DOCUMENT CONTROL PAGE		
Title	**Title:** **Mortality Review Policy** **Version:** 1 **Reference Number:**	
Supersedes	**Supersedes:** Not applicable **Changes:**	
Minor Amendment	**Date:** Not applicable **Notified to:** **Date:** **Summary of amendments:**	
Ratification	**Ratified by:** Trust Clinical Effectiveness Committee **Date of Ratification:** June 2017	
Application	All staff	
Circulation	**Issue Date: 27th June 2017** **Circulated by:** Mrs S Corcoran **Dissemination and Implementation:** Intranet, CHDs, DDs, HoNs	
Review	**Review Date: June 2019** **Responsibility of:** Director of Clinical Governance	
Date placed on the Intranet:	Please enter your EqIA Registration Number here: 60/17	

1. Introduction

1.1. A number of reports in recent years have presented a clear case for consistent reporting on mortality across the NHS. There are lessons to be learned from the review of deaths in respect of care delivery, treatment outcomes and local variables in care organisation and patient pathways.

1.2. It is now recognised that the review of mortality statistics can give an indication to the levels of quality and safety and help identify causes of deaths in hospitals that are avoidable through better, safer and more efficient or effective healthcare delivery.

1.3. Research suggests that preventable deaths due to problems in care only make up around 5% of deaths and that the variation seen in the 'Summary Hospital-Level Mortality Indicator' (SHMI) and other indicators is likely to be due to other factors. However as yet the NHS as a whole has been unable to demonstrate categorically what these variances are due to and clinical review of cases in imperative going forward in order to expand our understanding of mortality and clinical outcomes.

1.4. The Secretary of State for Health commissioned a report into the understanding of UK deaths[1] and they found the following:

- *Sometimes not treated with kindness, respect and sensitivity; can feel their involvement is tokenistic; and often question the independence of the reports*
- *The NHS does not prioritise learning from deaths and misses countless opportunities to learn and improve as a result*
- *There is no single framework which sets out how local NHS organisations should identify, analyse and learn from deaths of patients in their care or who have recently been in their care*

1.5. This report made a number of recommendations to which the Trust is responding and this policy sets out that response in the form of a procedural document on which mortality review Trust wide will now be based. These recommendations are:

1.5.1. Collect a range of specified information on deaths that were potentially avoidable and serious incidents, and consider what lessons need to be learned on a regular basis

1.5.2. Publish that information quarterly

1.5.3. Publish evidence of learning and action

1.5.4. Feed the information back to NHS Improvement

1.5.5. Identify a Board-level leader as Patient Safety Director to take responsibility for this agenda

[1] CQC Review of deaths of NHS patients, December 2016

1.5.6. Ensure that investigations of any deaths that may be the result of problems in care are more thorough and genuinely involve families and carers

1.5.7. Follow a standardised national framework

1.5.8. Particular priority to be given to identifying patients with a mental health problem of a learning disability to make sure their care responds to their particular needs; and that particular trouble is taken over any mortality investigations to ensure wrong assumptions are not made about the inevitability of death

1.5.9. Ensure that the NHS reviews and learns from all deaths of people with learning disabilities, in all settings. The Learning Disabilities Mortality Review Programme will provide support to both families and local NHS areas to enable reporting and independent, standardised review of all learning disability deaths between the ages of 4 to 74

1.6. These recommendations were detailed in further guidance published in March 2017 by NHS England[2].

2. Purpose

2.1. This policy sets out the requirements in respect of mortality review for the organisation. The aims of the policy are to:

2.1.1. Further the organisational understanding of quality of care, clinical outcomes and avoidable mortality

2.1.2. Meet the requirements of the revised guidance on mortality review in the NHS Improvement National guidance

3. Roles and Responsibilities

3.1. The **Trust Board of Directors** will receive annual reports on mortality that provide assurance that all is being reasonably done with regards to providing safe and high quality care.

3.2. The **Chief Executive** is the accountable officer with overall responsibility for quality of care in the organisation. As such, the Chief Executive must gain assurance that the systems and processes for mortality review are in place and meet the objectives set out in the policy.

