Berkshire Healthcare
NHS Foundation Trust

CCR157

LEARNING FROM DEATHS

Berkshire Healthcare NHS Foundation Trust

 Did you print this document yourself?
Please be advised that Berkshire Healthcare discourages the retention of hard copies of policies and can only guarantee that the policy on Nexus is the most up-to-date version.

Re-issued: **July 2023**
Review Date: **July 2025**
Version:. **3**

<table>
<tr><td>Policy Number:</td><td>CCR157</td></tr>
<tr><td>Title of Policy:</td><td>Learning from Deaths</td></tr>
<tr><td>Category:</td><td>Clinical Care and Risk.</td></tr>
<tr><td>Committee responsible for final sign off</td><td>Safety, Experience, Clinical Effectiveness Group (SECEG) – October 2023</td></tr>
<tr><td>Re-issued:</td><td>July 2023</td></tr>
<tr><td>Review Date:</td><td>July 2025</td></tr>
<tr><td>Designated Lead:
Policy author (authors)</td><td>Medical Director and
Head of Clinical Effectiveness & Audit</td></tr>
<tr><td>Version History</td><td>Version 3: Addition of Medical Examiner process and clarification of responsibilities section

Version 2: version 2 is updated to reflect implementation of SJR process (including flowchart of process) and information for families following bereavement. Also, amendments to criteria for reporting.</td></tr>
<tr><td>Individuals ratified by:</td><td>
<table>
<tr><td>Name</td><td>Date Ratified</td></tr>
<tr><td>Medical Director</td><td>July 2023</td></tr>
<tr><td>Director of Nursing & Therapies</td><td>July 2023</td></tr>
<tr><td>Directorates Clinical Governance Lead</td><td>July 2023</td></tr>
<tr><td>Deputy Director of Nursing for Patient Safety & Quality</td><td>July 2023</td></tr>
</table>
</td></tr>
<tr><td>Relevant meetings, groups, committees ratified by</td><td>Mortality Review Group</td></tr>
<tr><td>Date endorsed by Policy Scrutiny Group:

Date endorsed by Committee responsible for final sign off:</td><td>September 2023</td></tr>
<tr><td>For policy information:</td><td>Policy Administration
Berkshire Healthcare NHS Foundation Trust
London House
London Road
Bracknell
RG12 2UT
0300 247 3000</td></tr>
</table>

This policy has been assessed for compliance with CQC Fundamental Standards.

Contents

1 INTRODUCTION

The CQC report: Learning, Candour, and Accountability (2016) identified inconsistencies in: the process of identifying and reporting the death; how decisions to review or investigate a death were made; variation in the quality of reviews and investigations; and variation in the governance around processes and questionable demonstration of learning and actions. In March 2017 the National Quality Board published its guidance on Learning from Deaths which provides a framework for identifying, reporting, investigating and learning from deaths in care.

It is acknowledged that most deaths do not occur as a result of a direct patient safety incident. None the less, it is important that opportunity for learning from deaths and learning from the review of the care provided and the experience of our services in the period prior to the person's death are not missed and that when deaths are deemed not to require any further investigation the rationale and justification for this is clearly documented.

Since the 1990s, there have been a number of reports and case studies which have consistently highlighted, that in England, people with learning disabilities die younger than people without learning disabilities. The Confidential Inquiry of 2010-2013 into premature deaths of people with learning disabilities (CIPOLD) reported that for every one person in the general population who died from a cause of death amenable to good quality care, three people with learning disabilities would do so. Overall, people with learning disabilities currently have a life expectancy at least 15 to 20 years shorter than other people

This document sets out the procedures for reporting, reviewing and investigating deaths of people who have been in receipt of services from Berkshire Healthcare NHS Foundation Trust (hereinafter referred to as Berkshire Healthcare). It provides staff with information in relation to which deaths should be reported internally on the Berkshire Healthcare incident management system (Datix), subsequent review and the level of investigation that is required.

This policy and procedure supports Berkshire Healthcare's Policy for Incidents/Near Misses, Serious Incidents Requiring Investigation and Coroner Requirements (ORG007) and should be read in conjunction with this.

For ease of reference, the term 'patient' is used throughout this procedure document. This is intended to refer to all people who make use of any of the health care services provided by Berkshire Healthcare.

2 PURPOSE OF POLICY

The purpose of this policy is to ensure:

- A consistent approach to undertaking mortality reviews.
- That all Inpatient deaths are reviewed by a Medical Examiner prior to the medical certificate of Cause of Death (MCCD), or coroner referral being completed.
- Learning from mortality reviews is identified and shared.
- Compassionate and professional engagement with patients' families when any death occurs and when a death is reviewed. Compliance with the reporting requirements of NHS Improvement and other external agencies is met.

