

Mortality Report – Learning from Deaths 1st April 16 to 31st March 17

Meeting information:

Date of Meeting: 26 th September 2017	Agenda Item: 11
Meeting: Trust Board	Reporting Officer: David Walker

Purpose of paper: (Please tick)

Assurance <input checked="" type="checkbox"/>	Decision <input checked="" type="checkbox"/>
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Has this paper considered: (Please tick)

Key stakeholders:	Compliance with:
Patients <input checked="" type="checkbox"/>	Equality, diversity and human rights <input type="checkbox"/>
Staff <input type="checkbox"/>	Regulation (CQC, NHSi/CCG) <input checked="" type="checkbox"/>
	Legal frameworks (NHS Constitution/HSE) <input checked="" type="checkbox"/>

Other stakeholders please state:

Have any risks been identified <input checked="" type="checkbox"/> <i>(Please highlight these in the narrative below)</i>	On the risk register? No
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Executive Summary:

1. ANALYSIS OF KEY DISCUSSION POINTS, RISKS & ISSUES RAISED BY THE REPORT

The requirements set out in the Care Quality Commission Learning from Deaths review have been incorporated into Trust policy. This has included changing the mortality database to reflect the review process. This report details the actions taken and those still outstanding, to embed the process along with the first report and classification of deaths recorded and reviewed during 2016/17 financial year. The classification for these deaths has been mapped from the old system to the new. The importance of reviewing deaths within the 3 month timescale is critical to ensure the reporting is accurate and provides a useful overview on the number of deaths that were actually or potentially avoidable. This is the only risk remaining with the learning from deaths process changes and was highlighted to consultant staff at the recent mortality summit.

2. REVIEW BY OTHER COMMITTEES (PLEASE STATE NAME AND DATE)

The Mortality and Morbidity Policy has been reviewed and approved at the Clinical Outcomes Group in August 2017 which supports the learning from death process.

3. RECOMMENDATIONS (WHAT ARE YOU SEEKING FROM THE BOARD)

The Board are requested to note the report and agree the format for future learning from death reports required on a quarterly basis.

The Board are asked to formally adopt the attached Mortality and Morbidity Policy.

Learning from Deaths Report

Executive Summary

In December 2016, the Care Quality Commission (CQC) published its review “Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England”. The CQC found that none of the Trusts they contacted were able to demonstrate best practice across every aspect of identifying, reviewing and investigating deaths and ensuring that learning is implemented.

This report has two elements;

- **Part 1** - An update of the progress to the Learning from Deaths requirements to meet CQC national recommendations;
- **Part 2** - The first Board report on learning from deaths using the national template;

The Trust is now compliant with the requirements outlined in the review. The data from the deaths reviewed during 2016/17 demonstrates 80% compliance to all death reviews although not all these would have been within the 3 month timescale. There are a total of 372 deaths not recorded on the mortality database as having a review. Only 3 deaths were deemed to be probably avoidable based on the new classification system during the year.

Part 1

A brief outline of the main requirements for learning from deaths detailed in the national CQC review are as follows;

- Appoint an Executive (DW) and Non-Executive Director (SB) to lead the learning from death process;
- Review as a minimum all inpatient and Accident and Emergency deaths;
- Ensure those conducting death reviews have the skills to conduct effectively and use the structured judgement review methodology suggested by the Royal College of Physicians;
- Provide quarterly reports to the Board on learning from deaths to include number of deaths, number reviewed and the classifications;
- Ensure clear policy in place to reflect the actions;
- Review all deaths involving patients with Learning Disabilities using the LeDeR programme (Learning Disabilities Mortality Review) – launched Sept 2017;
- Review deaths where bereaved families raised concerns;
- Raise concerns as incidents where identified and ensure reported to the National Reporting and Learning System (NRLS).

The Trust has achieved all the requirements in the bullet points above in terms of setting up the systems, updating the mortality database and describing the new processes within the Mortality and Morbidity Policy. The systems now need embedding into practice such as improving the timeliness of the death reviews. The table below details the main actions that have been completed and those on track for completion.

Action	Status / Completion Date	Owner
Mortality database changes completed to include the new National Learning from Deaths Template for review.	Completed	J. Wilkinson
Database guidelines distributed and training accessible.	Completed	J. Wilkinson
Review and amendment of Mortality and Morbidity Policy to include requirements from the National Guidance on learning from Deaths	Completed – Awaiting final ratification and uploading on intranet	A.Parrott / J. Wilkinson
New process established to identify where concerns have been raised by Family members or Relatives. The Bereavement Team ask each family if they had any concerns over the care provided. this is recorded on the database and concerns sent to the Associate Director of Governance to review and action as required – this could be through discussion with Medical Director (or Deputy) and Senior Nursing Team or escalation to weekly patient Safety Summit.	Completed	J.Knight / A.Parrott
Mortality Summit held for all Consultants to reinforce new processes and standards	Completed	D. Walker / J. Wilkinson
Reporting template for Consultant review rates developed and circulated	Completed	D. Walker
Learning from Deaths Trust Board report produced and presented for 2016/17 as example to confirm format.	Completed	A.Parrott / J. Wilkinson / J.Knight
Learning from Deaths Trust Board report produced and presented for Q1 data to next Board meeting after September 17	Oct 17	D. Walker
A summary report will be required for the Quality Account 2017/18 to include the data for the year and learning. Publish report in Trust Quality Account	Completed	E.Tate / J.Knight
Include the outstanding deaths requiring review within each quarterly report dating back to the 1 st April 2017	Oct 17	J.Knight / D.Walker
Include a summary of number of deaths where family raised concerns and actions taken as a result within each Quarterly report	Oct 17	J.Knight / D.Walker
Include number of complaints and serious incidents raised following a death and include in quarterly report. Cross reference against the death review rating.	Oct 17	J.Knight / D.Walker
Continue to increase compliance with death reviews within the maximum of 3 months by Consultants	On-going	D.Walker / J.Wilkinson

Part 2

The Learning from Deaths Dashboard is the suggested tool to use for recording and reporting to the Board designed by NHS England. This report includes the data for all of 2016/17 but in future it will detail data in each quarter during the financial year. The additional information on family concerns, serious incidents and complaints and total number of deaths during the year still not reviewed will be included within the next report covering 2017/18 quarter 1.

See Learning from Deaths Dashboard

Author Ashley Parrott, Associate Director of Governance

7th September 2017

Dashboard produced/populated by Jacqui Knight

Description:

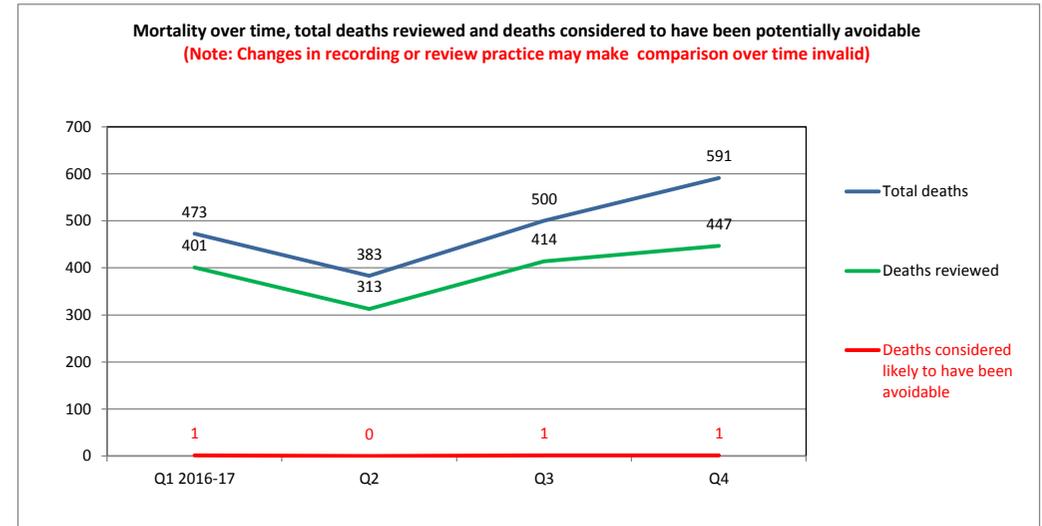
The suggested dashboard is a tool to aid the systematic recording of deaths and learning from care provided by NHS Trusts. Trusts are encouraged to use this to record relevant incidents of mortality, number of deaths reviewed and cases from which lessons can be learnt to improve care.

