Healthcare from the heart of your community

Berkshire Healthcare NHS
NHS Foundation Trust

CCR157

LEARNING FROM DEATHS

Policy& Procedure

Berkshire Healthcare NHS Foundation Trust

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POLICY DEVELOPMENT

CCR157 – LEARNING FROM DEATHS

History:	Version 1: New policy and procedure developed to meet national requirements.
Designated Leads:	Medical Director and Head of Clinical Effectiveness & Audit
Policy Consultants/ Distributed for Comments:	Medical Director Director of Nursing Lead Clinical Director Deputy Director of Nursing for Patient Safety & Quality Members of the Mortality Review Group Lead Non-Exec Director for Learning from Deaths Policy Quality Executive Group
Endorsed by:	Policy Scrutiny Group - 14th July 2017

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

Contents

1. INTRODUCTION

1.1 It has become increasingly important for Trusts to evidence that they are systematically and continuously reviewing patient outcomes including mortality.

1.2 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.

1.3 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.

1.4 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

1.5 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.

1.6 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.

1.7 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. SCOPE

2.1 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.

3. AIM

3.1 The aim of this policy is to ensure:-

- A consistent approach to undertaking mortality reviews.
- Learning from these reviews is identified and shared.
- Compassionate and professional engagement with patients' families when any death occurs and when a death is reviewed.
- Berkshire Healthcare complies with the reporting requirements of NHS Improvement and other external agencies.

4. ROLES AND RESPONSIBILITIES

4.1 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.

4.2 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.

4.3 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.

4.4 The Director of Nursing and Governance

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

4.5 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 localities 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 reviews are completed.

4.6 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.

4.7 Clinical Directors and Heads of Service

Clinical Directors and Heads of Service are responsible for ensuring that appropriate investigations and reviews are completed in line with this policy. That where appropriate these are reviewed by a multi-disciplinary team and that any learning which is identified is then shared within their own services and where relevant across localities.

4.8 Medical Staff

All medical staff are expected to participate fully in mortality reviews that are relevant to their practice.

4.9 Nurses, Allied health Professionals and other Clinical Staff

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 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)http://10.210.81.119/datix/live/index.php

A Guidance booklet on completion of Datix can be sought from any line or senior manager or from the 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.

5. GROUPS AND COMMITTEES WITH OVERARCHING RESPONSIBILITY

5.1 Berkshire Healthcare 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 p15. They will also gain assurance through the activities and minutes of the relevant groups and committees as detailed in the Berkshire Healthcare governance structure (Appendix A). Deaths which are classified as Serious Incidents will be reported to and overseen by the Board in line with the Serious Incident Policy ORG007.

5.2 Quality Assurance Committee

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.

5.3 Quality Executive Group

The Quality Executive 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.

5.4 Executive Mortality Review Group

The Executive mortality review group consists of the Medical Director, Director of Nursing and Governance, Lead Clinical Director, 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.

5.5 Berkshire Healthcare Mortality Review Group

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

- Correct Governance of investigation of unexpected deaths.
- Review of all deaths reported in the prior month.
- Review of all Initial findings review (IFR)/ Case reviews / Sub SI reports.
- Identify if there was a lapse in care which contributed to a death.
- Recommend to Medical Director and Director of Nursing if any of the deaths require further investigation.
- Report quarterly to the identified committees, providing assurance about mortality review process.
- Promote learning from themes arising from unexpected deaths via Clinical Directors.
- Advising Clinical Directors of implementation of actions required at service level in the localities, following review of deaths.
- Identification of areas for further review which do not meet the criteria identified in Figure A and B, will be considered Quarterly by the TMRG and will take into account the areas identified in the Berkshire Healthcare quality concerns report.
- Identification of Quality improvement required in Berkshire Healthcare services, arising from learning from the mortality review process.

5.6 Locality Patient Safety and Quality Groups (PSQ's)

Locality PSQ's are responsible for ensuring that there is a mechanism for sharing learning from the mortality processes with the wider staff teams.

5.7 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).

5.8 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. PROCEDURE OF REVIEW

6.1 Figures A and B identify the criteria for reporting a death on the Berkshire Healthcare Datix system for 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.

6.2 **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. http://10.210.81.119/datix/live/index.php

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.
All Mental Health Services	All suicides or suspected suicides that occur within 12 months of last contact (regardless of whether an open referral or discharged). 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: The patient was transferred from a Berkshire Healthcare inpatient unit to an acute hospital and they died within 7 days of this transfer. At the time of their death, the patient had an open/ active referral to Berkshire Healthcare MH services.
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 on the LD caseload within the last year prior to 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 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) Inpatients: The patient was transferred from a Berkshire Healthcare inpatient unit to an acute hospital and they died within 7 days of this transfer.