3 SCOPE OF POLICY

This policy and procedure is applicable to all staff whether they are employed by Berkshire Healthcare permanently, temporarily, through an agency or bank arrangement, are students on placement, are party to joint working arrangements or are contractors delivering services on behalf of Berkshire Healthcare.

4 ASSOCIATED DOCUMENTS

CCR072 Child Protection (Safeguarding and Promoting the Welfare of Children)
ORG007 Incidents/Near Misses, Serious Incidents Requiring Investigation and Coroner Requirements

5 ROLES AND RESPONSIBILITIES

Chief Executive
The Chief Executive has overall responsibility for ensuring there are effective and robust governance processes in place within Berkshire Healthcare. They have accountability for the actions of staff providing they act within the framework of their codes of professional conduct as well as in accordance with Berkshire Healthcare policy.

Medical Director
The Medical Director is the Executive lead for mortality review and is responsible for the implementation of this policy. They will provide assurance to the Board that the mortality review process is functioning in line with this policy, escalating any concerns identified.

Chair of Quality Assurance Committee (QAC)
The Chair of the Quality Assurance Committee is the nominated Non-Executive Board lead for Mortality review. They have responsibility to challenge and have oversight of the process through the quarterly reports to the QAC and provide assurance to the Board on this.

The Director of Nursing and Therapies
The Director of Nursing and Therapies has the lead accountability for implementing and monitoring the risk management process including the reporting, management and learning from serious incidents (SI).

The Deputy Director of Nursing Patient Safety and Quality
The Deputy Director of Nursing Patient Safety and Quality has responsibility for determining when an incident is designated as a SI and when an internal investigation should be carried out, or when an incident is to be investigated or notified externally including the requirement under Regulations 17 that any death of a patient detained under the Mental Health Act (1983) is reported to the Care Quality Commission without delay. Their team is responsible for the management of the incident reporting process across divisions and ensuring that localities implement the action plans from SI's and monitor that families have been informed and had an opportunity to be involved in the SI investigation (Duty of Candour). They will have oversight of the Datix process and ensure that all mortality reviews are completed.

Head of Clinical Effectiveness & Audit
The Head of Clinical Effectiveness & Audit has delegated responsibility on behalf of the Medical Director for the operational implementation and further development of Berkshire Healthcare's mortality process. This includes being responsible for:

- All aspects of the Berkshire Healthcare Mortality Review Group (TMRG).
- Collation of review findings, learning points and actions for improvement for each mortality meeting.
- Ensuring participation in the Learning Disabilities Mortality Review (LeDeR) programme supporting requests for case note reviews and that learning is shared within the organisation.
- Review and analysis of data to inform quarterly reporting and identify any areas of concern.
- Production of the quarterly reports.

- The oversite and providing assurance that the medical examiner process is followed for all inpatient deaths.

Clinical Directors

Clinical Directors are responsible for:

- Ensuring effective clinical governance process are in place to support all staff to report deaths in line with the criteria set out in this policy.
- Ensuring that 2nd stage reviews are completed in line with this policy as requested by EMRG.
- Ensuring that all relevant services contribute to the 2nd stage review.
- Ensuring that 2nd stage reviews are objective and not completed by an individual directly involved in the patient's care.
- Providing an overall Clinical Judgement for all 2nd stage reviews or delegate to appropriately senior clinical member of staff within the division.
- Ensuring effective mechanisms for sharing of learning that have occurred within their division.
- For ensuring that the medical examiner process is followed (Appendix A) for all inpatient deaths within their division.

Medical Staff

For Inpatient deaths the medical examiner process must be followed (Appendix A) for the completion of the medical certificate of cause of death (MCCD) and coroner referrals.

All Healthcare Professionals

All healthcare professionals should be involved in mortality reviews meetings, as part of their clinical practice. This involvement could range from simply being aware of the outcome of such reviews insofar as they affect their area of practice, to full involvement in the production of data, reports and implementation of recommendations.

All clinical staff have a duty to follow this policy by reporting any death which meets the criteria in figure A and B **within 24 hours**, according to the procedures outlined in this document. This will be through completion of an Adverse Event Reporting Form on Datix (the Berkshire Healthcare incident reporting system) Datix: Adverse Incident form - Form ID24 For use by Berkshire Healthcare NHS Foundation Staff only (thirdparty.nhs.uk)

A Guidance booklet on completion of Datix can be sought from any line or senior manager or from the Compliance & Risk Team or Patient Safety Team. Training in this process is mandatory and is provided as part of the induction process for all staff at Trust and departmental level.