Summary of total number of deaths and total number of cases reviewed (between 1-4-16 to 31-3-17)

Total Number of Deaths, Deaths Reviewed and Deaths Deemed Avoidable (does not include patients with identified learning disabilities)

Total Number of Deaths in Scope		Total Deaths Reviewed		Total Number of deaths considered to have been potentially avoidable (RCP Score <=3)	
This Month	Last Month	This Month	Last Month	This Month	Last Month
168	187	127	147	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
591	500	447	414	0	1
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
1947	0	1575	0	3	0

Time Series:	Start date	2016-17	Q1	End date	2016-17	Q4
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Total Deaths Reviewed

Score 1 Definitely avoidable	Score 2 Strong evidence of avoidability	Score 3 Probably avoidable (more than 50:50)	Score 4 Probably avoidable but not very likely	Score 5 Slight evidence of avoidability	Score 6 Definitely not avoidable
This Month	0	-	This Month	0	-
This Quarter (QTD)	0	-	This Quarter (QTD)	0	-
This Year (YTD)	0	0.0%	This Year (YTD)	0	0.0%
This Month	0	-	This Month	0	-
This Quarter (QTD)	0	-	This Quarter (QTD)	0	-
This Year (YTD)	0	0.0%	This Year (YTD)	3	0.2%
This Month	0	-	This Month	0	-
This Quarter (QTD)	0	-	This Quarter (QTD)	0	-
This Year (YTD)	0	0.0%	This Year (YTD)	12	0.8%
This Month	0	-	This Month	0	-
This Quarter (QTD)	0	-	This Quarter (QTD)	0	-
This Year (YTD)	0	0.0%	This Year (YTD)	168	10.6%
This Month	0	-	This Month	0	-
This Quarter (QTD)	0	-	This Quarter (QTD)	0	-
This Year (YTD)	0	0.0%	This Year (YTD)	1397	88.4%

Data shown is as at 1/08/2017. The "This Month" above is based on March 2017 data. The totals are for the whole of 2016/17 financial year.

The Trust Death classification ratings of the 2016/2017 reviews have been mapped to the new national ratings in order to complete this dashboard for 2016/2017. The new categorisation has been established on the mortality database and is recording from July 2017 onwards. The Q1 for 2017/18 has been mapped to the new classification. The 3 deaths where identified as potentially avoidable have all been reported as incidents. Two are Amber (internal reports) and one was a serious incident. The numbers above exclude Learning Disability deaths

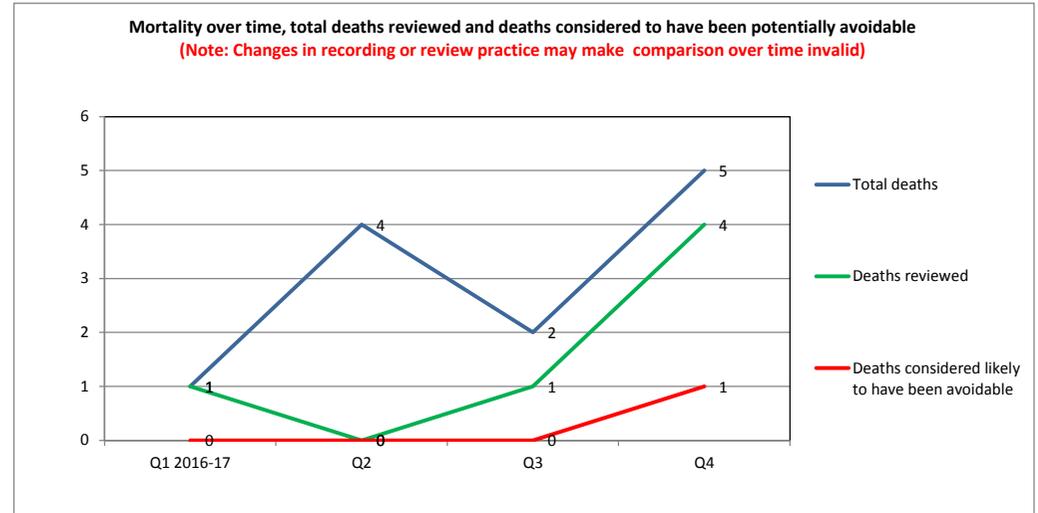
Summary of total number of learning disability deaths and total number reviewed

Total Number of Deaths, Deaths Reviewed and Deaths Deemed Avoidable for patients with identified learning disabilities

Time Series: Start date 2016-17 Q1

End date 2016-17 Q4

Total Number of Deaths in scope		Total Deaths Reviewed		Total Number of deaths considered to have been potentially avoidable	
This Month	Last Month	This Month	Last Month	This Month	Last Month
1	2	1	1	0	1
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
5	2	4	1	1	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
12	0	6	0	1	0



In March 2016 the Mortality database was updated, allowing the Learning disability team to enter review comments for Learning disability deaths. Data above for 2016/17 shows the Learning disability deaths which have been reviewed by the Trust Learning disability team prior to the national requirement of reviewing deaths using the new national LeDeR methodology. The LeDeR (learning disability mortality review) programme will be implemented by the end of 2017 when Learning disability deaths will be reviewed against the new criteria.

Mortality and Morbidity Policy

Version:	V4.1
Ratified by:	Senior Leadership Forum (TBC)
Date ratified:	TBC
Name of author and title:	Dr David Walker, Medical Director Dr James Wilkinson, Assistant Medical Director Jacqui Knight, Clinical Improvement Facilitator Ashley Parrott, Associate Director of Governance
Date Written:	
Name of responsible committee/individual:	Dr David Walker, Medical Director
Date issued:	
Issue number:	
Review date:	September 2019
Target audience:	Accountability - Clinical Unit Leads Responsibility - All clinical professionals Implementation – Clinicians, Clinical Unit Operational teams and central Governance Team.
CQC Fundamental Standard:	Regulation 17 – Good Governance
Compliance with any other external requirements (e.g. Information Governance):	
Associated Documents:	http://www.england.nhs.uk/ourwork/patientsafety/neve-r-events/ Death Certification and the Coroner guidelines for medical staff incident Reporting and Management Policy

Did you print this yourself?

