaths and mortality review

8 Care Review Tool (Appendix 2)

8.1 The current version of the Care Review Tool will always be held within the Datix incident record. The version within appendix 2 is the version at the time of ratification of the policy.

8.2 From April 2019 the Trust adopted the Royal College of Psychiatrists Care Review Tool for Mortality reviews in Mental Health Trusts[1]. This Care Review Tool was developed by the Royal College of Psychiatrists through its Centre for Quality Improvement, with funding from NHS England. It is based on the Structured Judgement Review methodology, originally developed by the Royal College of Physicians. The Care Review Tool is suitable for supporting mortality reviews for patients who were under the care of mental health Trusts. The tool[2] has two sections:

- Section 1 should be completed as soon as possible after a patient's death and could be completed by the treating team.

- Section 2 should be completed for deaths that are selected for a structured judgement review, which would be those deaths that have a 'red flag' (defined on the next page), those where Trusts have identified local need for review, or those deaths that have been randomly selected. It is expected that the review would be conducted within 60 days of the death being reported.

[1] https://www.rcpsych.ac.uk/docs/default-source/improving-care/better-mhpolicy/policy/rcpsych_mortality_review_guidance.pdf
[2] https://www.rcpsych.ac.uk/improving-care/campaigning-for-better-mental-health-policy/care-review-tool-for-mental-health-trusts

8.3 The principles of the mortality review process are:

- All deaths are appropriately reviewed to assess if there is potential for organisational learning.
- The deaths selected for further review have a structured judgement review completed.
- The review of deaths is undertaken in a spirit of openness and transparency, and organisational learning, rather than blame.
- The review of deaths will involve families and those close to the deceased, where possible.

8.4 There may be occasions where completion of the Care Review Tool identifies a problem in care that would mean an in depth clinical review or serious incident investigation may be required. Where these problems are identified the local Trust processes for serious incident investigations should be followed instead of the Care Review Tool process. The Care Review Tool is not intended as a replacement for the other processes.

8.5 It is also important to note that there are currently recognised processes and programmes which focus on deaths of children, maternal deaths, deaths of people with learning disabilities, and homicides linked to mental disorder. The Care Review Tool should therefore not be used in these circumstances as the other processes should be followed.

8.6 At each meeting there will be a case presentation from each directorate of one mortality review that has been conducted. This will be an opportunity for the Mortality Review Group to quality check the use of the Care Review Tool.

8.7 Care Review Tool (CRT) Section 1

Section 1 of the CRT should be completed electronically by a senior clinician within **3** working days (dependent on service operating hours) of notification of the death on Datix. If there is a red flag, or if randomly selected, then Section 2 of the CRT must be completed. Each directorate is responsible for randomly selecting cases for the completing of Section 2. A minimum of 5% of all cases will be randomly selected.

8.7.1 Each directorate might determine local red flags, which might be subject to change. These locally determined red flags, and any changes, must be discussed in the Mortality Review Group meeting and documented in the meeting's minutes.

8.7.2 Cause of death

A patient's cause of death is detailed on their death certificate and can be requested through legal services of directly from the Coroner. This may not be available within the 3 working days to complete part 1. Further attempts should be made to request the cause of death following the completion of part 1, the CRT can then be reviewed once received.

8.8 Care Review Tool (CRT) Section 2

Section 2 of the CRT should be completed within **60** working days of the notification of the death on Datix.

9. Fact Finding Report

9.1 The fact finding report is a concurrent initial incident review where more information or brief investigation is required. All incidents notified to service commissioners require a fact finding report. Fact finding reports should be completed within **two** working days (dependent on service operating hours) and are inputted electronically onto the Datix record. Further information can be found in the Incident Policy and Policy for the Investigation of Incidents, Complaints and Claims.

10. Training

Training is available on the use of Datix and structured investigations through the Education and Development Department, accessed using the Trust training portal LEAP.

