South Warwickshire
NHS Foundation Trust

Corporate Governance

SWH 01785
Mortality Review Policy

The Trust's Intranet holds the current approved guidance documents.

Notice to staff using a paper copy of this document.
Staff must ensure that they are using the most up-to-date document to guide their practice and must check that the version number of the paper copy matches that of the one on the Intranet.

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Document History

Issue Status e.g. Draft or Final	Catalogue and Version Number	Document Title	Date	Actioned by: (Job Title or Name of Approving/ Ratifying Body)	Page/ Section/ Paragraph	Comments
Draft	SWH 01785 v1.0	Mortality Review Policy	July 2017	Head of Governance	All	New Document
Draft	SWH 01785 v1.0	Mortality Review Policy	July 2017	Patient Safety Surveillance Group / Divisional Audit and Operational Governance Groups	Whole document	Approved document
Final	SWH 01785 v1.0	Mortality Review Policy	August 2017	Policy Review Group	Whole document	Ratified document.

Table of Contents

To access a section directly from the Table of Contents – 'hover' the mouse over the section you require and then press Ctrl and click the mouse.

1 Introduction

Investigations into the failures in NHS Hospitals have become high profile. By September 2017 NHS Trust Boards are to be assured that patient deaths across all settings are reviewed appropriately and any appropriate changes are made from lessons learned to ensure and maintain patient safety.

"For many people death under the care of the NHS is an inevitable outcome and they experience excellent care from the NHS in the months or years leading up to their death. However some patients experience poor quality provision resulting from multiple contributory factors, which often include poor leadership and system-wide failures. NHS staff work tirelessly under increasing pressures to deliver safe, high-quality healthcare. When mistakes happen, providers working with their partners need to do more to understand the causes. The purpose of reviews and investigations of deaths which problems in care might have contributed to is to learn in order to prevent reoccurrence. Reviews and investigations are only useful for learning purposes if their findings are shared and acted upon"
National Quality Board - National Guidance on Learning from Deaths First Edition (2017)

South Warwickshire NHS Foundation Trust (SWFT) hereafter referred to as the Trust, has had its own mortality review process in place for a number of years, however in order to meet the National Guidance on Learning from Deaths (2017) this document has been produced.

2 Purpose

This document outlines how the Trust should respond to, and learn from deaths of patients who die under its management and care, in response to the National Guidance on Learning from Deaths (First Edition March 2017)
https://www.england.nhs.uk/wp-content/uploads/2017/03/ngb-national-guidance-learning-from-deaths.pdf
which builds on the CQC Report on Reviews of Patient Deaths (December 2016)
http://www.cqc.org.uk/content/learning-candour-and-accountability

The aim of this process is to identify any areas of practice, both specific to the individual case and beyond that could potentially be improved, based upon peer review. Areas of good practice are also identified and supported. It will ensure that there are clear reporting mechanisms in place and any areas of concern are identified and escalated appropriately, thus ensuring that the Trust is aware and action as appropriate can be taken.

3 Audience

This document applies to all staff of the Trust involved in the Mortality Review process.

4 Associated Trust Documents

SWH 00020	Incident Management Policy including the Management of Serious Incidents
SWH 00356	Being Open and the Duty of Candour
SWH 00532	Bereavement Policy for In-Patients

SWH 00534	Management of Suspected and Confirmed Late Pregnancy Loss and Perinatal Death Guideline
SWH 00735	Maternal Death Guideline
SWH 00876	Caring for a Patient with a Mental Health Disorder in an Acute Setting: Policy & Procedures
SWH 01185	Sudden Unexplained Deaths in Infants & Children Under 18 Operating Procedure
SWH 01870	Mortality Review Process Standard Operating Procedure

5 Responsibilities/Duties

5.1 Board of Directors (BoD)

The BoD is responsible for determining the governance arrangements of the Trust including effective risk management processes. It is responsible for ensuring that the necessary clinical policies, procedures and guidelines are in place to safeguard patients and reduce risk. In addition they will require assurance that clinical policies, procedures and guidelines are being implemented and monitored for effectiveness and compliance. The National Guidance on Learning from Deaths (2017) states in Annex A that a Lead Executive Director and in Annex B the Lead Non-Executive Director will provide scrutiny and oversight as outlined.