Please be advised the Trust discourages retention of hard copies of procedural documents and can only guarantee that the procedural document on the Trust website is the most up to date version

Version Control Table

Version number and issue number	Date	Author	Reason for Change	Description of Changes Made
V1	Dec 2011	Dr Nick McNeillis Emma Tate	Comments from Consultation process	Change of review timeframe, from 2 months to 3 months.
V2	July 2014	Dr James Wilkinson Emma Tate	Changes in mortality review process and structures. Change in diagnostics provider from Dr Foster to CHKS.	
V3.0	November 2015	Dr James Wilkinson Emma Tate	Changes in Governance Structures	CGF role no longer exists – policy therefore amended. Job titles amended as per new Trust structure
V4.1	August 2017	Ashley Parrott James Wilkinson Jacqui Knight	Updated to include Government initiatives – Learning from Deaths.	Updated process, updated COG ToR, MRG ToR and added M&M RoR and M&M agenda.

Consultation Table

This document has been developed in consultation with the groups and/or individuals in this table:

Name of Individual or group	Title	Date
Clinical Outcomes Group		24/08/17
Policy Documentation Group		11/9/17

This information may be made available in alternative languages and formats, such as large print, upon request. Please contact the document author to discuss.

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1. Introduction

East Sussex Healthcare NHS Trust (ESHT) is committed to providing high quality patient care and to continuously improving patient safety and outcomes.

The review of inpatient deaths and mortality data is an essential clinical governance practice which provides Trust assurance that care is safe, effective and patient outcomes are improved through learning and implementing improvements.

2. Purpose and scope

The purpose of the policy is to provide a consistent and comprehensive framework in order to ensure:

- A standardised approach for reviewing inpatient deaths.
- The Mortality and Morbidity (M&M) process is used by Consultants and their teams to review, learn, make improvements and to provide assurance of a safe and effective service.
- Details of all reviews are clearly documented and records are centrally recorded on the Trust Mortality electronic database. This includes the clear recording of any actions and lessons.
- Roles and responsibilities are clearly identified and robust governance and reporting mechanisms are in place
- Clinical coding for all deaths is reviewed, wherever possible, as part of the M&M review process so there is confidence that risk adjusted mortality rates are based on accurate data.
- Mortality Alerts raised by internal or external sources are investigated consistently and actions are taken if required.
- Mortality data is utilised as part of a wider range of metrics to drive Clinical Improvement

The policy refers to deaths of:

- All inpatients in ESHT acute hospitals (Conquest and Eastbourne DGH) and
- Inpatients in community hospitals that have transferred from ESHT acute units.

3. Definitions

Mortality – relates to any in hospital death

Morbidity – relates to adverse outcomes

Serious Incident (SI) - an incident occurring on NHS premises that resulted in serious injury, and or permanent harm, unexpected or avoidable death. (Ref: Incident Reporting and Management Policy)

Mortality & Morbidity Meetings (M&M meetings) - An M&M meeting is where a multi-disciplinary group review and discuss clinical cases, outcome data and related information, for example SIs, complaints and benchmarked mortality data.

4. Accountabilities and Responsibilities

4.1. Medical Director

- Carries overall accountability and responsibility for clinical issues relating to the review of Morbidity and Mortality.
- Will review any CUSUM (Cumulative Sum Charts) Relative Risk Outlier Alert from external sources and identify a Specialty Lead to undertake a detailed audit to understand the cause.
- Will respond to external enquiries about mortality such as the Care Quality Commission's (CQC) mortality outlier letters.
- Respond to confidential enquiries that examine morbidity and mortality related issues.

4.2. Assistant Medical Director

- Chairs the Mortality Review Group
- Reports concerns to Clinical Outcomes Group
- Lead for M&M to ensure the process is robust and effective in practice

4.3. Divisional Management Team

- Collate, analyse and triangulate qualitative and quantitative data and report emerging trends to the Senior Management Team.
- Monitor and ensure the closure of all action plans from M&M reviews and provide highlight and progress reports to the Chiefs of Division
- Utilise the CHKS system to analyse and monitor mortality data and provide training to users through the Governance team.

4.4. Chiefs of Divisions

- Will ensure all deaths within the division have had a mortality review within the 3 month requirement
- Ensure all action plans are implemented then closed once satisfactory evidence is provided.
- Will identify specialty M&M leads and a clinician to investigate mortality data
- Will identify a Lead for liaison with Clinical Coding
- Will ensure that the outcomes and learning from M&M reviews and mortality data are discussed at Governance and Audit Meetings.
- Will work with the Divisional Associate Director of Nursing to ensure that learning from deaths applied across the division and shared with other Divisions

4.5. Assistant Director of Nursing for Divisions

- Ensure nursing input into specialty M&M meetings
- Work with the Lead Consultant on the development and implementation of action plans from M&M reviews
- Ensure M&M information is included within the Governance meetings for Division
- Ensure implemented changes have the desired effects and are sustainable.

4.6. Speciality M&M Leads

- Will champion the M&M review process and take action to ensure full engagement at meetings.
- Ensure deaths reviewed within 3 month timescale
- Coordinate the M&M review meetings and actively encourage allied health professionals, Lead Nurses and Nursing/Midwifery staff to attend.
- Communicate concerns or trends to Chiefs of Division

4.7. Consultant Medical Staff

- Ensure review, within three calendar months of the patient's death, of all deaths of inpatients under their care in an acute hospital or in intermediate care unit having stepped down from their care in the acute hospitals.
- Participate fully in all M&M reviews and meetings, contributing knowledge and experience to the meeting.
- M&M attendance and mortality review rate will form part of the individuals appraisal
- Review the clinical coding of all patient deaths to ensure risk adjusted mortality data is based on accurate information, including patients' diverse characteristics.
- Ensure leadership and support of junior staff to ensure full engagement in the process.
- Review any 'Death in Low risk groups' identified and develop and implement action plans to improve patient's safety and outcomes.
- Challenge practice which has been demonstrated to be unsafe.
- Disseminate and communicate learning

4.8. Associate Director of Knowledge Management

- Will ensure the provision of mortality data to enable robust review at Trust level
- Will manage the Clinical Coding Process
- Will ensure attendance by clinical coders at M&M meetings across the trust
- Will support the Mortality Groups by ensuring headline data on Crude and Risk Adjusted Mortality data are produced monthly
- Will ensure analyst support for specific in depth review of Mortality data.

4.9. Clinical Improvement Facilitator

- Support the development and production of the Mortality and Morbidity processes, promoting awareness and improvement at every stage.
- Support the Medical Director and Assistant Medical Director for all aspects of M&M
- Provide advice & support on a day to day basis to clinical and non-clinical staff across the organisation leading to improvement in the management of M&M
- Manage the trust M&M database
- Provide monthly mortality data to enable robust review at Divisional level

4.10. Governance Support Officers

- Arrange and support M&M meetings for each specialty
- Ensure M&M meeting dates, discussion points, lessons learnt and actions are recorded on the Mortality database
- Log attendance and cases discussed at specialty M&M meetings

- Ensure that all open actions are reviewed for update/closure at specialty M&M meetings
- Ensure learning is shared at governance meetings
- Support the Clinical Improvement Facilitator in communicating to consultants that mortality reviews and cases for presentation are outstanding within their divisions

4.11. Patient Safety and Quality Group

This group is responsible for ensuring all escalated issues from Clinical Outcomes Group and others are reviewed and actions taken to address them. This group triangulates information across all areas of quality and safety.

4.12. Clinical Outcomes Group (Appendix D)

To have oversight and scrutiny on mortality data and drivers across the trust and ensure clinical specialties or conditions affecting mortality are managed safely. This will require managing task and finish groups and specific programmes to improve clinical care. To review data and identify potential or actual outliers in mortality data and respond accordingly.