Where a member of staff is informed of a death, of an inpatient or patient under our direct care at the time of death they should also inform any other providers of care who have an interest if this is known including the deceased person's GP.

GROUPS AND COMMITTEES WITH OVERARCHING RESPONSIBILITY

Berkshire Healthcare NHS Foundation Trust Board

For effective implementation of this policy, there must be active support from the most senior members of Berkshire Healthcare. Therefore the Chief Executive and Board will receive a quarterly report on a number of specific metrics outlined on page 15. They will also gain assurance through the activities and minutes of the relevant groups and committees. Deaths which are classified as Serious Incidents will be reported to and overseen by the Board in line with the Serious Incident Policy ORG007.

Quality Assurance Committee (QAC)
The Quality Assurance Committee has delegated authority by the Board to receive the quarterly mortality report (containing information on deaths, case reviews and investigations) and to scrutinise, challenge, and subsequently provide assurance to the Board that appropriate governance processes are in place, that Berkshire Healthcare is providing safe care with systems existing to detect, investigate and learn lessons from avoidable deaths, in order to minimise the possibility of similar occurrences in the future.

Quality Executive and Performance Group (QPEG)
The Quality Executive and Performance Group is responsible for ensuring that any learning surrounding mortality has been implemented and shared throughout the organisation, and that any concerns are acted upon or escalated. They will do this through the review of the quarterly incident/SI report and quarterly mortality report for the organisation. They will scrutinise the contents; ensure that any action plans surrounding the report have been implemented; and ensure learning has been shared throughout the organisation.

Executive Mortality Review Group (EMRG)
The Executive mortality review group consists of the Medical Director, Director of Nursing and Governance, Lead Clinical Director, Divisional Clinical Directors, Deputy Director of Nursing for Patient Safety and Quality and the Head of Clinical Effectiveness & Audit. On a weekly basis they will review all deaths which have been reported through the Datix system, they will agree the initial level of investigation/review required, and if, in their opinion, no further investigation or review is required they will approve closure of the Datix form at first stage review.

Trust Mortality Review Group (TMRG)
The Trust Mortality Review Group will meet on a monthly basis and will ensure:

- Oversight of the number of 1st stage reviews (Datix) reported in the prior month.
- Review of all second stage reviews including: Structured Judgement Reviews (SJR), and Initial findings review (IFR) for cases which are not SI's
- Receive assurance that all 2nd stage reviews are conducted in line with this policy
- Identify if there are care concerns which may have contributed to a death and escalate for a patient safety review (PSR)to confirm learning from the events contributing to the patient death.
- SJRs requested by the medical examiner are completed
- Report quarterly to the identified committees, providing assurance about mortality review process.
- Promote learning from themes arising from deaths via Divisional Directors.
- Advising Divisional Directors of implementation of actions required at service level following review of deaths.
- Identification of areas for Quality improvement required in Berkshire Healthcare services, arising from learning from the mortality review process.

Divisional Patient Safety and Quality Groups (PSQ's)
Divisional PSQ's are responsible for ensuring that there is a mechanism for sharing learning from the mortality processes with the wider staff teams.

Medical Examiner's Office (MEO)
Nationally acute trusts Medical Examiner's offices are required to put in place measures to extend Medical Examiner scrutiny of deaths across all non- acute sectors so that all deaths are scrutinised by the end of March 2024.

The Royal Berkshire NHS Foundation Trust provide this service for the Trust and all Berkshire Healthcare inpatient deaths since December 2022 have been scrutinised. Appendix A details the

process which must be followed for all inpatient deaths.
Subject to parliamentary process this will become a statutory requirement in April 2024.

Working with Commissioners
Berkshire Healthcare will work with commissioners to review and improve our local approaches following the death of people receiving care from our services. Provider organisations and commissioners must work together to review and improve their local approach following the death of people receiving care from their services (Recommendation 7: Learning, Candour and Accountability).

Working with other Healthcare Providers
Berkshire Healthcare will engage with GPs, acute hospital providers in Berkshire (and other providers of mental health and community services as appropriate), to respond to their requests for information related to their review of deaths and will similarly request information to facilitate review of deaths in Berkshire Healthcare in relevant cases. In some cases, information will be requested from Local Authorities and Care Homes to facilitate learning from deaths.