5.2 Chief Executive

The Chief Executive Officer (CEO) has overall responsibility for patient safety and ensuring that there are effective risk management processes within the Trust which meet all statutory requirements and adhere to guidance issued by the Department of Health.

The CEO holds each line manager accountable for meeting objectives and to work together towards meeting the objectives approved by the Board.

5.3 Director of Nursing / Medical Director

The Director of Nursing is the Executive with delegated responsibility for implementation of Governance arrangements within the Trust.

The Director of Nursing and the Medical Director, supported by the Trust Lead for Mortality – Associate Medical Director for Governance are responsible for overseeing the implementation of this Policy.

The Medical Director will act as Chair of the Mortality Surveillance Committee which meets monthly.

5.4 Non-Executive Director

The Non-Executive Director with specific responsibility to provide oversight of this process is the Non-Executive Director and Chair of the Clinical Governance Committee.

5.5 Trust Lead for Mortality – Associate Medical Director for Governance

The Trust Lead for Mortality Review will be available to offer advice to colleagues involved

in the Mortality Review Process. They will

- Act as deputy Chair of the Mortality Surveillance Committee
- Arrange for cases graded as a "concern" by the first reviewer based on the grading system used to be referred for further review by the Mortality Surveillance Committee.
- Ensure incidents identified during this process are reported on Datix to enable them to be reviewed as part of the management process
- Review reports from Serious Incidents Resulting in a Death at the Mortality Surveillance Committee and ensure any associated concerns are resolved and lessons learned are disseminated through the appropriate channels
- Ensure that concerns raised out of the Serious Incidents Report review at the Mortality Surveillance Committee will be placed on the Risk Register and raised at Divisional Meetings and at Trust Management Board as necessary
- Ensure that the Individual Mortality Review will be discussed at the Mortality Surveillance Committee and it will be established as to whether the death was preventable following a Root Cause Analysis review (RCA)
- Ensure that all actions as determined in the Mortality Review process will be recorded, actioned and monitored appropriately
    - Further recommendations for the organisation to consider should be noted and actioned
- Will be responsible for ensuring the dissemination of Mortality Review forms for all deaths within the specialty. They will:
    - Ensure that these are completed by nominated consultants; Individuals reviewing cases for which they had sole clinical responsibility should be avoided
    - Ensure that each area keeps a copy of their completed Mortality Review within their specialty; they will follow up forms that have not been returned to them and ensure that all completed review forms are sent to the Patient Safety Team
    - Ensure that regular specialty mortality meetings are held to review all deaths, keeping a summary of the cases discussed, the findings and the management plan agreed upon, this summary should include the avoidable and unavoidable factors implicated in the death

5.6 Patient Safety Team

The Patient Safety Team will co-ordinate the processes covered by this policy, on behalf of the Trust Lead for Mortality and will ensure that all those involved in the process are aware of their responsibilities and the requirements of the policy.

6 Skills and Training

The Trust will review and, if necessary, enhance skills and training to support the use of the Mortality Review agenda. Providers need to ensure that staff reporting deaths have appropriate skills through specialist training.

7 Learning from a Review of Care

Learning from a review of the care provided to patients who die is integral to the Trust's clinical governance and quality improvement work. To fulfil the standards and new reporting set out in the National Guidance on Learning from Deaths (2017), the Trust's governance arrangements and processes include, facilitate and give due focus to the

review, investigation and reporting of deaths, including those deaths that are determined more likely than not to have resulted from problems in care. The Trust shares and acts upon any learning derived from these processes.

7.1 Data Collection & Reporting

Trusts are required to collect specified information on deaths and publish it on a quarterly basis (as determined by the National Quality Board 2017). The data should include the total number of the Trust's in-patient deaths (including Emergency Department deaths for acute Trusts) and those deaths that the Trust has subjected to case record review. Of these deaths subjected to review, Trusts will need to provide estimates of how many deaths were judged more likely than not to have been due to problems in care.

The Integrated Performance and Quality dashboard received monthly by the BoD will include the number of deaths judged to be preventable.

Furthermore, reports to Board should include evidence of learning and action taken as a result of the information gathered and an assessment of the impact of actions that the Trust has taken.