To ensure clinical specialties are collecting, monitoring and sharing clinical outcomes enabling early identification of improvement requirements and the sharing of success measures internally and externally. These may include patient reported outcomes (PROMS) patient reported experience measures (PREMS) and other measures of success following surgery/treatment.

4.13. Mortality Review Group (Appendix E)

To analyse and monitor a broad range of internal and external mortality data and indicators in association with other qualitative data to identify emerging trends or outlier areas.

To communicate areas of concern to Divisional and Specialty Clinical Leads requesting a review, report and associated action plan within 2 months, to be presented to the Clinical Outcomes Group (COG). Where an area of concern crosses Divisions the group will consider the most appropriate person(s) to undertake the review and recommend to COG for agreement.

To provide an exception report to the COG monthly, identifying all areas of concern and actions taken.

4.14. Divisional Governance meetings

Each Clinical Division conducts governance meetings to review and discuss all aspects of quality and safety. Any concern raised from this meeting is acted upon or escalated to the Divisional Integrated Performance Review. The Divisions review mortality data, outcomes, incidents, complaints, infection data, safeguarding and any other issues around quality.

4.15. Specialty M&M Meetings (Appendix F)

To be a multi-disciplinary group reviewing and discussing clinical cases, outcome data, lessons learnt and related information.

Meetings to be monthly, except for specialities where very few deaths occur. In this situation cases will be reviewed and discussed at a wider Audit meeting. If separate meetings, there will need to be an agreed process for ensuring the findings are shared and any actions co-ordinated. **See Appendix**

To routinely discuss all deaths with an 'Overall care assessment' of 1 or 2 – 'Poor' or 'Very poor' care, deaths in low risk groups, inquest cases and any additional discharges or deaths that the initial reviewer or consultant feel warrant wider discussion for other clinical or educational reasons.

To develop and monitor action plans for M&M cases which require further investigation.

To undertake a '2nd Stage Review' for all cases with an 'Overall care assessment' of 1 or 2 - 'Poor' or 'Very poor' care, entering issues identified and a level of avoidability score on the Mortality database.

5. Process

See Flow chart (Appendix A)

5.1. Administration

Details of all in-patient deaths are logged on the Mortality database by the bereavement office staff along with any concerns around care.

If any administrative errors on PAS (Patient Information System) for example, Primary Consultant or transfers of care must be reported to the Patient Administration System (PAS) team for amendment so all information systems are correct.

5.2. Review of Inpatient deaths

At the time of death certification, a summary of the key events during the admission must be documented on the electronic database (draft mortality review). This would normally be entered by the doctor certifying death, using the computers in the Bereavement Office.

The primary consultant at time of death is responsible for both death certification (see Death certification guidelines) and the M&M review.

All adult inpatient deaths are to be reviewed utilising the national Structured Judgement Review template on the Mortality database.

When signing off the review, the Primary Consultant will confirm the overall care rating and identify cases which need further discussion at M&M meeting.

If the patient spent the entire admission in Critical Care (ITU/HDU) the initial draft mortality review will be undertaken by ITU and the death placed on the admitting consultant M&M review list for further review and sign-off.

If the patient was transferred to ITU during admission, the draft review will remain the responsibility of the primary consultant at time of death. The ITU review record to be entered on the mortality database before primary consultant sign-off.

5.3. Post mortem reports

Post Mortem reports should be available within 28 days, unless delayed due to specialist histopathology testing, or an inquest is still pending.

A copy of the report will be attached to the inside cover of the notes in Histopathology and sent to the Primary Consultant's secretary. A second copy will be held by the Bereavement Service Manager.

5.4. Review at M&M meeting

The Clinical Improvement Facilitator will obtain patient details from the Mortality Database for deaths from the previous month and inform the Divisions.

Details of deaths outstanding for presentation at M&M meetings will also be highlighted to Divisions on a monthly basis. (Overall care rating 1 or 2, low risk deaths, Inquests and any deaths highlighted for discussion for other educational reasons)

The M&M meeting review should involve a systematic and comprehensive analysis of the facts to enable Consultants and Managers to understand and identify contributing factors or underlying causes for all deaths.

Discussion and learning points are to be entered on the Mortality database for all cases discussed at M&M meetings.

Mortality and Morbidity Policy

A second stage review at M&M meeting is required for all cases with an overall care rating of 1 or 2 ('Poor' or 'very poor' care), a level of avoidability score to be agreed and documented on the Mortality database.

Avoidability	Description
1	Definitely avoidable
2	Strong evidence of avoidability
3	Probably avoidable (more than 50:50)
4	Possibly avoidable but not very likely (less than
5	Slight evidence of avoidability
6	Definitely not avoidable

A case with a score of 1, 2 or 3 on the avoidability scale would indicate a governance cause for concern and should be considered under the criteria for a Serious Incident so therefore should be raised and discussed at the Weekly Patient Safety Summit. The Incident Reporting and Management Policy details the full process for serious incidents.

If the avoidability score is classified as 1, the Serious Incident (SI) guidelines should already be activated, please refer to the Incident Reporting and Management Policy.

In addition, SI investigations should be considered for the events below:

- If there is a 'cluster' of deaths in a particular diagnostic group or procedure - identified either through M&M reviews or via CHKS monitoring or a CUSUM alert
- If there is an Inquest which identifies failures in the process or care

5.5. Actions required following discussion of case.

If an action/Improvement plan is required following review/discussion of the case, this should be entered onto the Mortality Database. Open actions will be tracked at M&M meeting and closed on the database when completed.

5.6. Clinical Coding

Issues of coding accuracy arising from Mortality reviews should be discussed between the speciality and the Clinical Coding Department.

5.7. Timeframe for review process

Unless there are factors outside of the Trust's control, the standardised template should be completed at the earliest opportunity and within a maximum timeframe of three months from the month of death.

If an improvement plan has been identified this must be implemented within the timeframe specified – this will be monitored by the Division and the Mortality Review Group.

5.8. Inquest

Cases for Inquest should be expedited for review.

The review to be completed and presented at M&M meeting within 3 months, with discussion and learning points recorded on the mortality database.

The Clinical Improvement Facilitator will provide a record of the completed review to the Legal Department when requested for an Inquest.

A case undergoing an inquest where concern identified by the Trust should be reviewed and discussed at the Weekly Patient Safety Summit for a decision on whether an Amber (moderate harm) or Serious Incident (serious or catastrophic harm) investigation is required. This should then be dealt with following the Incident Reporting and Management Policy and then shared with the Coroner once approved through internal channels.

Duty of Candour will not be required if the coroner asked for a review of the case as part of the inquest when there had not already been an investigation triggered. This is because the family will already know the case is being reviewed and results will be shared with them at the inquest. If as per the Incident Reporting and Management Policy an incident was already identified a duty of candour should have happened prior to a request from the coroner.

6. Review of deaths for special groups

6.1. Infant or Child Deaths

The review process for baby and child deaths that occur in hospital aims to:

- establish, as far as possible, the cause or causes of each child death
- identify any potential contributory or modifiable factors
- provide on-going support to families
- ensure all statutory obligations are met
- learn lessons in order to reduce the risk of future child deaths

When an infant or child death occurs, an incident form should be completed immediately and a serious incident raised.