3.3. The **Medical Director** is the Executive Director Lead on the Board of Directors for understanding mortality and has delegated responsibility for the implementation, monitoring and review of this policy.

The Medical Director will also have overall responsibility for mitigation of the Mortality Risk on Corporate Risk Register.

3.4. A named **Non-Executive Director** is identified as the Board-level leader as Patient Safety Director to take responsibility for this agenda, working with the Medical Director and providing assurance that this policy is being implemented.

[2] National Guidance on Learning from Deaths, March 2017, NHS England

3.5. An **Associate Medical Director** has delegated responsibility from the Medical Director to ensure that Clinicians throughout the organisation fulfil their duties under the requirements of the policy.

3.6. **Clinical Heads of Division** are responsible for the local oversight of implementation, monitoring[3] and review. This will include the review of mortality review activity at the Divisional Clinical Effectiveness Board.
The Clinical Head of Division will ensure appropriate reporting, duty of candour and investigation of all reviews, which are graded at level 2 or 3.

3.7. The **Director of Clinical Governance** has delegated responsibility from the Medical Director to ensure that all other staff throughout the organisation fulfil their duties under the requirements of the policy by ensuring that an appropriate governance structure is in place for reporting and acting on themes and lessons learned.

The Director of Governance will also oversee any response required to external mortality alerts and changes to national guidance.

3.8. **Divisional Mortality Leads** are responsible for ensuring that mortality review and learning from same are undertaken for all patients required by the policy.

3.9. **Heads of Nursing** will support nursing staff to be involved in mortality review, contributing to findings and acting upon them.

3.10. **Heads of Allied Health Professions** will support AHP staff to be involved in mortality review, contributing to findings and acting upon them.

3.11. The **Associate Director of Clinical Governance** will be responsible for ensuring any required High Level Investigation is undertaken as required.

3.12. The **Head of Patient Services** will be responsible for ensuring that any concerns raised by families or carers of deceased patients are raised with the appropriate Mortality Lead.

3.13. **Clinical Coding** staff will be responsible for participating in mortality peer reviews where coding issues have been identified and application of lessons learned thereafter.

3.14. The **Bereavement Team** are responsible for the communication of mortality review information to families through the written information provided by the Trust. A letter will be provided to all next of kin informing them about the review process and inviting them to ask for a review and contribute questions.

3.15. **All staff** have a responsibility to contribute to the implementation of this policy and recognise their accountability in respect of quality and safety of services delivered. This may entail responding to recommendations made for improvements following mortality review or thematic analysis.

3.16. **All staff** will be responsible for clear, contemporaneous, accurate record keeping in order that coding reflects accurate mortality indices.

[3] To include processes for the review of mortality review findings at Consultant appraisal

4. Detail of Procedural Document

Deaths for Review

4.1. The Trust will review deaths in the following categories:

4.1.1. All deaths where the patient is aged under 18

4.1.2. All maternal deaths

4.1.3. All neonatal deaths

4.1.4. Any unexpected death

4.1.5. Any death as a result of VTE

4.1.6. All deaths where the patient has MRSA

4.1.7. Any death where the circumstances are subject to a HLI

4.1.8. Any death of a patient resulting from a 'Never Event'

4.1.9. Any death graded at a 3 (see classification score at 4.4) following an EBM meeting

4.1.10. All deaths where bereaved families and carers or staff, have raised a significant concern about the quality of care provision

4.1.11. All inpatient, outpatient and community patient deaths of those with learning disabilities[4] (the LeDeR review process outlined at Appendix 2 will be adopted)

4.1.12. All deaths in a service specialty, particular diagnosis or treatment group where an 'alert' has been raised with the Trust through whatever means (for example via a Summary Hospital-level Mortality Indicator or other elevated mortality alert, concerns raised by audit work, concerns raised by the CQC or another regulator)

4.1.13. All deaths in areas where people are not expected to die, for example in relevant elective procedures

4.1.14. Inpatient detained under Mental Health Act

Regulations require mental health providers to ensure that any death of a patient detained under the Mental Health Act (1983) is reported to the Care Quality Commission without delay.