7.2 Responding to Deaths

Following the death of a patient specific actions are required:

- Determine which patients are considered to be under the care of the Trust and included for case record review if they die
- Review the 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;
- Review the care provided to patients whose death may have been expected, for example those receiving end of life care;
- Record the outcome of their decision whether or not to review or investigate the death, which should have been informed by the views of bereaved families and carers;
- The Trust should ensure that the deceased person's General Practitioner (GP) is informed of the death and provided with details of the death as stated in the medical certificate at the same time as the family or carers. The GP should be informed of the outcome of any investigation
- The death will be reported within the organisation and to other organisations who may have an interest (e.g. the deceased person's district nursing, social care etc.)

7.2.1 Responding to the Death of an Individual with a Learning Disability –

The death of an individual with a Learning Disability should be reported through the Learning Disabilities Mortality Review (LeDeR) Programme
https://upload.leder.ac.uk/leder-notify/leder-notification.html

The death should also be reviewed using the SWFT Mortality Review Process and this can be submitted to the LeDeR notification web-based platform once their internal review is completed.

7.2.2 Responding to a Death of a Patient with Mental Health Needs

Inpatients detained under Mental Health Act

Regulation 17 of Health & Social Care Act (2015) requires 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. In 2015, the Care Quality Commission reported concern that providers were failing to make this notification in 45% of cases. The Commission has since updated its notifications protocols to ensure that providers ensure they report in a timely way.

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).

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

The Trust expects that such deaths will be reviewed in line with the SWH 00876 Caring for a Patient with a Mental Health Disorder in an Acute Setting: Policy & Procedure using both our and the expected national process.

7.2.3 Responding to an Infant or Child Death

SWH 01185 Unexplained Deaths in Infants & Children Under 18 Operating Procedure should be followed.

NHS England is seeking to address how infant or child deaths are reviewed by establishing a National Child Mortality Database to allow analysis and interpretation of child mortality data. The programme will also seek to improve, standardise and simplify the processes that follow the death of a child. This is predominantly to improve the experience of bereaved parents at such an overwhelming time, but also to enable uniformly robust data collection, to ultimately lead to a reduction in infant and child mortality in this country.

The Trust expects that such deaths will be reviewed using both the SWFT process and the expected national process.

7.3 Case Note Review

The Trust currently uses the PRISM evidence-based methodology for reviewing the quality of care provided to those patients who die under its management and care. The process for this is outlined in **Appendix A**. The Mortality Review Form can be found on the intranet at http://eforms.swft.nhs.uk/forms/mortalityreview/ or via the 'Systems' page.

In the future the National Guidance on Learning from Deaths (2017) will set out the Structured Judgement Review (SJR) case note methodology which will then be adopted https://www.rcplondon.ac.uk/projects/outputs/national-mortality-case-record-review-nmcrr-

programme-resources The Trust Mortality Surveillance Committee will monitor and evaluate the progress of this.

7.3.1 Categories and Selection of Deaths in Scope for Case Record Review

The three levels of scrutiny that the Trust applies to the care provided to someone who dies:

- Death certification
- Case record review
- Investigation

The three levels of scrutiny do not need to be initiated sequentially and an investigation may be initiated at any point, whether or not a Case Record Review has been undertaken (though a Case Record Review will inform the information gathering phase of an investigation together with interviews, observations and evidence from other sources). For example, the apparent suicide of an in-patient would lead to a Serious Incident investigation being immediately instigated in advance of death certification or any case record review. The three processes are summarised below:

Death Certification:
In the existing system of death certification in England, deaths by natural causes are certified by the attending doctor. Doctors are encouraged to report any death to the coroner that they cannot readily certify as being due to natural causes. Reforms to death certification, when implemented in England (and Wales), will result in all deaths being either scrutinised by a Medical Examiner or investigated by the Coroner in prescribed circumstances. Additionally, Medical examiners will be mandated to give bereaved relatives a chance to express any concerns and to refer to the coroner any deaths appearing to involve serious lapses in clinical governance or patient safety.