A review of the baby/child care will be undertaken by the head of nursing, a paediatrician and a representative from the Risk/Governance department. This review should be undertaken within 24 hours (48 hours if the death occurs at the weekend or on Public holidays) and documented. If no issues are identified by the review, a letter of condolence should be sent to the parents and the serious incident downgraded.

Where issues are identified by the review, a Duty of Candour letter will be sent and the serious incident remain open for full investigation

All deaths are to be discussed at an M&M meeting and any actions/learning points from the serious incident investigation/root cause analysis shared.

The mortality review will be completed on the mortality database by the primary consultant.

The discussion and learning points from the M&M meeting will be recorded within the database review.

6.2 Stillbirths

When a stillbirth occurs an incident form should be completed immediately and the case reviewed at the daily risk meeting to evaluate the need for a professional review.

The final severity of the incident will be decided at the Weekly Patient Safety Summit. Where issues are identified by the review, a Duty of Candour letter will be sent and the serious incident/amber case will remain open for full investigation.

If an amber investigation is required, this will be undertaken by the divisional risk lead. If a serious incident is raised, this should then be dealt with following the Incident Reporting and Management Policy.

All learning points identified from the serious incident investigation will be shared with staff and the patient involved, and all actions highlighted by the investigation completed.

The Maternity Bereavement Checklist is available on the Trust intranet for staff dealing with any fetal loss.

6.3 Maternal Deaths

When a maternal death occurs an incident form should be completed immediately and a serious incident automatically raised. This should then be dealt with following the Incident Reporting and Management Policy. Where issues are identified by the initial review, a Duty of Candour letter will be sent and the serious incident will remain open for full investigation.

All learning points identified from the serious incident investigation will be shared with staff and the patient involved, and all actions highlighted by the investigation completed.

The Maternal Death Guideline is available for staff on the Trust intranet under Obstetric and Gynaecology.

6.4 Deaths of Individuals with Learning Disabilities

Deaths of individuals with learning disabilities demands additional scrutiny under the Learning Disabilities Mortality Review Programme (LeDeR). This programme is commissioned by the Healthcare Quality Improvement Partnership for NHS England. The programme will receive notification of all deaths of people with learning disabilities, and support local areas to conduct standardised, independent reviews following the deaths of people with learning disabilities aged 4 to 74 years of age. These will be conducted by trained reviewers.

A summary of the review will be entered on the mortality database where a death has been reviewed under the LeDeR programme.

6.5 Deaths of Individuals with Mental Health Needs

Deaths of individuals with mental health needs will be reviewed on the Mortality database using the Royal College of Physicians structured case note review methodology and the Trust process followed to ensure a complete and robust review (Appendix A).

7. Review of Mortality Data

7.1. Mortality Data Metrics

Mortality data should be used in association with other metrics to understand the quality and performance of a Division, a hospital or the Trust; however areas which are highlighted as being significantly above the national benchmarks (Outliers) for particular diagnosis or procedure groups should be investigated to ascertain the causative factors. CHKS provides risk adjusted mortality rates and comparative analysis of the data in the form of:

- Risk Adjusted Mortality Index (RAMI)
- Hospital Standardised Mortality Ratio (HSMR)
- Summary Hospital level Mortality Indicator (SHMI).

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- Cumulative Sum Charts (CUSUM) which demonstrate the difference between the expected and actual outcomes over a series of patients.

7.2. Mortality Alerts

If CQC Intelligent Monitoring or Imperial College generate a CUSUM Alert for an outlier diagnosis or procedure group, the Medical Director or Assistant Medical Director will review the information and identify a Lead Clinician, who will undertake a detailed review and report back findings to the Clinical Outcomes Group (COG) and Medical Director.

The M&M templates detailing the original Mortality reviews at the time of death can be retrieved from the mortality database to aid the investigation into associative factors.

7.3. Mortality data and reports by Group

Data Source	Mortality Review Group	Clinical Outcomes Group	Trust Board
Learning from Deaths dashboard	N/A	Quarterly	Quarterly
Mortality Scorecard – each Division	Monthly	Quarterly	N/A
Trust wide and site RAMI, SHIMI, Crude Mortality	Monthly	Monthly (Part of summary report)	
CUSUM Alerts – Trust wide by condition	Monthly	Monthly (Part of summary report)	N/A – By exception
Learning from M&M reviews	Monthly	Monthly (Part of summary report)	
Mortality review rate (performance)	Monthly	Monthly (Part of summary report)	
1 and 2 Care ratings reported	Monthly	Monthly (Part of summary report)	

7.4. Divisional Mortality Review

Divisions should routinely discuss and share lessons learnt from the reviewing of in-patient deaths and monitor divisional review rates on a monthly basis.

Divisions are required to maintain regular surveillance of all Mortality data, including crude mortality, to identify any emerging trends or patterns of concern where the data indicates higher than the expected mortality against the national or regional benchmarks and to investigate the causative factors.

Divisions are required to investigate and take action to reduce mortality for diagnosis and procedure groups identified as significantly above the national benchmark.

Mortality data and trends from M&M reviews of inpatient deaths should be routinely analysed and reported to the Mortality Review Group (MRG) and COG on the monthly KPI scorecard. Other quality measures are reviewed through the Patient Safety and Quality Group and Divisions..

7.5. Mortality reviews incomplete after 3 months

Every inpatient death must be reviewed within 3 months as described in this policy. Should a death review fall outside this period it must still be completed. A monthly report will be provided to each Division on their outstanding deaths awaiting a review. This will be escalated to the Divisional Integrated Performance review conducted by the Chief Executive.

7.6. Accuracy of Mortality database and information submitted

A quarterly quality review of randomly selected cases, looking at the accuracy of database entries, is undertaken by the Assistant Medical Director and Clinical Improvement Facilitator. The quality and quantity of the review entry on the Mortality database is assessed against the record of patient care documented in the patient notes.

7.7. Ensuring accuracy of mortality reviews

To provide assurance the deaths are reviewed accurately by individual Consultants and that the care ratings have been correctly allocated the following actions are undertaken on a monthly basis:

- A review of the cases where the family raised concerns about the care delivered will be checked against the care rating, incidents reported and where required the health records. Bereaved relatives are specifically asked if they had any concerns in care as part of the bereavement process.
- Serious Incidents and Amber Incidents where death occurred are cross checked against the care rating assigned.
- Inquests and claims not identified as an issue through a complaint, serious incident or amber incident are cross checked against the care rating.
- Complaints involving a patient death are cross checked against the care rating and where required the health records reviewed to determine if the rating was appropriate.

The above 4 tests should provide some assurance on a monthly basis the mortality reviews are accurate. If clear lapses in care are identified that are not matching the care rating a deep dive will be undertaken for the specialty concerned to ensure there are no other inappropriate ratings.

In addition to this any deep dive on specific conditions identified as a requiring review will include a check against the care rating when looking at each case. If inappropriate rating identified a trigger for a deep dive to the specialty on the reviews will be completed and reported to the Mortality Review Group.

8. Equality and Human Rights Statement

An Equality Impact assessment has been undertaken and specific advice sought.

9. Training

Divisional, specialty teams and individual consultants requesting this, will receive training in the use of the CHKS tools to enable them to understand and track relevant mortality data. This will be provided by the Clinical Improvement Facilitator or the supplier themselves, CHKS.

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Incoming medical staff will receive instruction in how to access and use the electronic mortality database as part of their induction pack. Additional support is provided by the Bereavement Office staff on an ad hoc basis.