6 POLICY CONTENT

6.1 PROCEDURE OF REVIEW

Figures A and B identify the criteria for reporting a death on the Berkshire Healthcare Datix system for first stage review. Figure A highlights the specific requirements which should also be considered for reporting in line with the serious incident policy (ORG007). At any point a death reported in line with Figure B may be escalated if it is believed to be a SI.

All Staff in clinical services have a duty to follow this policy by reporting any death (which meets the criteria for reporting) within 24 hours, according to the procedures outlined in this document. This will be through completion of an Adverse Event Reporting Form on Datix. Datix: Adverse Incident form - Form ID24 For use by Berkshire Healthcare NHS Foundation Staff only (thirdparty.nhs.uk)

Figure A

Criteria for deaths which must be reported in line with the SI ORG007 policy as potential Serious Incidents	**Including**
Mental Health Inpatients	All inpatient deaths (must be reported in line with the Medical Examiner process Appendix A).
All Mental Health Services	All suicides, suspected suicides that occur within 12 months of receiving MH treatment from a service (regardless of whether on the caseload or discharged at the time of death. Unexpected deaths. Any death of a patient being treated under the Mental Health Act.
All Services (Mental Health and Physical Health) (Adults and Children's)	Where the death has been reported to the Coroner, or concerns have been raised by any individual or organisation as to the circumstances surrounding the death. If the death is unexpected or believed to be avoidable.

	If any acts, omissions or concerns in care provided by Berkshire Healthcare services are suspected.

Figure B

Criteria for reporting all other deaths	Including
All services (Mental Health and physical health)	There was an open safeguarding referral relating to the patient at the time of their death All deaths where bereaved families and carers, or staff, have raised a concern about the quality of care provision Where another organisation notifies us and suggests that Berkshire Healthcare should review the care provided to the patient but who were not under our care at the time of death.
Adult Mental Health	Inpatients (which don't meet the SI criteria in table A): The patient was transferred from a Berkshire Healthcare inpatient unit to an acute hospital and they died within 7 days of this transfer. All patients with a diagnosis of psychosis, autism or eating disorders during their last episode of care, who were under the care of services at the time of their death, or who had been discharged within the 6 months prior to their death. All patients who were under a Crisis Resolution and Home Treatment Team (or equivalent) at the time of death.
Older Persons Mental Health	The patient was an inpatient at the time of their death (informal and those identified as receiving end of life care) Inpatients: The patient was transferred from a Berkshire Healthcare inpatient unit to an acute hospital and they died within 7 days of this transfer. Community patients At the time of their death, the patient had an open/ active referral to Home Treatment Team or Care Programme Approach.
Adult Learning Disabilities	Any patient under the care of Learning Disability (LD) services (Inpatient or Community teams) at the time of death Any patient with a confirmed diagnosis of learning disability who was in receipt of care from BHFT services within the last year prior to their death.
Children with a Learning Disability	Any child with an identified learning disability who dies whilst under the care of any of our children's services (see section 8.3 for definition of LD)
Children's Services: Mental and Physical Health,	Infant or Child death should be reported in line with local CYPF child death reporting procedure and CCR072 Child Protection (Safeguarding and Promoting the Welfare of Children)
Community Physical health	The patient was an inpatient at the time of their death (including patients whose death may be expected and identified as receiving end of life care)(The death must be reported in line with the Medical Examiner process Appendix A). Inpatients: The patient was transferred from a Berkshire Healthcare inpatient unit to an acute hospital and they died within 7 days of this

	transfer. Any unexpected death of a patient open to the Community Nursing service to be reported if: the patient had a Category 3 or 4 pressure ulcer the patient had suspected sepsis

6.2 EXCLUSIONS

In principle, no services are excluded from reporting deaths and criteria identified above are based on risk and the opportunity for learning. Deaths which will not be routinely reported via the Datix system include:

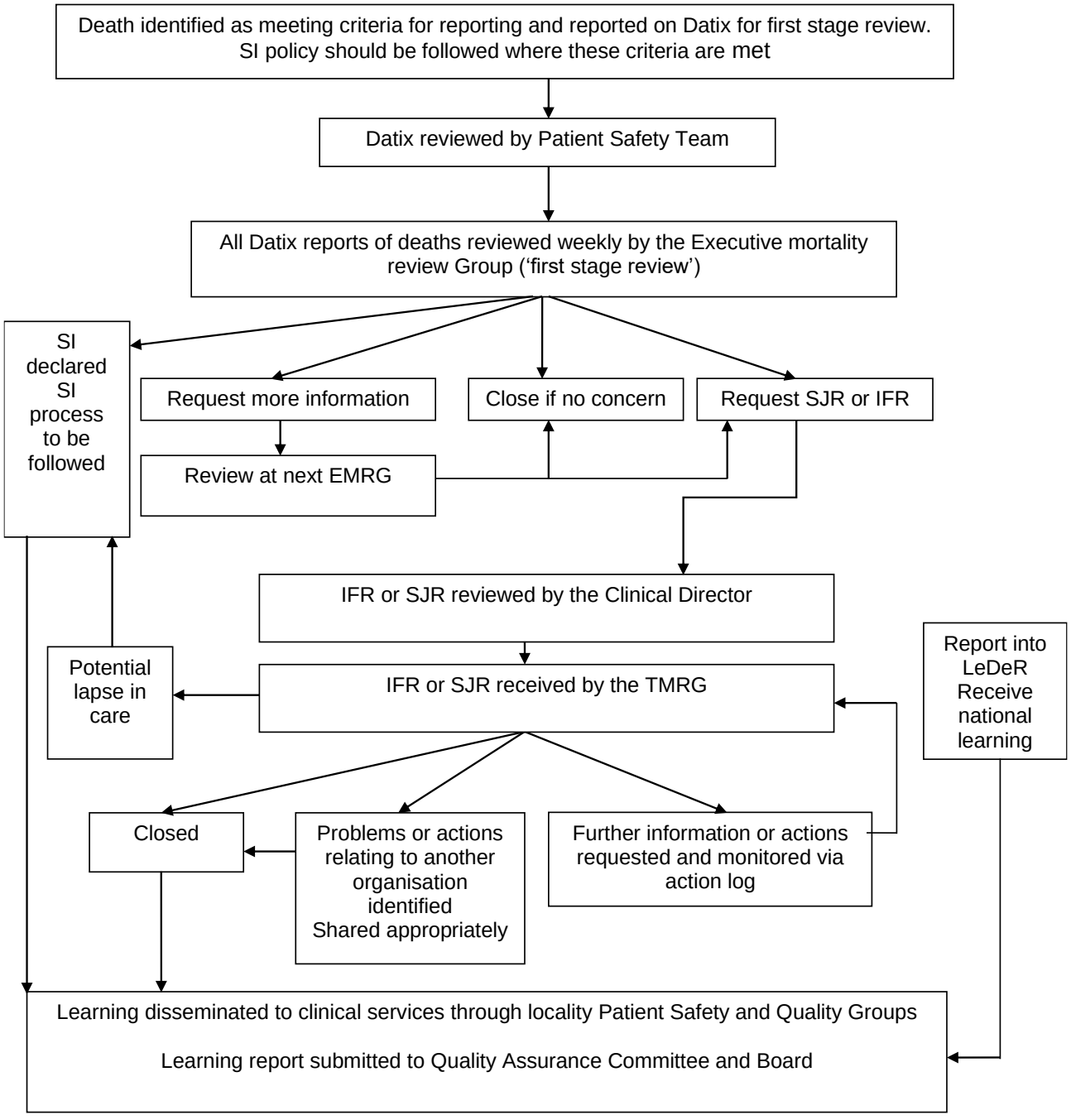
1. Deaths in hospital during the neonatal period.

2. Deaths which do not meet the criteria for reporting as above and where the patient has been in contact with one of the Berkshire Healthcare's community services in the past 12 months. These deaths will be reported in the quarterly mortality data report and will be subjected to the quarterly random sampling for learning and improvement.

3. Patients who are transferred and we are not notified of the death. In this case deaths within 7 days will be reported retrospectively on Datix and are subject to notification of the death on the central spine being uploaded to the RiO system.

6.3 MORTALITY REVIEW PROCESS

Figure C



**Death of a patient with a diagnosed learning disability or Autism is required to be submitted to LeDeR; this will not be a barrier to an SI, Sub SI or Case review being conducted.*

At any point an incident may be deemed an SI and will then follow that process.

All inpatient deaths must also be notified to the Medical Examiner's Office in line with Appendix A

6.4 PURPOSE AND TYPE OF REVIEW TO BE CONDUCTED

The purpose of the local reviews of death is to identify any potentially avoidable factors that may have contributed to the person's death and to develop plans of action that individually or in

combination, will guide necessary changes in health and social care services in order to reduce premature deaths of people with learning disabilities.

The type of review will be decided in line with the flowchart outlined Figure C. At any point the type of review may be escalated by a member of the executive mortality group or the TMRG if there is a gap in information or a cause for concern.