Case Record Review:
Some deaths are subject to further review by the Trust, looking at the care provided to the deceased as recorded in their case records in order to identify any learning. The Trust focuses reviews on in-patient deaths in line with the following criteria:

- All deaths where bereaved families and carers have raised a significant concern about the quality of care provision as identified by the Bereavement Office or by staff e.g. through the incident reporting system Datix;
- All in-patient, out-patient and community patient deaths of those with learning disabilities (the LeDeR review process should be adopted in those regions where the programme is available otherwise the Structured Judgement Review or another robust and evidence-based methodology should be used) and those with severe mental illness as identified by the Bereavement Office;
- All deaths in a service specialty, particular diagnosis or treatment group where an ‘alarm’ has been raised with the provider 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, concerns raised by the Mortality Surveillance Committee following review of the Mortality Scorecard);
- All deaths in areas where people are not expected to die, for example in relevant

elective procedures.
    - The Elective division will continue to review 100% of deaths.
- Deaths where learning will inform the Trust's existing or planned improvement work, relevant deaths should be reviewed as determined by the Trust.
    - Thematic review of such deaths should be considered to maximise learning;
- A sample of any other deaths that do not fit the identified categories that the Trust chooses so as to obtain an overview of other areas where learning and improvement is needed
    - The majority of specialities aim to review all deaths, however in the specialities with the largest number of deaths such as Care of the Elderly; mortality reviews are performed on a risk basis **where the predicted risk of death** is less than 20%.

The National Guidance on Learning from Deaths (2017) advises that in particular contexts, and as these processes become more established, Trusts should include cases of people who had been an in-patient but had died within 30 days of leaving hospital. The Trust's Mortality Surveillance Committee will now monitor the Trust's SHMI using NHS Digital's new interactive analysis of diagnosis group pilot tool http://content.digital.nhs.uk/shmi-diagnosisanalysis to help identify any conditions where this may be helpful, as well as any individual patient deaths identified through the mechanisms described above.

8 Communication of Learning from Mortality Reviews

The learning from mortality reviews is shared within the Trust through the following:

- Audit and Operational Governance Groups
- Grand Rounds
- Multidisciplinary Mortality Meetings
- Speciality Department Governance Meetings
- Patient Safety Monthly Reports
- Patient Safety Newsletters
- ePulse, screensavers
- Safety Practice Alerts
- Investigation Reports

9 Further Developments

The National Guidance on Learning from Deaths (2017) has advised that in 2017-18, further developments will include:

- The Care Quality Commission will strengthen its assessment of provider's learning from deaths including the management and processes to review and investigate deaths and engage families and carers in relation to these processes.
- NHS England, led by the Chief Nursing Officer, will develop guidance for bereaved families and carers. This will support standards already set for local services within the Duty of Candour and the Serious Incident Framework and cover how families should be engaged in investigations. Health Education England will review training of doctors and nurses on engaging with bereaved families and carers.
- Acute Trusts will receive training to use the Royal College of Physicians' Structured Judgement Review case note methodology. Health Education England and the Healthcare Safety Investigation Branch will engage with system partners, families and

carers and staff to understand broader training needs and to develop approaches so that NHS staff can undertake good quality investigations of deaths.
- NHS Digital is assessing how to facilitate the development of provider systems and processes so that providers know when a patient dies and information from reviews and investigations can be collected in standardised way.
- The Department of Health is exploring proposals to improve the way complaints involving serious incidents are handled particularly how providers and the wider care system may better capture necessary learning from these incidents.
- Primary Care Mortality alerts should be dealt with using the same due process.

10 Incident Reporting

In the event of an incident relating to an unexpected and avoidable death it will be reported via the Incident Reporting system (Datix) as described in the Incident Management Policy including the Management of Serious Incidents (SWH 00020) and the Being Open and the Duty of Candour (SWH 00356).

11 Monitoring Compliance

The MRC will ensure that the key processes set out in this document are audited. The results will be fed back via the Clinical Governance Committee on a quarterly basis **Appendix B**.

Where monitoring has identified deficiencies, recommendations and an action plan will be developed to improve compliance with the document.

12 Equality Impact Assessment

All Trust documents are required to have a preliminary Equality Impact assessment (EIA) performed on them in order to establish whether any group of people will be impacted on unfairly by the document. An EIA has been performed on this document and the outcome is shown in **Appendix C**.