11. Support for Staff

The Trust takes its duty of care to protect the physical and mental wellbeing of its staff seriously and is committed to providing appropriate support to staff involved in traumatic/stressful incidents based on their needs. It is the line manager's responsibility to discuss the support required by an individual, signposting or referring them to support services and refer them as appropriate to minimise the harmful effects of these events

The Critical Incident Staff Support Service (CISS) aims to provide support to staff who have been involved in a significantly distressing incident at work. The CISS service runs alongside existing staff support services and provide teams with the opportunity to discuss the events. Further information can be found in the Trust Policy on Staff Supporting Staff Policy.

12. Governance and Assurance

12.1 Trust wide Mortality Review Group

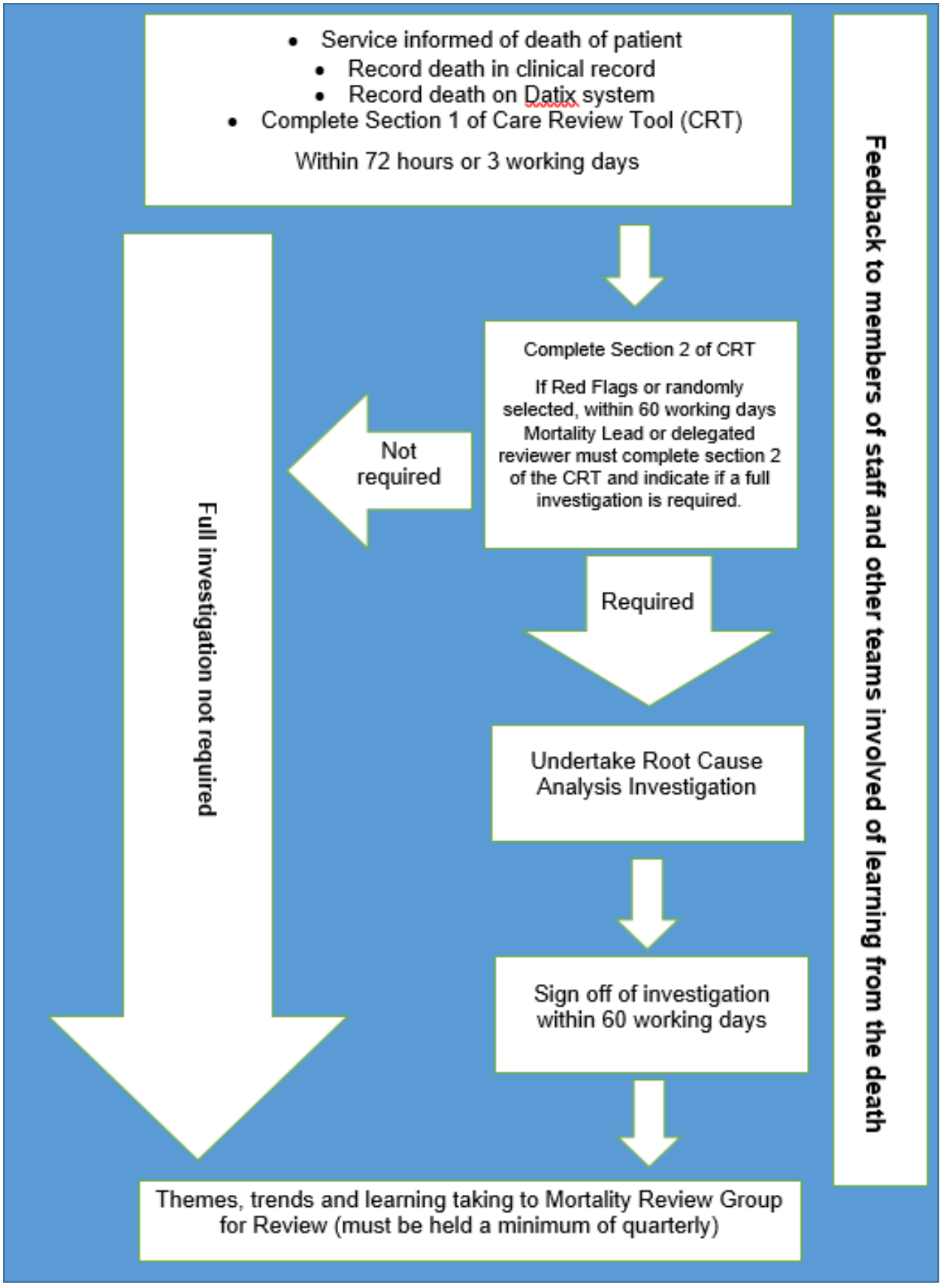
In 2106, the Mortality Review Group (MRG) in SLaM was moved to a central group from individual directorate processes. This change was implemented following advice from NHS England to improve individual Trust's self-assessment of mortality and to ensure that learning was embedded. Further detail can be found in the terms of reference, appendix 1.