2nd stage reviews (SJR or IFR) must be led by a clinician or service lead who did not provide direct patient care. The specific methodology for 2nd stage review is different across services and this is line with the evidence base and national guidance. Services will be informed of the type of review they are required to conduct and where required, will receive appropriate training in the methodology.

Clinical Directors are required to include an overall judgement of care which should be discussed and shared with the relevant clinical team prior to being received by the Berkshire Healthcare Mortality Review Group. Feedback of good care should be shared with both the individual staff and the wider teams, concerns should also be discussed with services to identify areas for learning and improvement.

6.4.1 Initial Findings Report (IFR) for SI

A 72 hour/ initial findings report is carried out by the service(s) following a request from the Governance (Patient Safety & Compliance) Team for all cases considered to be potential or actual SIs. The aim of this review is to take any immediate clinical or managerial action necessary to ensure safety or make any necessary urgent changes to policies and procedures. A further purpose of this review is to identify any immediate support needs for patients; carers or staff and put in place such support. Also, to determine the initial facts and identify which staff will be required to give a statement to the Coroner for unexpected deaths. The template can be obtained from the Governance Team. The Coroner's statement template and guidance documents are embedded in the initial 72 hour/ initial findings report.

6.4.2 Deaths of People with Learning Disabilities or Autism (all will be subject to this process)

From September 2017 all reported deaths of patients with an identified learning disability and as of March 2022 all deaths where the patient had an autism diagnosis should be submitted for review to the learning disabilities mortality review programme (LeDeR). All deaths should be notified, this is in order to ascertain nationally the numbers of people with learning disabilities or autism who die each year, and their characteristics.

All deaths of people aged 4 years and over will be reviewed, regardless of whether the death was expected or not. The link below details the current most recognised definition of what it is to have a learning disability or autism as well as some groups who do not fall within this delineation. It also explains who will and who will not be included in the LeDeR review programme LeDeR - Home .

6.4.3 Deaths of Children and Young People (all will be subject to this process)

Infant or Child death will be reviewed in line with CCR072 Child Protection (Safeguarding and Promoting the Welfare of Children) and Chapter 5 of the statutory guidance document, Working Together to Safeguard Children. Learning from these deaths will be included in the quarterly report. Learning from the regional child death overview panel (CDOP) will be shared at the TMRG.

6.4.4 All other services (requirement determined by the Executive Mortality Group)

Case review methodology will use the Structure Judgement Review (SJR) template (on RiO).

6.4.5 All deaths where family, carers or staff have raised a concern about the quality of care provision

Case review methodology will use the IFR or SJR template as decided by the EMRG as most appropriate,

6.4.6 All deaths in a service on the Quality Concerns list

Case review methodology will use the relevant methodology as identified in 8.1 -8.7.

6.4.7 Cross-System Reviews & Investigations

Where it is identified that more than one organisation is involved in the care of any patient who dies, or where possible problems are identified relating to other organisations, the mortality review group will ensure notification.

6.5 INVOLVEMENT OF FAMILIES AND CARERS

We recognise the importance of communicating openly and effectively with families, that if they have any concerns/questions that these should be addressed wherever possible by the review, and that they should be involved or kept informed as much as they want to be in the process.

The Berkshire Healthcare Open Communication “A Duty to be Candid” should be followed for the involvement of families where:

- The SI process is being followed
- A concern over care has been raised
- The patient is an inpatient or receiving direct care at the time of death

All inpatient deaths (including End of life and unexpected) will be reviewed by the Medical Examiner, the Medical Examiner’s review includes a conversation with the next of kin where they have the opportunity to raise any concerns and the cause of death is explained to them.

If there is a cause for concern by a patient’s family, staff or the medical examiner then a 2nd stage review (SJR or RCA) will be requested by the EMRG.

Deaths of inpatients where the patient is an expected EOL death, in most cases these are closed at a first stage review level and no further action is required.

If no further action is required and the Datix is being closed: The trust EOL letter must be sent together with the Trust Bereavement Leaflet.

If a more detailed review is required such as an SJR, RCA or SI: The Deputy Director of Nursing will inform you and confirm what letter / Communication should be sent.

Unexpected Deaths of patients reported as a Datix (the specific requirements on which deaths must be reported can be found in the learning from deaths policy).

The Deputy Director of Nursing will inform the service of the outcome of the EMRG, if an SJR is requested then the service will need to send the Trust standard condolence letter together with the Trust Bereavement Letter, the Deputy Director of Nursing will confirm this. If the death is classed as an SI, then the SI duty of candour process should be followed and the condolence letters should NOT be sent. You will always be informed which letter and process to follow.