Training is now mandatory for medical staff with Clinical Coding providing training to repeat offenders

There are no other specific training requirements for this policy.

10. Monitoring Compliance with the Document

The monitoring of mortality reviews is an on-going process and will be managed through the Mortality Review Group and the Clinical Outcomes Group. The mortality indicators are tracked on a monthly basis and there are specific Key Performance Indicators in place for the Clinical Outcomes group that includes mortality review compliance.

Monitoring Table

Element to be Monitored	Lead	Tool for Monitoring	Frequency	Responsible Individual/Group/ Committee for review of results/report	Responsible individual/group/ committee for acting on recommendations/action plan	Responsible individual/group/ committee for ensuring action plan/lessons learnt are Implemented
Mortality Reviews	Medical Director	On-going audit	Monthly	Clinical Outcomes Group	Clinical Outcomes Group	Clinical Outcomes Group

11. Evidence base and references

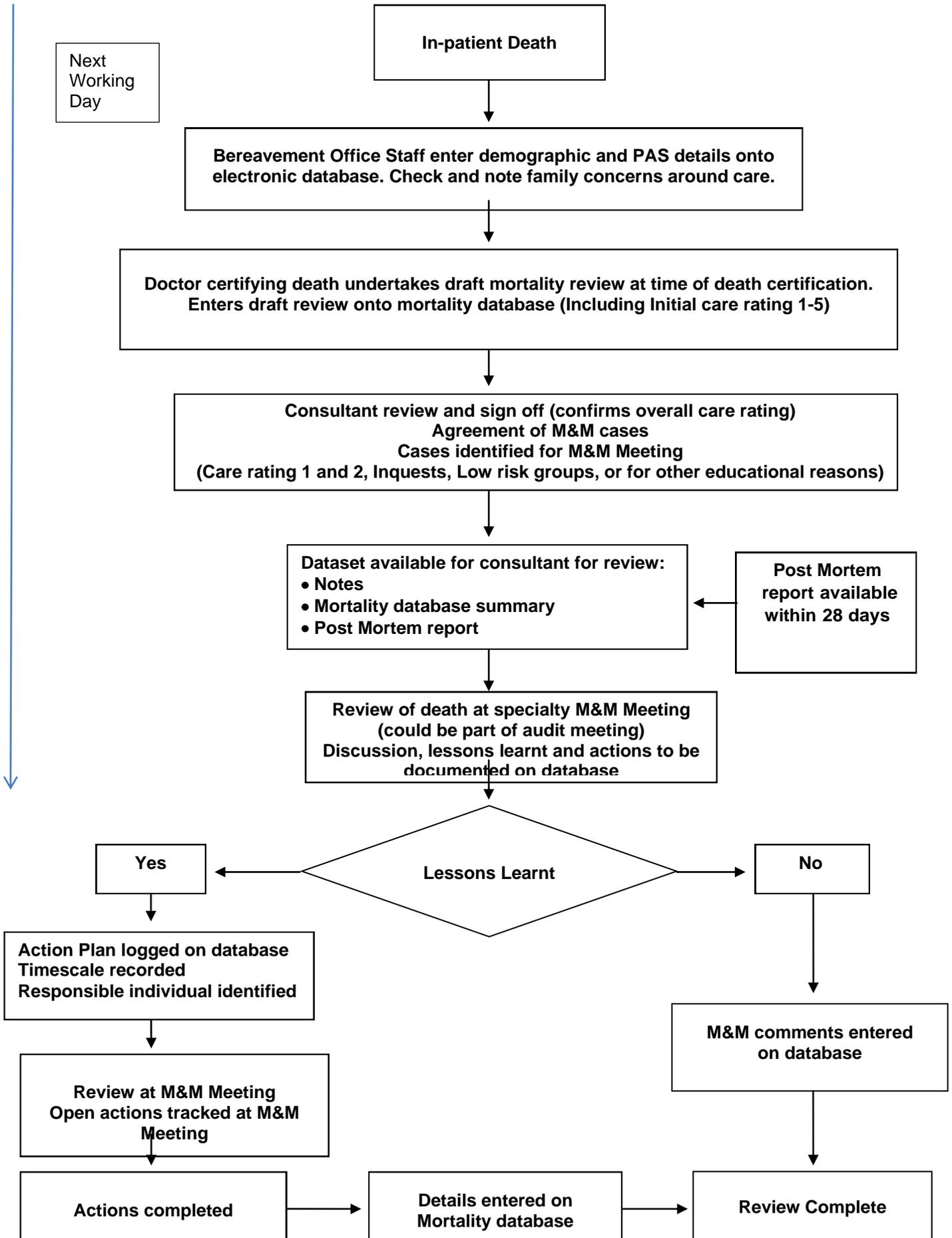
Mid Staffordshire, NHS Foundation Trust Inquiry; Independent Inquiry into care provided at Mid Staffordshire NHS Foundation Trust, Jan 2005 – March 2009 Chaired by Robert Francis QC. Published 24th February 2010

The Leeds Teaching Hospital NHS Trust 2009, Morbidity and Mortality Policy

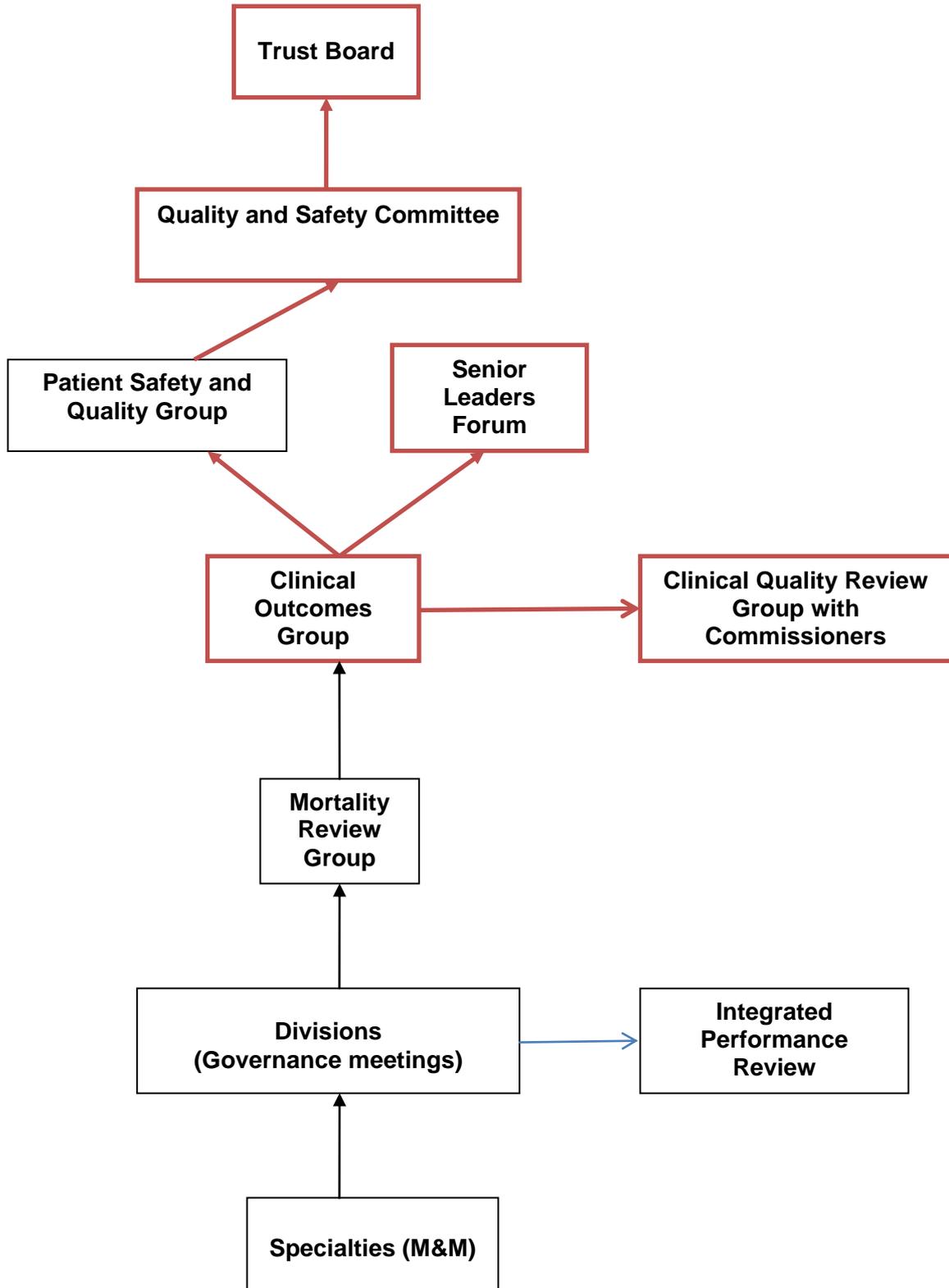
University of Leicester 2011, Morbidity and Mortality Reviews Policy