12.1.1 The MRG is held quarterly and is a sub-group of the Trust Board chaired by the Medical Director. Attendance at the group is expected from all the Directorates within the Trust. Each Directorate should have a mortality lead and ensure that their processes align to feed into the MRG.

12.2 Local Mortality Review Processes

Directorates will facilitate local Mortality Review processes/ forums on a monthly basis which will review CRTs and to ensure a consistent approach to Reviews. Data and themes from deaths will be reviewed and forwarded to the Trust wide Mortality review Group on a quarterly basis, along with details of any shared learning or matters identified for further review on a Trust wide basis.

13 Death Reporting Process



14 Monitoring Compliance

What will be monitored i.e. measurable policy objective	Method of Monitoring	Monitoring frequency	Position responsible for performing the monitoring/ performing co-ordinating	Group(s)/committee (s) monitoring is reported to, inc responsibility for action plans and changes in practice as a result
Policy Compliance	Audit	Annual	Audit Team	Mortality Review Group

15 Associated Documentation

- Incident Policy, (SLaM)
- Policy for the Investigation of Incidents, Complaints and Claims, (SLaM)
- Being Open and Duty of Candour Policy, (SLaM)
- Policy for Supporting Staff Involved in Incidents, Complaints or Claims, (SLaM)
- Safeguarding Adults Policy
- Safeguarding Children Policy

16 References

NHS England (2015), Serious Incident Framework. Available from: https://www.england.nhs.uk/wp-content/uploads/2015/04/serious-incidnt-framwrk-upd.pdf

National Quality Board (March 2017), National Guidance on Learning from Deaths. Available from: https://www.england.nhs.uk/wp-content/uploads/2017/03/nqb-national-guidance-learning-from-deaths.pdf

CQC (2016) Learning, candour and accountability. Available from: https://www.cqc.org.uk/sites/default/files/20161213-learning-candour-accountability-full-report.pdf

NHS England (2015) Independent review of deaths of people with a Learning Disability or Mental Health problem in contact with Southern Health NHS Foundation Trust April 2011 to March 2015. Available from: https://www.england.nhs.uk/south/wp-content/uploads/sites/6/2015/12/mazars-rep.pdf

NHS England (2017) Guidance for the conduct of local reviews of the deaths of people with learning disabilities. Available from: http://www.bristol.ac.uk/media-library/sites/sps/leder/Guidance%20for%20the%20conduct%20of%20reviews%20%20FINALv2.2.pdf

Royal College of Psychiatrists (2018) Using the Care Review Tool for mortality reviews in Mental Health Trusts: Guidance for reviewers. Available at: https://www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/policy/rcpsych_mortality_review_guidance.pdf

17 Freedom of Information Act 2000

All Trust policies are public documents. They will be listed on the Trust's FOI document schedule and may be requested by any member of the public under the Freedom of Information Act (2000).

Appendix 1

Terms of Reference for Mortality Review Group (MRG)
April 2019 (v4)

Overall aim or purpose
To establish the cause of death of our patients and if there is anything we can do in the way we deliver our services or work with partners to improve avoidable or premature death.