For all deaths where a patient was known to have a learning disability, a letter of condolence and trust bereavement leaflet will be sent by the Learning Disability Service.

6.6 QUARTERLY MORTALITY REPORT

It has been recognised that whilst services can learn from each case, more can be learnt from the aggregation of cases, where patterns of poor care and good care emerge.

A report will be generated by the Head of Clinical Effectiveness & Audit and submitted to the identified committees on a quarterly basis. This will include information on the following:

- The number of deaths reported in line with figure A and B including those which follow the SI /Safeguarding or complaints process. Of these deaths subjected to review, we will provide estimates of how many deaths were judged more likely than not to have been due to problems in care.
  Total number of deaths of patients with a Learning Disability (1st stage reviews)
- Total number of deaths judged > 50% likely to be due to problems with care (Avoidability score of 1, 2 or 3))
- Details of family and carer involvement in reviews.
- Evidence of good practice and learning identified as a result.
- Details of reviews which are escalated or shared with other organisations.
- Identifying areas for further review which do not meet the criteria, taking into account the areas identified in the Berkshire Healthcare Quality Concerns Report and areas of existing or planned improvement work (see Audit section).

6.7 AUDIT

To ensure that Berkshire Healthcare can take an overview of where learning and improvement is needed most overall, the following actions will be taken:

- The numbers of all deaths recorded on RiO (the patient electronic record) where the patient has had contact with a Berkshire Healthcare service in the 365 days preceding death will be reviewed quarterly data by the TMRG, detailing the total number of deaths recorded by service.
- we may recommend internal review of service processes or clinical audits from time to time depending upon themes which emerge from our review of deaths e.g., we could be proposing an audit of a specific aspect of care of patients who have a fall with possible head injury.

7 REFERENCES:

Learning Disabilities Mortality Review (LeDeR) programme https://leder.nhs.uk/

https://www.gov.uk/government/speeches/cqc-review-of-deaths-of-nhs-patients]

Care Quality Commission (CQC) report Learning, candour and accountability: A review of the way NHS Trusts review and investigate the deaths of patients in England.

National Quality Board: National Guidance on Learning from Deaths March 2017.

University of Bristol: Confidential Inquiry into premature deaths of people with learning disabilities (CIPOLD). March 2013.

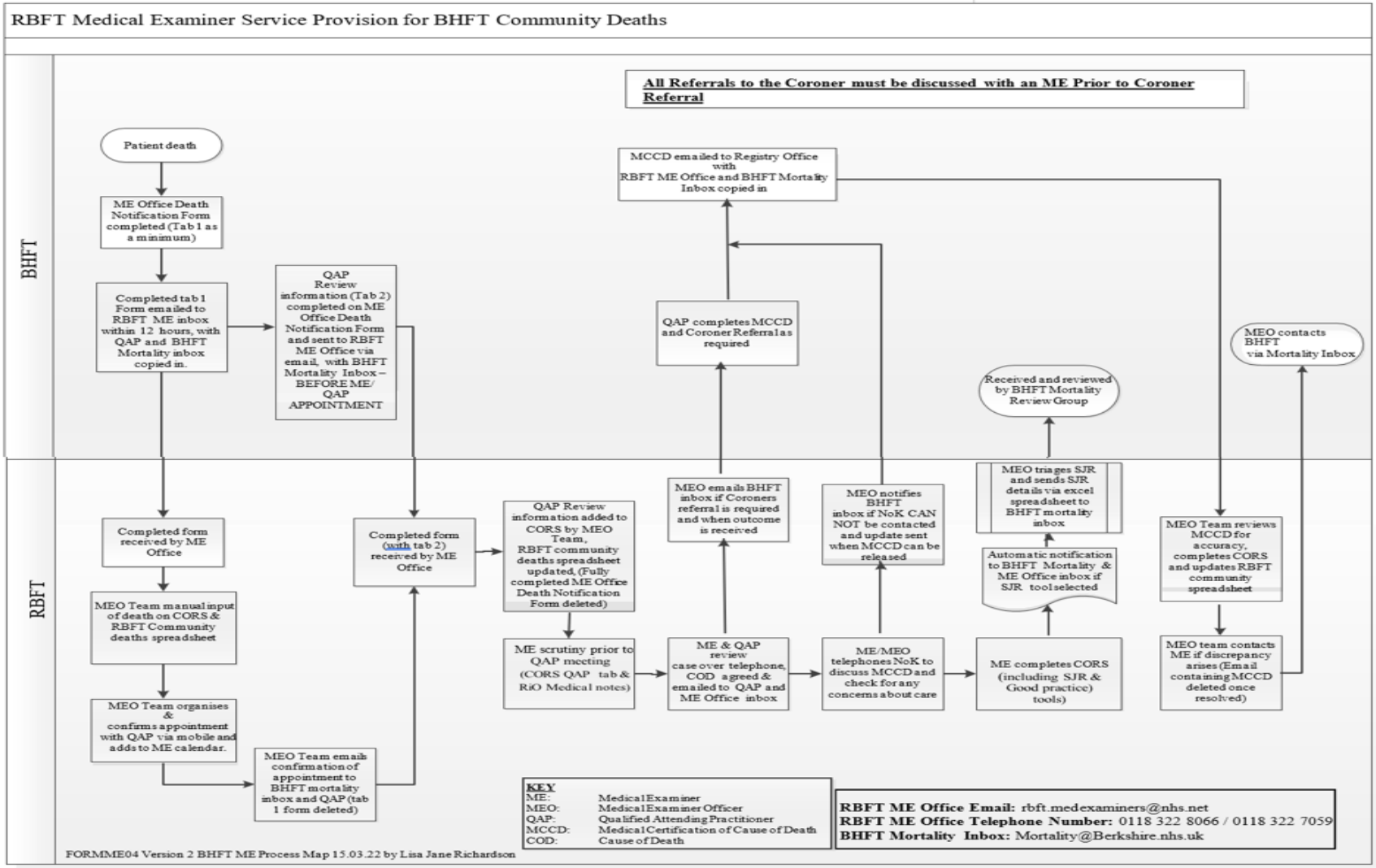
Trust Policy: ORG007 Incidents/near misses, serious incidents requiring investigation and Coroner requirements 2016