6.3 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:

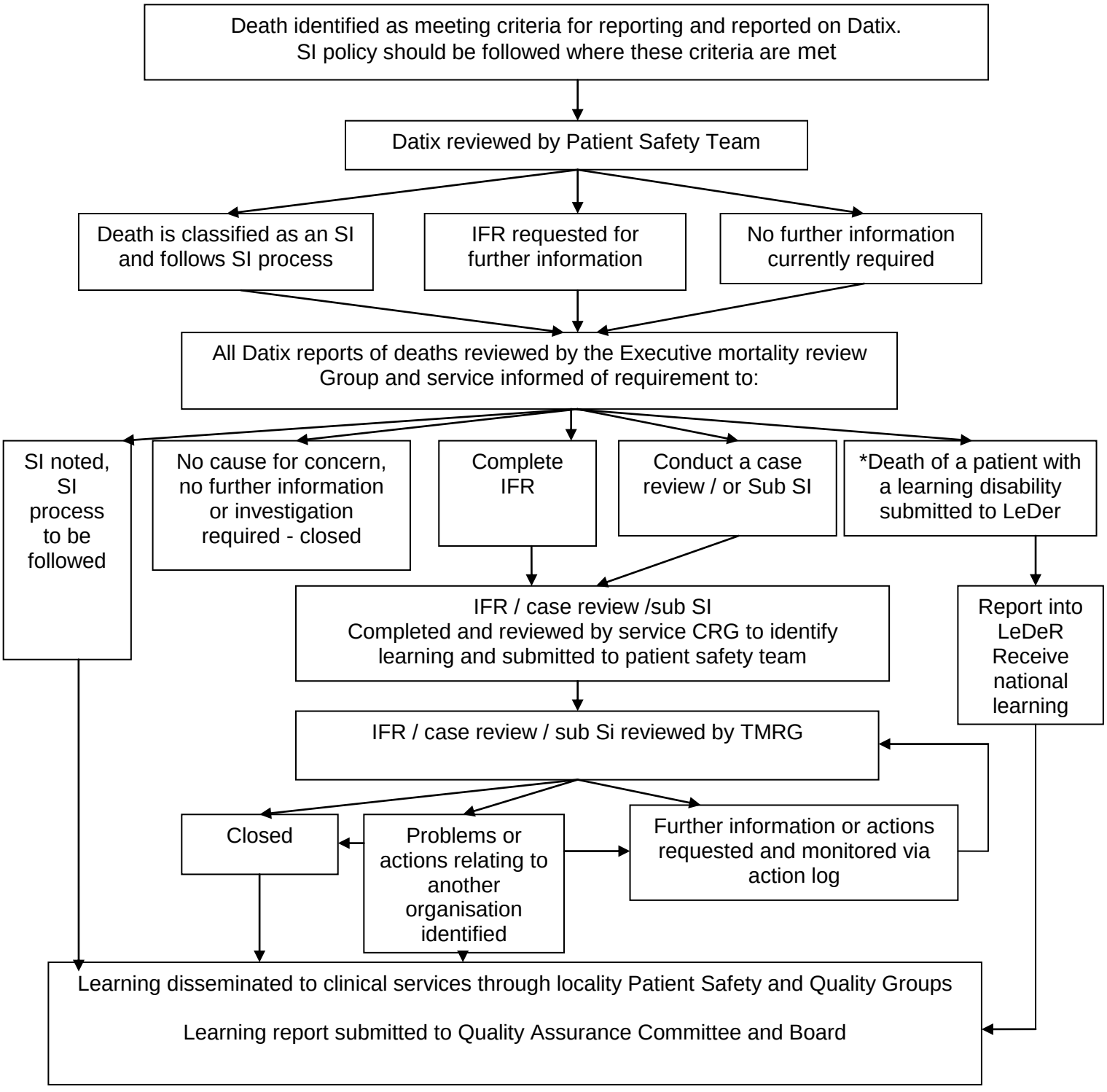
1. Deaths during the neonatal period.

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.

7. MORTALITY REVIEW PROCESS

Figure C



**Death of a patient with a learning disability 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.

8. 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.

Case review should be led by a clinician or service lead who did not provide direct patient care. The specific methodology for case 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.