13 Author

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14 Contributors

Emma Ratley	Compliance Specialist
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Dominique White	Clinical Lead, Patient Safety

15 References

Hogan H, Healey F, Neale G, Thomson R, Vincent C, Black N, Preventable deaths due to problems in care in English acute hospitals: a retrospective case record review study. **BMJ Quality Safety** 2012: 21: 737-45.

Hogan H, Zipfel R, Neuberger J, Hutchings A, Darzi A, Black N Avoidability of hospital

deaths and association with hospital-wide mortality ratios: a retrospective case record review and regression analysis **BMJ** 2015; 351:h3239

Learning Disabilities Mortality Review (LeDeR) Programme
http://www.bristol.ac.uk/sps/leder/

Royal College of Physicians' **Structured Judgement Review case note methodology.**

National Quality Board **National Guidance on Learning from Deaths (First Edition)** (2017)

South Warwickshire NHS Foundation Trust (2015) SWH 00020 Incident Management Policy including the Management of Serious Incidents

South Warwickshire NHS Foundation Trust (2015) SWH 00356 Being Open and the Duty of Candour

South Warwickshire NHS Foundation Trust (2011) SWH 00532 Bereavement Policy for In-Patients

South Warwickshire NHS Foundation Trust (2016) SWH 00534 Management of Suspected and Confirmed Late Pregnancy Loss and Perinatal Death Guideline

South Warwickshire NHS Foundation Trust (2015) SWH 00735 Maternal Death Guideline

South Warwickshire NHS Foundation Trust (2015) SWH 01185 Unexplained Deaths in Infants & Children Under 18 Operating Procedure

16 Further Reading

Care Quality Commission (2016) **Learning, Candour and Accountability: A review of the way NHS Trusts review and investigate the deaths of patients in England** CQC

Hogan H, Healey F, Neale G, Thomson R, Vincent C, Black N, Preventable deaths due to problems in care in English acute hospitals: a retrospective case record review study. **BMJ Quality Safety** 2012: 21: 737-45.

Hogan H, Zipfel R, Neuberger J, Hutchings A, Darzi A, Black N Avoidability of hospital deaths and association with hospital-wide mortality ratios: a retrospective case record review and regression analysis **BMJ** 2015; 351:h3239

Learning Disabilities Mortality Review (LeDeR) Programme
http://www.bristol.ac.uk/sps/leder/

NHS England (2015) Serious Incident Framework NHS England

National Quality Board **National Guidance on Learning from Deaths (First Edition)** (2017)

Office for National Statistics (2015) Response to the Consultation on Reviewing the Definition of Avoidable Mortality

Office for National Statistics (2016) Revised Definition of Avoidable Mortality for Children and Young People

Royal College of Physicians' **Structured Judgement Review case note methodology**

17 Appendices

Appendix A: Mortality Review Process

Appendix B: Monitoring Compliance Form

Appendix C: Equality Impact Assessment

18 Appendix A: Mortality Review Process

This appendix sets out clear instruction as to the process to be followed when conducting a Mortality Review.

Audience

This document applies to all Medical, Nursing and Allied Healthcare Professional staff working for South Warwickshire NHS Foundation Trust, hereafter referred to as the Trust.

Mortality and Morbidity Meetings (M&M Meetings)

The M&M meeting is a clinical team, multi-disciplinary group review and discussion of clinical cases, the outcome data (clinician and patient reported) and any other related information e.g. Serious Incident Requiring Investigation (SIRI), complaints. Such meetings may also be part of the Audit Meeting process, however if they are separate there needs to be an agreed process to ensure that the findings and learning from both are shared and any necessary actions are co-ordinated.

Process

A step by step outline of the process is provided below:

1. The Associate Director of Information & Performance (ADIP) will email a summary of the inpatient deaths that have occurred in a single month to:
   - Associate Medical Director for Governance (AMDG)

   NB. Data will usually be provided one to two months after each period of data e.g. February's mortality data will usually be provided by the end of April.

2. The AMDG will create individual spreadsheets filtered by speciality and email the Consultants within each speciality with:

   a. A spreadsheet of the mortality data for the inpatient deaths within their speciality

   b. A request for the deaths to be reviewed and for the completed mortality review forms to be returned to Patient Safety by the end of the following month (usually about 6 weeks)

   N.B. For certain specialities such as geriatrics where they have a high number of inpatient deaths, this request will usually specify that the deaths highlighted on the spreadsheet with a SHMI of 20% or less (that are considered to have a lower probability of death from their coding) are reviewed.