- To act as the strategic Trust mortality overview group with senior leadership and support to ensure the alignment of the services across the Trust for the purpose of reducing all avoidable deaths.
- Learning from death is a key purpose of this group and commissioning thematic reviews arising from the various reports or issues highlighted by the data.
- Strategic oversight of mortality review committee(s) both local and Trust wide.
- To produce a Mortality Reduction Strategy that aligns Trust systems such as audit, information services, training and clinical directorates. This strategy will be reviewed on an annual basis by the Medical Director
- Sign off of action plans and methodologies that are designed to reduce morbidity and mortality across the trust.
- Sign off of all regulatory mortality responses.
- To report on Mortality performance to the Board.

Operational functions
- To work towards the elimination of all avoidable mortality.
- To review on a monthly basis, available benchmarked mortality rates of the Trust.
- To consider the mortality data in conjunction with other qualitative clinical data as well as national benchmarking data available and identify areas for future investigation.
- To receive reports from the Physical Health Implementation Board and evaluate how to incorporate learning and recommendations to improve physical health of patients
- To investigate any alerts received from the Care Quality Commission (CQC) or identified by the Mortality monitoring information systems e.g. Dr Foster, HED, etc.
- To maintain data collection systems to ensure the Trust's mortality data is timely robust and in line with national and international best practice.
- To ensure mortality information is accurate, contextual and engenders a culture of clinical excellence.
- To develop an annual mortality clinical coding improvement plan and receive regular reports on its implementation.
- Working with Directorates to establish how clinicians receive the latest guidelines on care protocol implementation and clinical coding best practice.
- To review and monitor compliance with other Trust policies including DNAR and Death Certification Policy.
- To monitor and consider the information from the electronic review of all in Trust deaths.

Accountability: The MRG is formally accountable the Trust Board

Membership:

Chair – Medical Director	**Information Department Representation**
Director of Nursing or Deputy	Senior Nurse Operations Directorate Rotation)
Doctor – medical representative from each Directorate	Junior Doctor Representation & Nursing
Patient Safety Team representative	Audit Team representative
Trust Carers Lead	Physical healthcare Lead
Academic representation- IOP	

Quorum: Four members plus the Chair (one nurse, two doctors and a governance representative).
Frequency of meetings: The group will meet Quarterly.

Appendix 2

Care Review Tool

the current version will always be on the Datix record

Care review tool for mortality reviews

Section 1

This section should be completed as soon as is possible.
If it is deemed appropriate to complete Section 2, it should be completed within 60 days of selected patients' deaths.

Patient identification number:		**Gender:**	
Date of birth (dd/mm/yyyy)		**Age:**	
Social deprivation index (first 3−4 letters of postcode)		**Ethnicity:**	
Date of death		**Time of death:**	
Location of death			
Was the patient identified as being within the last 12 months of life?			
Cause of death (if known)			
Primary diagnosis, including ICD-10 code			
Co-morbidities			
Learning disability (if present, this death should be reviewed through the LeDeR process)			
Healthcare teams involved in the patient's care at the time of death			
Dates of last admission to a psychiatric hospital (where relevant)			
Patient summary (can be completed by the clinical team)			
Concerns from family members or carers about the patient's care (please outline concerns, or state if there were no concerns)			
Concerns from staff about the patient's care (please outline concerns, or state if there were no concerns)			
Red flags indicating further review where the death is not being investigated by other means (please indicate):			
Family, carers or staff have raised concerns about the care provided ☐			
Diagnosis of psychosis or eating disorders during the last episode of care ☐			
Psychiatric inpatient at time of death, or discharged from inpatient care within the last month ☐			
Under Crisis Resolution and Home Treatment Team (or equivalent) at the time of death ☐			
Other locally determined criteria for review (please state): …… ☐			
Case selected at random ☐			

If a red flag is identified, or it has been agreed this death is for a review of care, please proceed to completion of Section 2. **Trusts may add additional red flags and should choose an additional random sample of other cases to review.**

Time taken to complete Section 1 of this form (minutes): ……
Date of completion: ……
Name of person completing Section 1: ……
Job title of person completing Section 1 ……

Section 2

Please state the information sources used for the review, including the names of the electronic systems accessed:

2.1. Phase of care: Allocation and initial assessment or review (where relevant) **Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice.** **Please also include any other information that you think is important or relevant.**
Please rate the care received by the patient during this phase as: **5 Excellent care ☐** **4 Good care ☐** **3 Adequate care ☐** **2 Poor care ☐** **1 Very poor care ☐** **Section not applicable ☐**
2.2. Phase of care: Ongoing care (where relevant)

- **Was mental health monitored adequately?**
- **Was physical health monitored adequately?**
- **Please list medication if known and relevant, and comment on medication monitoring where appropriate**

Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice.
Please also include any other information that you think is important or relevant.