Under the Coroners and Justice Act 2009, Coroners must conduct an inquest into a death that has taken place in state detention, and this includes deaths of people subject to the Mental Health Act. Providers are also required to ensure that there is an appropriate investigation into the death of a patient in state detention under the Mental Health Act (1983).

[4] See definition of learning disability at Appendix 2

In circumstances where there is reason to believe the death may have been due or in part due to, problems in care – including suspected self-inflicted death – then the death must be reported as a serious incident and investigated appropriately and via StEIS to the provider's commissioner(s). Consideration should also be given to commissioning an independent investigation as detailed in the Serious Incident Framework[5].

4.1.15. 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

4.1.16. A further sample of other deaths that do not fit the identified categories so that the Trust can take an overview of where learning and improvement is needed most overall. This does not have to be a random sample, and could use practical sampling strategies such as taking a selection of deaths from each weekday. This must include patients whose death was expected and may have had an End of Life Care Plan in place

4.1.17. The Trust will review a case record review following any linked inquest and issue of a 'Regulation 28 Report on Action to Prevent Future Deaths' in order to examine the effectiveness of the review process

4.1.18. The Trust may be required to review care provided to patients who they do not consider to have been under their care at the time of death but where another organisation suggests that the Trust should review the care provided to the patient in the past

Process for Review

4.2. All mortality reviews will be undertaken using the online mortality review form. This form is based on the Structured Judgement Review and meets the requirements of NHSI reporting. See Appendix 1.

4.3. In addition to the Trust internal review of any death of a patient with a recognised learning disability as defined by the Learning Disabilities White Paper 'Valuing People' 12 (2001) will be referred to the Learning Disabilities Mortality Review (LeDeR) programme. See Appendix 2 for definition detail.

4.4. All mortality reviews will receive a classification score of:

Grade 0 – no suboptimal care

Grade 1 – suboptimal care but different management would not have prevented the death

Grade 2 – suboptimal care, different care might have made a difference (possibly avoidable death)*

Grade 3 – suboptimal care, different care would reasonably have been expected to make a difference (probably avoidable death)**

[5] Serious Incident Framework – Supporting learning to prevent recurrence, NHS England 2015

*****Grade 2 reviews will be fed back to the clinical team, actions undertaken and lessons shared

**Grade 3 reviews will be as for Grade 2 and reported to the Clinical Head of Division for further investigation and management.

4.5. A standard reporting template will be in place and will be used for monitoring purposes at the Mortality Scrutiny Committee. The information required will be a summary of the Hospital report.

4.6. If a review undertaken identifies an individual omission or error in care that constitutes a level 4 or 5 harm, this must be reported as an incident and investigated accordingly. If a number of lower level events lead to a classification score of 3, this may not need a high level investigation but this should be discussed and the reasons for not undertaking one clearly documented.

4.7. Where possible all relevant information should contribute to the review; this may include the multi-disciplinary health record (all sources), reports prepared for HM Coroner, post-mortem examination reports[6], testimony of family, parents, loved ones or carers and incident / complaints information.

4.8. The Trust will report all deaths within the organisation and to other organisations who may have an interest (including the deceased person's GP), and early discussion must take place after death as to any other interested party to whom the death must be reported. This may include HM Coroner, another Trust in which the patient may have been cared for, Social Services the patient may have been receiving or the Police.

4.9. When the death of a child involves treatment across the health care pathway (primary; secondary; tertiary care), it is expected that child mortality review processes will not be duplicated and that a single overarching meeting will be convened. Child mortality review processes will interface with existing Trust governance systems. The NHS England child death review programme is mindful of expectations arising from the Serious Incident Framework, which sets out the circumstances in which further investigation is warranted in certain situations. It is therefore anticipated that when a review identifies a problem in care that meets the definition of a patient safety incident (any unintended or unexpected incident which could have or did lead to harm to one or more patients receiving NHS care) then this is reported via the risk management systems to the National Reporting and Learning System (NRLS).