Berkshire Healthcare links to Safeguarding
https://nexus.berkshirehealthcare.nhs.uk/safeguarding

Berkshire Healthcare links to Complaints
https://nexus.berkshirehealthcare.nhs.uk/complaints

8 APPENDICES

Appendix A Medical Examiner Process flow chart



9 EQUALITY IMPACT ASSESSMENT

Equality Analysis – Template
'Helping you deliver person-centered care and fair employment'

Title of policy/programme/service change being assessed:	Learning from Deaths
Date of Assessment:	July 2023
Assessment Author:	Head of Clinical Effectiveness

1. Briefly describe the aims, objectives and purpose of the policy/programme/service change.

To ensure that we learn from deaths of patients receiving our services, including and with specific focus on vulnerable groups including patients with a learning disability, Mental health and children's where the case review will also consider protected characteristics.

2. Who is likely to be affected by the policy/programme/service change?

Policy is relevant to all staff and is being implemented to improve patient care

3. Analysis of Impact - what impact will the policy/programme/service change have on protected groups. Indicate below whether the impact on each protected group will be positive, neutral or negative and give a reason for your assessment.

Protected Characteristic	Nature of any Impact			Reason for Impact Identified
	Positive	Neutral	Negative	
Sex		X		All groups will be treated equitably
Age		X		All groups will be treated equitably
Disability		X		All groups will be treated equitably
Race/Ethnicity		X		All groups will be treated equitably
Religion/Belief		X		All groups will be treated equitably
Sexual Orientation		X		All groups will be treated equitably
Gender Reassignment		X		All groups will be treated equitably
Maternity & Pregnancy		X		All groups will be treated equitably
Marriage & Civil Partnership		X		All groups will be treated equitably
Carers		X		All groups will be treated equitably
Other Group(s) (please specify)		X		All groups will be treated equitably

4. Action Plan - for any negative impact(s) identified above, complete the action plan below to identify the actions needed to reduce the negative impact on specified protected groups
(where no negative impact has been identified, please move to summary section 5 below)

Negative Impact	Action needed to reduce negative impact, including changes, options and alternatives to be considered	Lead	Timescale

5. Summary – please indicate below which of the following impact statements best describes the

overall impact of the policy/programme/service change on equality		
Highly likely to have an adverse effect on equality **High Risk**	May have an adverse effect of equality **Moderate Risk**	Unlikely to have an adverse effect on equality **Low Risk**
Highly likely to promote equality of opportunity and good relations **High Potential**	May promote equality of opportunity and good relations **Moderate Potential**	Unlikely to promote equality of opportunity or good relations **Low Potential**