Please rate the care received by the patient during this phase as:

5 Excellent care ☐ **4 Good care ☐** **3 Adequate care ☐** **2 Poor care ☐** **1 Very poor care ☐**

Section not applicable ☐

2.3. Phase of care: Psychiatric Inpatients – comment on care during admission (where relevant)

Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice. Please also include any other information that you think is important or relevant.
Please rate the care received by the patient during this phase as: 5 Excellent care ☐ 4 Good care ☐ 3 Adequate care ☐ 2 Poor care ☐ 1 Very poor care ☐ Section not applicable ☐

2.4. Phase of care: End of life care (where relevant) Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice. Please also include any other information that you think is important or relevant.
Please rate the care received by the patient during this phase: 5 Excellent care ☐ 4 Good care ☐ 3 Adequate care ☐ 2 Poor care ☐ 1 Very poor care ☒ Section not applicable ☐

2.5. Phase of care: Discharge plan of care (where relevant) Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice. Please also include any other information that you think is important or relevant.

Please rate the care received by the patient during this phase: **5 Excellent care ☐ 4 Good care ☐ 3 Adequate care ☐ 2 Poor care ☐ 1 Very poor care ☐** **Section not applicable ☐**

2.6. Other area of care (please specify) **Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice.** **Please also include any other information that you think is important or relevant.**
Please rate the care received by the patient during this phase as: **5 Excellent care ☐ 4 Good care ☐ 3 Adequate care ☐ 2 Poor care ☐ 1 Very poor care ☐** **Section not applicable ☐**

2.7. Overall care
Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice.
Areas identified where learning could occur, including areas of good practice, should be included in addition to any potential areas of further investigation.
Please also include any other information that you think is important or relevant.

Please rate the care received by the patient during this phase as:

5 Excellent care ☐ **4 Good care ☐** **3 Adequate care ☐** **2 Poor care ☐** **1 Very poor care ☐**

Section not applicable ☐

2.8. If care was below an acceptable standard, did it lead to harm? If yes, please provide details and state an action plan (consider whether a serious incident investigation or another Trust process is required).

2.9. Was the patient's death considered more likely than not to have resulted from problems in care delivery or service provision? If yes, please provide details and state an action plan