4.10. Regardless of the type of review, its findings must form an integral part of and feed into the Trust clinical governance processes and structures. Review findings should be considered alongside other information and data including complaints, clinical audit information, patient safety incident reports and other outcomes measures to inform the Trust's wider strategic plans and safety priorities.

4.11. The process for mortality review should be done in a reasonable time and must not delay any other process, for example release of the deceased for burial or cremation. Clinical staff should aim to have a mandated review completed within one month of the patient's death in order that duty of candour not exceed a reasonable time and that improvements can be made where needed.

[6] These will not be shared by HM Coroner until all clinical reports have been submitted to the Coroner's Office

Governance

4.12. The Trust will have a Mortality Scrutiny Committee (MSG). The scope and duties of this committee will include oversight of the implementation of this policy, oversight of Trust specific alerts, oversight of performance on Trust mortality metrics and external reporting.

4.13. The primary role of the MSG is to provide assurance to the Trust Board of Directors on patient mortality. Mortality indicator statistics do not in themselves constitute evidence regarding the standard of care delivered. The group will review data on patient deaths, including results and learning generated by local mortality review, and consider strategies to improve care and reduce avoidable mortality.

4.14. Each Hospital will have a Mortality Review Group. This group will be chaired by the Mortality Lead (can be a rotational Chair if more than one). The Chair must be a Consultant. Example Terms of Reference are at Appendix 3.

4.15. The Mortality Review Groups will report to the Hospital Clinical Effectiveness meeting and mortality review will be a standing item on the agenda. As a minimum this agenda will include:

4.15.1. Total number of deaths for the quarter
4.15.2. Number of reviews completed
4.15.3. Breakdown of patient groups as per Section 4.1
4.15.4. Detail on themes identified and recommendations for action
4.15.5. Details of any mortality alerts and response

4.16. The Trust will report, as required, at the public meeting of the Board of Directors. This data will include the total number of the Trust's inpatient deaths (including Emergency Department deaths, maternal deaths, neonatal deaths and stillbirths) and those deaths that the Trust has subjected to mortality review. Of these deaths subjected to review, the Trust will provide estimates of how many deaths were judged more likely than not to have been due to problems in care.

4.17. Regulations now require that the data providers publish be summarised in Quality Accounts from June 2018, including evidence of learning and action as a result of this information and an assessment of the impact of actions that a Trust has taken. This will be included in future Quality Report.

5. Procedure for engagement with bereaved families, parents and carers

5.1. The Trust aims to engage meaningfully and compassionately with bereaved families, parents and carers – this will include informing the family, parents or carers if the Trust intends to review or investigate the care provided to the patient. In the case of an investigation, this will include details of who families / carers will be involved to the extent that they wish to be involved. Initial contact with families / carers should, where possible, be managed by the Clinicians responsible for the care of the patient.

5.2. Given the Trust must offer families, parents or carers the opportunity to express concerns about the care given to patients who have died, then the involvement of Clinicians who cared for the patient may be considered a barrier to raising

concerns. The Trust will therefore offer other routes for doing this. This will include support from the Bereavement Team or, in a case where concerns are raised, the nomination of a single point of contact.

5.3. The Trust will offer guidance, where appropriate, on obtaining legal advice for families, parents, carers or staff. This will include clear expectations that the reasons, purpose and involvement of any legal representation by the Trust will be communicated clearly from the outset, preferably by the clinical team, so families, parents and carers understand the reasons and are also offered an opportunity to have their own advocates.

6. Equality Impact Assessment

6.1. The Trust is committed to promoting Equality, Diversity and Human Rights in all areas of its activities.

6.2. It is important to address, through consultation, the diverse needs of our community, patients, their carers and our staff. This will be achieved by working to the values and principles set out in the Trust's Equality, Diversity and Human Rights Strategic Framework.