National Guidance on Learning from Deaths – National Quality Board March 2017

Appendix A: Flow Chart of Mortality Review Process



Appendix B: Mortality and Morbidity Reporting structure



Appendix C: Divisional M & M dataset

KPI – In hospital deaths
Number of deaths for review
Reviewed within 3 months
Number of Death classified and C D or E
Number above discussed at MDT M&M meeting
Number of deaths in Low risk groups (on database)
Post-Mortems
Deaths referred to Inquest
KPI – Mortality
Risk adjusted mortality index
In Hospital SHMI
Rates of deaths in hospital within 30 days of Non-elective surgery
Rates of deaths in hospital within 30 days of Elective surgery
Deaths in hospital within 30 days of emergency admission for hip fracture
Rate of death in hospital within 30 days of emergency admission with a heart attack (myocardial infarction) for patients aged 35 to 74
Deaths in hospital within 30 days of emergency admission for a stroke
Deaths in Low Mortality HRG Groups
Deaths in Low Mortality CCS Groups
KPI – Patient Safety
Complication Rate Attributed
Complication Rate Treated
Misadventure rate
Readmissions within 28 days
Risk Adjusted Length of Stay Index
Discharge to usual place of residence within 56 days of emergency admission from there with a stroke
Retained Instrument post operation
IV administration of mis-selected concentrated potassium chloride
Decubitus ulcer
Complications of anaesthesia
Post-operative pulmonary embolism or deep vein thrombosis
Post-operative sepsis
Post-operative acute respiratory failure
Accidental puncture or laceration
Potential in hospital fall resulting in hip fracture
% of patients discharged or transferred to a rehabilitation facility within 19 days of fracture neck of femur

Appendix D: Clinical Outcomes Group - Terms of Reference

Clinical Outcomes Group - Terms of Reference

1. Purpose

To have oversight and scrutiny on mortality data and drivers across the trust and ensure clinical specialties or conditions affecting mortality are managed safely. This will require managing task and finish groups and specific programmes to improve clinical care. To review data and identify potential or actual outliers in mortality data and respond accordingly.

To ensure clinical specialties are collecting, monitoring and sharing clinical outcomes enabling early identification of improvement requirements and the sharing of success measures internally and externally. These may include patient reported outcomes (PROMS) patient reported experience measures (PREMS) and other measures of success following surgery/treatment.

2. Duties

Key Responsibilities include;

- Monitor Mortality Metrics for the organisation (HSMR, RAMI, SHMI)
- Monitor lessons learnt and actions on death reviews across the trust
- Monitor compliance and quality of M&M reviews across the trust
- Deep dive on mortality outliers, trends/ themes
- Monitor and review mortality and patient safety indicators at each speciality level
- Monitor and respond to VTE compliance
- Monitor and respond to Sepsis compliance
- Review and monitor risks to safety from mortality or mortality drivers
- Monitor and respond to EOLC compliance
- Monitor and respond to AKI compliance
- Review findings of inquests
- To ensure clinical specialties are collecting and reviewing clinical outcomes and to have oversight of these for the organisation
- To ensure successes from clinical outcomes are shared internally and externally and included within the Trust Annual Report
- To establish and monitor sub groups where required to ensure there is a robust review of mortality (Mortality Review Group)

3. Membership

Medical Director
Assistant Medical Director
Associate Director of Knowledge Management
Deputy Director of Nursing or Representative
Associate Director of Governance
Clinical Coding Data Quality and Audit Manager or Representative
Chief Medical Lead or nominated Deputy from each Division
Clinical Lead for each sub group (EOLC, VTE, Sepsis, AKI)
Project Manager for Mortality

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- 4. Chair**
Chair - Medical Director
Deputy Chair - Assistant Medical Director
- 5. Quorum**
Minimum of 3 members including Chair
- 6. Frequency**
Monthly
- 7. Reporting arrangements**
This group reports to the Patient Safety & Quality Group

The terms of reference will be reviewed on an annual basis.
- 8. Notice of meetings**
The agenda and papers will be circulated one week prior to the meeting. Dates and meeting venue will be established at the beginning of each financial year for the year ahead.

At the discretion of the Chair papers may be tabled at the meetings.
- 9. Conduct of meetings**
Meetings of the Clinical Outcomes Group shall be conducted in accordance with its Terms of Reference.
- 10. Notes of meetings**
The Medical Director's Personal Assistant shall take notes of all meetings of the Group, including recording the names of those present and in attendance. Notes of the meeting will record actions arising from the meeting.

Next Review Date: 1/11/17

Appendix E: Mortality Review Group Terms of Reference

Mortality Review Group Terms of Reference

Constitution

The Mortality Review Group is a working group established by and accountable to the Trust Clinical Outcomes Group (COG)

Membership

Chair - Associate Medical Director
Consultant – General Surgery
Associate Director of Knowledge Management or deputy
Assistant Director of Nursing
Clinical Coding Data Quality and Audit Manager
CHKS Consultant
Clinical Improvement Facilitator

Purpose

The purpose of the Mortality Review Group is to analyse and monitor a broad range of internal and external mortality data and indicators in association with other qualitative data to identify emerging trends or outlier areas.

The group will communicate areas of concern to Divisional and Specialty Clinical Leads requesting a review, report and associated action plan within 2 months, to be presented to the Clinical Outcomes Group (COG). Where an area of concern crosses Divisions the group will consider the most appropriate person(s) to undertake the review and recommend to COG for agreement.

The group will provide an exception report to the COG monthly, identifying all areas of concern and actions taken.

Specific objectives

The group will analyse and monitor -

- Key performance indicators for the review of all inpatient deaths within three months via the Trust Mortality Database and request exception reports from Divisions to COG, for any death classified as potentially having suboptimal care identified on the trust database (Deaths recorded with a death classification of C, D or E and deaths recorded with an overall care assessment of 1 or 2).
- Coroner's cases and Inquest cases on a monthly basis and specific review of Rule 43 Coroners reports.
- Numbers of referrals to the coroner, to be reported monthly by Divisions as part of scorecard.