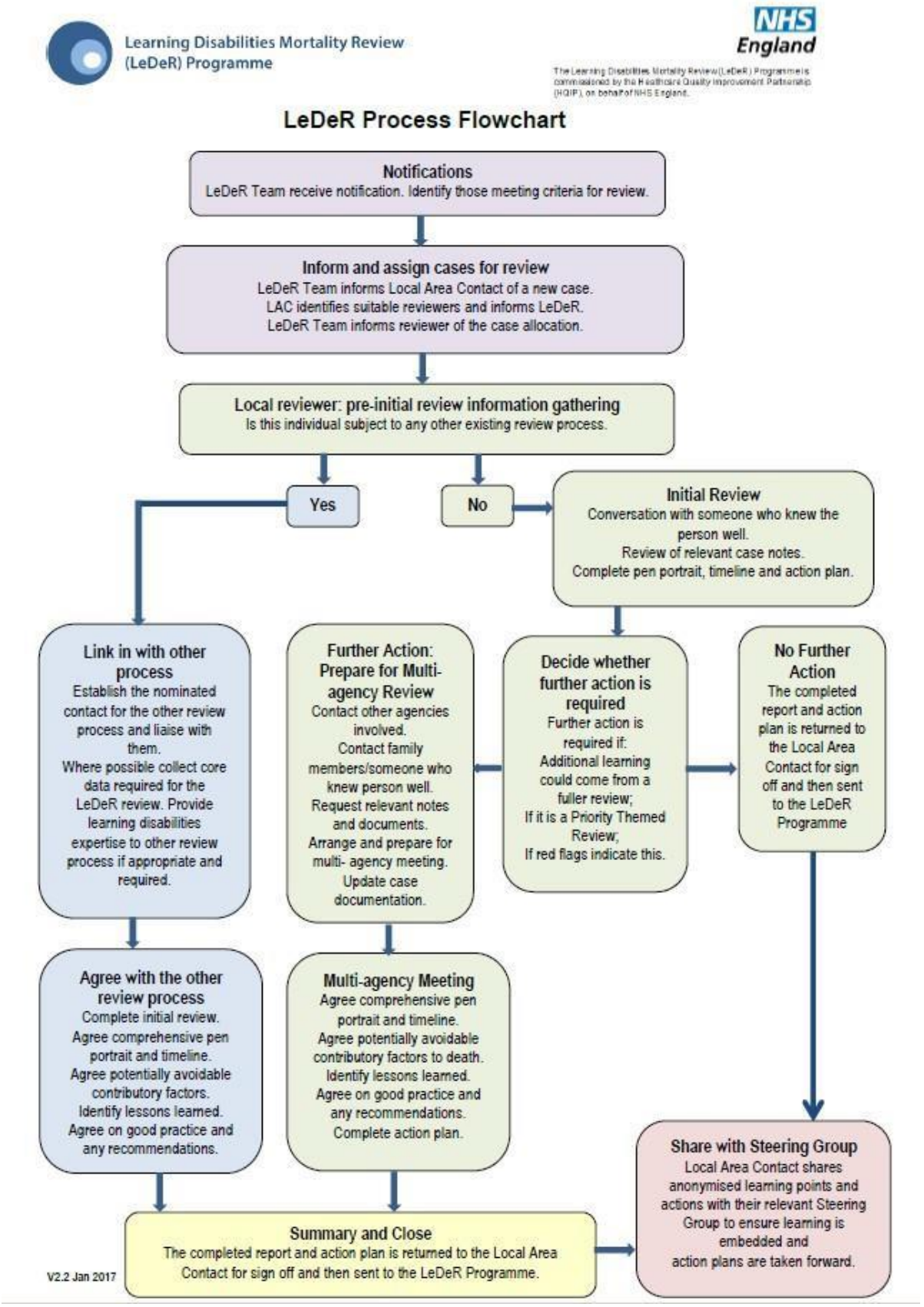
(consider whether a serious incident investigation is required).

2.10. If a family member, carer, or staff raised concerns, please outline any feedback provided and state who was responsible for providing this feedback. Please state further action required. If no feedback was provided, please consider how the outcome of this review should be fed back to the relevant people, considering the duty of candour principle.

2.11. Were the patient records adequate for the purpose of the review?	Yes ☐ No ☐
Please outline any difficulties in accessing appropriate information:	

Time taken to complete Section 2 of this form (minutes): ……
Date of completion: ……
Name of person completing Section 2: ……
Job title of person completing Section 2: ……

Appendix 3. LeDeR Process Flowchart



Appendix 4

LEDER PROCESS FOR MHLD STAFF TO FOLLOW

NOTIFICATION OF DEATH OF PLD INFORMED BY (Confirmed by ID e.g NHS Number/DOB):

- Family/Carer/PLD
- GP
- Local Hospital
- Joint CLDT/Team Meetings
- GSTT/CLDT
- AWLD SLL/ASC G
- LeDeR

Escalate to Team Leaders & CSL if case is SI caused by SLAM Services.

SLAM/MHLD Process

MHLD Team member (ideally Care Co-ordinator or Team Leader) to complete DATIX report via Intranet - Datix Form

Update ePJS/DATIX with LeDeR notification.

Type of Incident - Death
(this will populate a form to complete).