6.3. To enable the Trust to meet its legislative duties and regulatory guidance, all new and revised procedural documents, services and functions are to undertake an equalities impact assessment to ensure that everyone has equality to access, opportunity and outcomes regarding the activities. Contact the Service Equality Team (SET) on extension 66897 for support to complete an initial assessment. Upon completion of the assessment, SET will assign a unique EqIA Registration Number.

6.4. The Trust undertakes Equality Impact Assessments to ensure that its activities do not discriminate on the grounds of:

Religion or belief	Age
Disability	Race or ethnicity
Sex or gender	Sexual orientation
Human Rights	Socioeconomic

6.5. Before any committee, group or forum validate a policy or procedural document, an EqIA Registration Number will be required.

7. Consultation, Approval and Ratification Process

7.1. This Policy was consulted through both the Trust Mortality Scrutiny Group and the Clinical Effectiveness Committee (June 2017)

8. Dissemination and Implementation

8.1. The Policy has been distributed via the intranet.

9. Implementation of Procedural Documents

9.1. Implementation will be undertaken by the Trust Mortality Leads.

10. Monitoring Compliance of the Mortality Review Policy

Process for Monitoring Compliance and Effectiveness

10.1. The Director of Clinical Governance is responsible for monitoring compliance with the Mortality Review Policy. This will be done by commissioning an internal audit.

10.2. This will be on a once every two years basis and reported to the Mortality Surveillance Group.

10.3. The following will be monitored for compliance:

- The provision of Board of Directors' reports and discussion at public meetings
- The completion of mortality review on mandated groups of patients as set out in Section 4
- The number of reviews complete as a percentage of overall deaths
- Divisional response to themes identified
- Timeliness of mortality review completion
- Performance against key mortality metrics – crude death rate, HSMR and SHMI

Additional assurance will be sought throughout the year at the Mortality Surveillance Group. A small number of randomly selected reviews will be examined by a second clinical team to ensure consistency in findings.

10.4. Any shortfalls identified will have an action plan put in place to address which will have timescales included for re-audit / monitoring.

11. Standards and Key Performance Indicators 'KPIs'

11.1. Publication of quarterly information
11.2. The production of an annual report within the Quality Account
11.3. Bi-annual internal audit of the policy

12. Associated Trust Documents

12.1. The Trust Incident Reporting and Duty of Candour Policies

13. Appendices

13.1. Appendix 1 Mortality Review Tool
13.2. Appendix 2 Mortality Review for Patients with a Learning Disability
13.3. Appendix 3 Mortality Governance Structure

Appendix 1

Mortality Review for – xx xx xx

Patient Safety Details			
Patient's Name XXX XXX	**Hospital Number** 0000000	**Gender** Male	**Date of Birth** 01/01/1901
Lead Consultant Dr XXX XXX	**Date of Admission** 01/02/2016	**Date of Death** 02/02/2016	**Age at Death** 82 years
NHS Number 4000000	**Learning Disability** No		

The Patient		
Primary Diagnosis on Admission N/A		
Confirmed Primary Diagnosis after tests etc. N/A		
Was the patient's death expected in 24hrs prior to death? N/A	**Raised EWS in last 24hrs** N/A	
Was policy met (within 1 hour or ½ hour for 6+)? N/A	**Please detail why it was not applicable** N/A	
Was an End of Life Care Plan in place? N/A		
Cause of Death (taking all into account including PM) 1a : Unkno : wn 1b : Unkno :		
Was there a post mortem? N/A	**Was the Coroner notified or consulted?** N/A	**Was malignancy present event if it was not the main diagnosis?** N/A
Reviewer XXX XXX	**Date of Review** 31/03/2017	

Significant co-existing			
Acute Myocardial Infarction False	**Cerebral Vascular Accident** False	**Congestive Heart Failure** False	**Connective Tissue** False
Dementia False	**Diabetes** False	**Liver Disease** False	**Peptic Ulcer** False
Peripheral Vascular Disease False	**Pulmonary Disease** False	**Cancer** False	**Diabetes Complications** False
Paraplegia False	**Renal Disease** False	**Metastatic Cancer** False	**Severe Liver Disease** False
HIV False			