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- Monthly trust site and divisional mortality scorecard including crude mortality and trust HSMR/SHMI and RAMI
- Monthly mortality benchmarked performance data by Clinical Classification System (CCS) diagnostic Group available via CHKS
- CHKS Patient Safety Indicators and Mortality Dashboards at trust and divisional level
- Death in Low risk groups, requesting exception reporting to COG.
- Quarterly SHMI data, including post-discharge deaths.
- Weekend vs weekday Mortality on a quarterly basis
- CQC mortality indicators highlighted in the quarterly Intelligent Monitoring report.
- Instigate investigation of any CUSUM Alerts received from the Care Quality Commission (CQC)
- Quarterly review a random sample of electronic morbidity and mortality reviews to provide assurance of quality.
- National Audit data on Mortality such as TARN and ICNARC data.

Accountability

- The MRG is accountable to the Clinical Outcomes Group.
- An action log will be created and maintained for all actions identified by the group.
- The group will report to the Clinical Outcomes Group monthly, identifying key areas of concern and actions taken
- The group will communicate with Divisions or nominated individuals, to request review, action and exception reporting to COG on areas of potential concern.

Quorum

- The meetings will be considered quorate when at least 4 members are present, including the chair (or delegated chair).
- All members are expected to attend at least 8 of the scheduled meetings held within each 12 month period.

Frequency

The group will meet monthly.

Review of Terms of Reference

These terms of reference will be reviewed annually. The next review date is August 2018.

Appendix F (Part 1)

SPECIALTY MORTALITY & MORBIDITY REVIEW MEETING

TERMS OF REFERENCE

Constitution

East Sussex Healthcare NHS Trust has established Mortality and Morbidity meetings that will incorporate the review of all issues relating to speciality Morbidity and Mortality.

Membership

Membership shall comprise of:
Speciality M&M Lead Consultant
Speciality Consultants
Speciality Junior Doctors
Speciality Multi-Disciplinary Team Members
Coding department representative

Quorum

The meetings will be considered quorate when at least 3 members are present, including the chair (or delegated chair).
Consultants are expected to attend at least 60% of the scheduled meetings held per year.
Junior doctors are expected to attend at least 3 of the scheduled meetings held per year.
Meetings should be multidisciplinary, with nursing, management and coding input, as well as medical participation.

Purpose

The Mortality and Morbidity review meetings have been established as multi-disciplinary group reviews to discuss clinical cases, outcome data, lessons learnt and related information.

Duties

- Meetings should routinely discuss all deaths which fall into the following groups:
 - ❖ Deaths given a 'Classification' of C, D or E prior to the updated review template which now requires a 'Care rating' selection.
 - ❖ Deaths with a Consultant 'Overall care rating' of 1 or 2 – 'Poor' or 'Very poor' care.
 - ❖ Death in Low Risk Groups
 - ❖ Inquest cases
 - ❖ Any additional discharges or deaths that the initial reviewer or consultant feel warrant wider discussion, for other clinical or educational reasons.
- Develop and monitor action plans to deal with M&M cases which require further investigation.
- Complete '2nd Stage Review' on the Mortality database for all cases with a Consultant 'Overall care rating' of 1 or 2 - 'Poor' or 'Very poor' care.

Frequency

Meetings should be held monthly, except for specialities in which very few deaths occur. In this situation cases may be reviewed and discussed at a wider Audit or Clinical Governance meeting. If separate meetings, there will need to be an agreed process for ensuring the findings/lessons learnt are shared and any actions arising from these are co-ordinated.

Authority

To evaluate and respond to Morbidity and Mortality issues and use the Trust's Clinical Governance framework to initiate actions where necessary.

To use evidence based practice to reduce future healthcare risks within the Division and to highlight issues to be addressed by the Risk Management team if necessary.

Reporting Arrangements

Discussion and learning points of each case reviewed should be recorded on the Mortality database for assurance purposes. Attendance and cases discussed to be recorded on the Trust M&M attendance log.

Lessons learnt and issues to be highlighted should be reported to the Divisional Clinical Governance meetings on a regular basis and shared amongst speciality teams.

Review

The Mortality and Morbidity Review meeting Terms of Reference will be reviewed on an annual basis.

Appendix F (part 2)

Specialty Morbidity and Mortality Meeting

Agenda

- Attendance & Apologies
- Review of Mortality Log actions remaining open and any actions closed since last meeting
- Presentation and Review of any deaths with an overall care rating of 1-2 (or categorised as C, D or E prior to updated review system)
- Presentation and review of any deaths in Low Risk Groups
- Review of Inquest cases
- Presentation of any other patients (either mortality or morbidity) agreed for discussion
- Agreed actions arising from deaths reviewed at this meeting
- AOB
- Details of next meeting

The category grading of all mortality cases presented should be reviewed in the light of the discussion at the meeting.

Appendix G – EHRA Form

A Due Regard, Equality & Human Rights Analysis form must be completed for all procedural documents used by East Sussex Healthcare NHS Trust. Guidance for the form can be found [here on the Equality and Diversity Extranet page](#).

Due Regard, Equality & Human Rights Analysis

Title of document:
Who will be affected by this work? E.g. staff, patients, service users, partner organisations etc.
Please include a brief summary of intended outcome:

		Yes/No	Comments, Evidence & Link to main content
1.	Does the work affect one group less or more favourably than another on the basis of: (Ensure you comment on any affected characteristic and link to main policy with page/paragraph number)		
	• Age		
	• Disability (including carers)		
	• Race		
	• Religion & Belief		
	• Gender		
	• Sexual Orientation (LGBT)		
	• Pregnancy & Maternity		
	• Marriage & Civil Partnership		
	• Gender Reassignment		
	• Other Identified Groups		
2.	Is there any evidence that some groups are affected differently and what is/are the evidence source(s)?		(Ensure you comment and link to main policy with page/paragraph number)
3.	What are the impacts and alternatives of implementing / not implementing the work / policy?		(Ensure you comment and link to main policy with page/paragraph number)
4.	Please evidence how this work / policy seeks to “eliminate unlawful discrimination, harassment and victimisation” as per the Equality Act 2010?		(Ensure you comment and link to main policy with page/paragraph number)
5.	Please evidence how this work / policy seeks to “advance equality of opportunity between people sharing a protected characteristic and those who do not” as per the Equality Act 2010?		(Ensure you comment and link to main policy with page/paragraph number)
6.	Please evidence how this work / policy		(Ensure you comment and link to main

Mortality and Morbidity Policy

	will “Foster good relations between people sharing a protected characteristic and those who do not” as per the Equality Act 2010?	policy with page/paragraph number)
7.	Has the policy/guidance been assessed in terms of Human Rights to ensure service users, carers and staff are treated in line with the FREDA principles (fairness, respect, equality, dignity and autonomy)	(Ensure you comment and link to main policy with page/paragraph number)
8.	Please evidence how have you engaged stakeholders with an interest in protected characteristics in gathering evidence or testing the evidence available?	(Ensure you comment and link to main policy with page/paragraph number)
9.	Have you have identified any negative impacts or inequalities on any protected characteristic and others? (Please attach evidence and plan of action ensure this negative impact / inequality is being monitored and addressed).	(If yes ensure you comment and link to main policy with page/paragraph number)