3. Each speciality will complete a Mortality Review Form for all deaths that occur within their speciality monthly. The Trust currently uses the PRISM evidence-based methodology for reviewing the quality of care provided to those patients who die under its management and care the process for this Mortality Review Process.

   The Mortality Review Form can be found at http://eforms.swft.nhs.uk/forms/mortalityreview/ usually as part of their Mortality & Morbidity Meeting and the review forms will be submitted to the CLPS either via the internal post or electronically via the form on the Staff Intranet *(Systems → Mortality Form)*

   N.B. a central inbox has been set up by IT – mortality.reviews@swft.nhs.uk. Any

mortality review completed electronically via the Staff Intranet will be emailed to this Inbox which is accessible by the AMDG and the Patient Safety Team.

4. The CLPS will collect all of the mortality review forms received in hard format or electronically and use the information on each form to populate the current year's Mortality Data spreadsheet.

   N.B. The Mortality Data spreadsheet is maintained by the CLPS. Each set of data that is received from the ADIP will be added to the spreadsheet; the CLPS will then use the data on each mortality review form to complete columns at the end of each patient's record relating to whether or not the death has been reviewed and whether the death was considered to be preventable. This then feeds into certain graphs and tables that are included in the Mortality pages of the monthly Patient Safety Report.

5. The Mortality Review Forms that are received in hard format are collated and the AMDG will look through them on a weekly basis. This process enables the identification of any learning that could be included in future Patient Safety Reports for cascading across the Trust. The AMDG currently annotates the review form with any learning and this is then inputted into the Mortality Data spreadsheet by the CLPS.

6. The CLPS sends the AMDG a summary of the current status of the mortality reviews, including any learning, on a monthly basis prior to the generation of the Patient Safety Report.

7. The AMDG will provide the Patient Safety Team with the text content for the mortality pages of the Patient Safety Report on a monthly basis; this will include messages/learning from mortality reviews for cascading across the Trust.

Learning from Mortality Reviews

The learning from mortality reviews is shared within the Trust through the following:

- Audit and Operational Governance Groups
- Grand Rounds
- Multidisciplinary Mortality Meetings
- Speciality Department Governance Meetings
- Patient Safety Monthly Reports
- Patient Safety Newsletters
- ePulse, screensavers
- Safety Practice Alerts
- Investigation Reports

19 Appendix B: Monitoring Compliance Form

Title of Document	Mortality Review Policy	
Relevant Standards	**Health & Social Care Act**	**Other e.g. West Midlands Quality Review Service, Peer Reviews etc**
	Health and Social Care Act 2008 (Regulated Activities) [Amendment] Regulations 2015: Regulations 12, 17	

Monitoring/Audit Plan

Process / minimum requirement to be audited / monitored	Lead	Tool/How	Written Reporting Frequency	Written Reporting Arrangements
Divisional Participation rates will be monitored	Individual General Managers	Using MR tool	Monthly – fed back to MRC	Feed back to Mortality Review Committee
Learning Reported of patient safety issues highlighted by the Divisional Audit and Operational Governance Groups, Clinical Effectiveness Department and the Patient Safety Group	Chair of each Committee	Review of Meeting Papers	Quarterly	Feed back to Mortality Review Committee
The above Table outlines the minimum requirements to be audited/monitored; additional audits will be commissioned in response to deficiencies identified within the service through morbidity and mortality reviews/benchmark data provided by CHKS or in response to national initiatives e.g. NICE, RCOG guidelines and CNST standards. **Lessons learnt and action plans will be shared with all the relevant stakeholders.**				

Name:	Fraser Millard	**Job Title:**	Dr F Millard - Associate Medical Director Governance	**Date:**	9th August 2017

20 Appendix C: Equality Impact Assessment Form

Has an Equality Impact Assessment been carried out?	**YES**
Preliminary Stage 1 Equality Impact Assessment (must be completed if required*)	
What date was Stage 1 completed and published?	4th July 2017
Has a Full Assessment Stage 2 Equality Impact Assessment Tool been undertaken*?	NO
If yes, what was the date of assessment and publication of Stage 2 and action plan?	NA