The start of the hospital	
Time patient first arrived to first clinical review N/A	**Time patient first arrived to first Consultant review** N/A
Seen within 12 hours of admission? N/A	

First 24 Hours	
Was there evidence of a clear management plan?	**Details** N/A
Were essential investigations obtained without delay?	**Details** N/A
Were the initial management steps appropriate?	**Details** N/A
Were there any omissions in initial management?	**Details** N/A

During the admission	
Was the patient admitted to the appropriate ward the first time (exc. ED/AMU)?	**Details** N/A
How many wards was the patient on?	**Details** N/A
Did the medical staff write in the notes every day (exc. Weekends)?	**Details** N/A
Were there any periods when the patient was not reviewed by a Consultant >48hrs?	**Details** N/A
Did the patient have surgery or other interventional procedures?	**Details** N/A
Was sepsis present (defined as >=2 SIRS criteria plus suspected or present source of infection) on or during the admission?	**Details** N/A
Was this recognised promptly?	**Details** N/A
Was this treated appropriately and in a timely manner?	**Details** N/A
Did poor nutrition or fluid balance contribute the patient's death?	**Details** N/A
Was a DNACPR discussion noted?	**Details** N/A
Was a decision reached?	**Details** N/A

Escalation of Care – did the following take place?	
Was there a review from Critical Care?	**Details** N/A
Was the admission to Critical Care appropriate?	**Details** N/A
If the patient was admitted to Critical Care, was the time from 'decision to admit' to admission less than 4 hours?	**Details** N/A
If the patient was not admitted to Critical Care, was this appropriate?	**Details** N/A

Medication	
Are there are recognisable errors?	**Details** N/A

On reviewing the whole case, in your opinion, was there any evidence of….	
Delay in diagnosis?	**Details** N/A
Delay in delivering care?	**Details** N/A
Poor communication, including with other specialties (Surgery, Cardiology etc.)?	**Details** N/A
Organisational failure?	**Details** N/A
Areas of concern/adverse event but made no difference to eventual outcome?	**Details** N/A
In your opinion, was there anything that could have been done differently?	**Details** N/A
Highlight any aspects of notable 'Good Quality' care N/A	
Please rate the standard of documentation between 1 and 7 (1= excellent, 7= very poor) N/A	
Further comments N/A	

Classification score
Cause of death (taking all into account including PM) N/A

Assessment	
Were there any problems with the care of the patient? Yes	
1. Problem in assessment, investigation or diagnosis (including assessment of pressure ulcer risk, venous thromboembolism (VTE) risk, history of falls) No	**If 'Yes', did the problem lead to harm?** No
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2. Problem with medication / IV fluids / electrolytes / oxygen (other than anaesthetic? No	**If 'Yes', did the problem lead to harm?** Yes
Details N/A	
3. Problem related to treatment and management plan (including prevention of pressure ulcers, falls, VTE) No	**If 'Yes', did the problem lead to harm?** No
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4. Problem with infection control? Yes	**If 'Yes', did the problem lead to harm?** No
Details N/A	

5. Problem related to operation / invasive procedure (other than infection control)? Yes	**If 'Yes', did the problem lead to harm?** Yes
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6. Problem in clinical monitoring (including failure to plan, to undertake or to recognise and respond to changes)? Yes	**If 'Yes', did the problem lead to harm?** No
Details N/A	
7. Problem in resuscitation following a cardiac or respiratory arrest (including cardiopulmonary resuscitation (CPR)? Yes	**If 'Yes', did the problem lead to harm?** Probably
Details Curabitur turpis nisl, blandit nec ornare non, scelerisque a nunc. Morbi non ante dapibus, fringilla est eu, pretium sapien. Donec fringilla porttitor elit, porttitor dictum nibh mollis nec. Vestibulum ante ipsum primis in faucibus orci luctus et ultrices posuere cubilia Curea; Nam quis elementum nisl. Donec non lorem una. Curabitur efficitur, massa eu cursus posuere, justo nisl interdum massa, vitae condimentum tellus metus in enim	
8. Problem of any other type not fitting the categories above? Yes	**If 'Yes', did the problem lead to harm?** Probably
Details Sed a blandit libero. Sed vitae consectetur tellus. Cras vitae lectus sapien. Nullam nibh risus, laoreet id enim eget, eleifend varius magna. Proin feguiat ante elit, vitae iaculis ipsum volutpat eget. Etiam eget ultrices odio. Sed ornard, nisl sit amet sagittis vehicular, urna ipsum pretium urna, egt malesuada libero arcu ut diam. Integer lobortis viverra nisi, nec rutrum urna consectetur nec	