Consultant Psychiatrist/Speciality Doctor to complete the Mortality Review Form on DATIX.

Team Leader will allocate person to complete Fact Finder.

Check Safeguarding have been notified

Admin Lead copied into DATIX so add to MHLD Spreadsheet for next LD Mortality Meeting.

Team Leader or Consultant Psychiatrist will present at next LD Mortality Meeting.

Feedback used to develop services

Feedback disseminated to teams via Business Meetings.

LeDeR Process

MHLD Team member to complete LeDeR Notification (if not already notified)
www.bristol.ac.uk/sps/leder/notifyadeath/
Tel: 0300 773 4774

LeDeR will allocate two local reviewers* from:

- MHLD, GSTT, CLDT, Social Services

MHLD reviewers must inform Team Leader to discuss process.

MHLD reviewers must inform Team Leader to discuss process

MHLD Reviewer will implement review process along with second reviewer. Process Diagram on www.review.leder.ac.uk

Review submitted to LeDeR

Feedback to be provided by LeDeR

*Reviewer has to have completed LeDeR reviewer training

Appendix 5. Equality Impact Assessment

PART 1: Equality relevance checklist

The following questions can help you to determine whether the policy, function or service development is relevant to equality, discrimination or good relations:

- Does it affect service users, employees or the wider community? Note: relevance depends not just on the number of those affected but on the significance of the impact on them.
- Is it likely to affect people with any of the protected characteristics (see below) differently?
- Is it a major change significantly affecting how functions are delivered?
- Will it have a significant impact on how the organisation operates in terms of equality, discrimination or good relations?
- Does it relate to functions that are important to people with particular protected characteristics or to an area with known inequalities, discrimination or prejudice?
- Does it relate to any of the following 2013-16 equality objectives that SLaM has set?
    1. All SLaM service users have a say in the care they get
    2. SLaM staff treat all service users and carers well and help service users to achieve the goals they set for their recovery
    3. All service users feel safe in SLaM services
    4. Roll-out and embed the Trust's Five Commitments for all staff
    5. Show leadership on equality though our communication and behaviour

Name of the policy or service development: Policy for Mortality Review

Is the policy or service development relevant to equality, discrimination or good relations for people with protected characteristics below?

Please select yes or no for each protected characteristic below

Age	**Disability**	**Gender re-assignment**	**Pregnancy & Maternity**	**Race**	**Religion and Belief**	**Sex**	**Sexual Orientation**	**Marriage & Civil Partnership** *(Only if considering employment issues)*
Y	Y	Y	Y	Y	Y	Y	Y	

If yes to any, please complete Part 2: Equality Impact Assessment

If not relevant to any please state why:

Date completed: 4/3/19
Name of person completing: Simon Sherring
Service / Department: Nursing Directorate

Please send an electronic copy of the completed EIA relevance checklist to:

1. macius.kurowski@slam.nhs.

PART 2: Equality Impact Assessment

1. Name of policy or service development being assessed?

POLICY FOR MORTALITY REVIEW

2. Name of lead person responsible for the policy or service development?

Michael Holland, Medical Director

3. Describe the policy or service development

What is its main aim?
To provide guidance on the process of mortality review in order to ensure learning from deaths.

What are its objectives and intended outcomes?

Ensure that mortality reviews are completed in line with Trust policy and protocols

What are the main changes being made?

Review in light of the Royal College of Psychiatrists guidance.

What is the timetable for its development and implementation?
To implement from 1st April 2019

4. What evidence have you considered to understand the impact of the policy or service development on people with different protected characteristics?

Royal College of Psychiatrists Guidance

5. Have you explained, consulted or involved people who might be affected by the policy or service development?

Consultation with Service leads, clinical working group and the Trust's Mortality Review Group

6. Does the evidence you have considered suggest that the policy or service development could have a potentially positive or negative impact on equality, discrimination or good relations for people with protected characteristics?