Mortality Meeting Review
Is a secondary review needed? N/A

Appendix 2

Mortality Review for patients with a Learning Disability

For the purposes of this policy, a Learning Disability is defined thus:

- a significantly reduced ability to understand new or complex information, to learn new skills (impaired intelligence) with
- a reduced ability to cope independently (impaired social functioning)
- which started before adulthood, with a lasting effect on development

This definition encompasses people with a broad range of disabilities. The presence of a low intelligence quotient, for example an IQ below 70, is not of itself, a sufficient reason for deciding whether an individual should be provided with additional health and social care support. An assessment of social functioning and communication skills should also be taken into account when determining need.

Many people with learning disabilities also have physical and/or sensory impairments. The definition covers adults with autism who also have learning disabilities, but not those with a higher level autistic spectrum disorder who may be of average or even above average intelligence – such as some people with Asperger's Syndrome.

'Learning disability' does not include all those who have a 'learning difficulty', which is more broadly defined in education legislation[7].

All deaths of people with learning disabilities are notified to the programme. Those meeting the inclusion criteria for mortality review receive an initial review of their death by an independent, trained reviewer.

The process for mortality review and reporting to the LeDeR programme is as follows:

All patients with a Learning Disability will have a mortality review undertaken as per the requirements set out at Section 4. This review may contribute to the National process below.

The lead clinician should ensure that the National team is notified and this should be documented in the patient's notes.

National team notified of death of person between 4-74 years with learning disability via notification site (leder-team@bristol.ac.uk / **0117 3310686**).

1. National team notify GM Coordinator (england.gmldmr@nhs.net / **01138 250763**)

2. GM Coordinator identifies if the deceased is subject to any other review and liaises with review lead to incorporate LeDeR requirements

3. GM Coordinator circulates form L to GP Community Learning Disability team and Local Authority LeDeR contact to complete and liaises to identify who is best placed to make contact with the family

4. Local Reviewer to offer support to the GP practice to complete form L and to identify any other agencies required to complete

[7] Valuing People A New Strategy for Learning Disability for the 21st Century – DoH 2001

5. LeDeR information leaflet and letter to be sent to family via identified contact

6. GM Coordinator reviews returned information and prepares collated document and seeks further guidance / information if indicated from preparing initial summary document

7. GM Coordinator forwards each set of collated review documents to Learning Disability Review Panel members two weeks ahead of panel meetings via a secure nhs.net or gcsx email

8. Panel meet and complete review. Actions / learning identified and recorded by GM Coordinator

9. GM Coordinator completes review information and action plans on LeDeR national platform and provides local feedback to CCG and LA contacts

10. Quarterly report identifying emerging themes / trends and any developments following previous action plans reported to Transforming Care Partnership Board; local Safeguarding Boards and Identified Local Area Contacts in each GM CCG

11. If safeguarding concerns arise during the completion of the review local processes for escalating will be implemented.

12. GM Learning Disability Mortality Review Panel – suggested membership (co-opted members to be agreed as required)

    - Designated Safeguarding Adult Nurse
    - Family / Carer representative with support
    - Expert by Experience
    - GP
    - Public Health Dr (Chair preferably)
    - Social Care
    - Housing
    - LD Community Team representative
    - Mental Health Practitioner
    - Minutes and administrative support from GM Coordinator

Agenda Item 8.1

Appendix 3

Mortality Governance Structure