(Please select yes or no for each relevant protected characteristic below)

Age	**Positive impact:** No	**Negative impact:** No
Please summarise potential impacts:		

Disability	**Positive impact:** No	**Negative impact:** No
Please summarise potential impacts:		
Gender re-assignment	**Positive impact:** No	**Negative impact:** No
Please summarise potential impacts:		
Race	**Positive impact:** No	**Negative impact:** No
Please summarise potential impacts:		
Pregnancy & Maternity	**Positive impact:** No	**Negative impact:** No
Please summarise potential impacts:		
Religion and Belief	**Positive impact:** No	**Negative impact:** No
Please summarise potential impacts:		
Sex	**Positive impact:** No	**Negative impact:** No
Please summarise potential impacts:		
Sexual Orientation	**Positive impact:** No	**Negative impact:** No
Please summarise potential impacts:		
Marriage & Civil Partnership *(Only if considering employment issues)*	**Positive impact:** N/A	**Negative impact:** N/A
Please summarise potential impacts:		
Other (e.g. Carers)	**Positive impact:** Yes or No	**Negative impact:** Yes or No
Please summarise potential impacts:		

7. Are there changes or practical measures that you can take to mitigate negative impacts or maximise positive impacts you have identified?

YES: *Please detail actions in PART 3: EIA Action Plan*

NO: *Please explain why*

We don't anticipate any negative impacts as a result of this policy.

8. What process has been established to review the effects of the policy or service development on equality, discrimination and good relations once it is implemented?

Yearly review of policy, future audits will include further review of equality and characteristics of those who have mortality review completed.

Date completed: 04/03/19
Name of person completing: Simon Sherring
Service / Department: Nursing Directorate

Please send an electronic copy of the completed EIA relevance checklist to:
1. macius.kurowski@slam.nhs.uk

PART 3: Equality Impact Assessment Action plan

Potential impact	Proposed actions	Responsible/ lead person	Timescale	Progress
Monitor equality impacts of the policy	Future Mortality Audit plan to include review of demographics on ePJS, CRIS data and Datix information.	Medical Director	May 2020	
Monitor equality impacts of the policy	Review EIA	Policy Lead	June 2020	

Please send an electronic copy of the completed EIA relevance checklist to:
macius.kurowski@slam.nhs.uk

Appendix 6

Human Rights Assessment

To be completed and attached to any procedural document when submitted to an appropriate committee for consideration and approval. If any potential infringements of Human Rights are identified, i.e. by answering Yes to any of the sections below, note them in the Comments box and then refer the documents to SLaM Legal Services for further review.

For advice in completing the Assessment please contact Anthony Konzon, Claims and Litigation Manager [anthony.konzon@slam.nhs.uk)

HRA Act 1998 Impact Assessment	Yes/No	If Yes, add relevant comments
The Human Rights Act allows for the following relevant rights listed below. Does the policy/guidance NEGATIVELY affect any of these rights?		
Article 2 - Right to Life [Resuscitation /experimental treatments, care of at risk patients]	No	
Article 3 - Freedom from torture, inhumane or degrading treatment or punishment [physical & mental wellbeing - potentially this could apply to some forms of treatment or patient management]	No	
Article 5 – Right to Liberty and security of persons i.e. freedom from detention unless justified in law e.g. detained under the Mental Health Act [Safeguarding issues]	No	
Article 6 – Right to a Fair Trial, public hearing before an independent and impartial tribunal within a reasonable time [complaints/grievances]	No	
Article 8 – Respect for Private and Family Life, home and correspondence / all other communications [right to choose, right to bodily integrity i.e. consent to treatment, Restrictions on visitors, Disclosure issues]	No	
Article 9 - Freedom of thought, conscience and religion [Drugging patients, Religious and language issues]	No	
Article 10 - Freedom of expression and to receive and impart information and ideas without interference. [withholding information]	Np	
Article 11 - Freedom of assembly and association	No	
Article 14 - Freedom from all discrimination	No	

Name of person completing the Initial HRA Assessment:	Simon Sherring

Date:	04/03/19
Person in Legal Services completing the further HRA Assessment (if required):	Anthony Konzon
Date:	08/05/19