Case reviews 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.

8.1 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.

8.2 Root Cause Analysis

All deaths which are classed as a serious incident (SI) will follow the review methodology set out in the serious incident policy (ORG007).

Sub SI the appropriate methodology for review will be undertaken based on service, this will then be used to complete the Sub Si to identify service and care delivery problems. The documentation to be used will be the SI template.

8.3 Deaths of People with Learning Disabilities (all will be subject to this process)

From September 2017 all reported deaths of patients with an identified learning disability will 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 who die each year, and their characteristics.

All deaths of people with learning disabilities 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 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.

http://www.bristol.ac.uk/media-library/sites/sps/leder/Briefing%20paper%201%20-%20What%20do%20we%20mean%20by%20learning%20disabilities%20V1.2.pdf

8.5 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.

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

Case review methodology will use the IFR template (Appendix B). This template has been adapted to include relevant elements of structured judgement review (SJR) to critically review cases and identify if there was a lapse in care which attributed to a death.

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

Case review methodology will use the IFR template, this will feed into and inform the complaints investigation process and outcome.

8.8 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.

8.9 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.

9. INVOLVEMENT OF FAMILIES AND CARERS

9.1 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.

9.2 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

9.3 For patients not under our direct care at the time of death it is the responsibility of the clinician undertaking the review to make a judgment of involvement based on when the patient last had contact. This should be clearly documented as part of the review process and advice sought from the patient safety team if there is any uncertainty.

10. QUARTERLY MORTALITY REPORT

10.1 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.

10.2 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 total number of deaths recorded on RiO (by service lines) where the patient was seen within the last 365 days before death.
- The total number of deaths recorded on Rio of patients seen by the Community Team for People with a Learning Disability (CTPLD) within the last 365 days before death.
- The number of people who died with a learning disability who were seen by another service in the preceding 365 days before death who were not under the care of CTPLD.
- 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.
- 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).

11. AUDIT

11.1 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 included within the quarterly data report to the Board, detailing the total number of deaths recorded by service

- Of these, a sample of deaths that do not fit the identified categories (Figure A&B) will be reported on retrospectively in line with Figure C. This random sample which are not classified as SIs or LD service deaths, will be identified by the Berkshire Healthcare Mortality Review Group, additional requests may be made by the Chief Executive, Board or Quality Assurance Committee and should take into account the areas identified in the Berkshire Healthcare Quality Concerns Report.

- Deaths recorded by the Westcall Out of Hours Service which meet the criteria for SI will follow the SI investigation process. Westcall Medical Director will review on a weekly basis all deaths identified on the Adastra system, identify any learning for the Mortality Review Group or escalate as appropriate.

- The WestCall Medical Director will also investigate, and when appropriate report upon, the death of any patient for whom a WestCall Adastra case has been closed where a subsequent death has been notified by another healthcare provider and which may in some way be related to the WestCall clinical activity recorded in the case.

12. REFERENCES

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

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
http://teamnet.berkshire.nhs.uk/clinical/safe/children/policies/Pages/home.aspx
http://teamnet.berkshire.nhs.uk/clinical/safe/Documents/Forms/Adult.aspx

Berkshire Healthcare links to Complaints
http://teamnet.berkshire.nhs.uk/ss/pc/complaints/Pages/home.aspx

Berkshire Healthcare Protocol for responding, reporting and reviewing the death of people with learning disabilities.

Appendix A **Reporting Structure**

Appendix B – IFR Template

Healthcare from the heart of your community

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Serious Incident Initial Findings Report (IFR)

(To be returned to the Patient Safety Team within 72 working hours)

Please note that a full investigation will still be required if a Serious Incident is identified following the submission of this form.

The Patient Safety Team will confirm what level of investigation is required.

A Datix form should also have been completed

This form should be completed by the relevant Service Manager

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SI Reference Number:	
Datix WEB Reference Number:	
Date / Time / Location of incident including Hospital / Ward / Team level:	
Name of Patient / Client:	
NHS Number:	
Age & DOB:	
GP Name and Address:	
Diagnosis/ medical conditions	
Incident Type:	
Brief description of incident and immediate action taken:	

Brief description of care delivery and events leading up to the incident including reason for admission and diagnosis (for mental health please include Mental Health Act status and date of referral and last contact):	
Was the patient open to any other services?	**YES / NO**
If yes please detail here and ensure the other services are included in the completion of the IFR.	
Have any clinical or patient safety risks been identified which require immediate action to mitigate further risk to others (including environmental factors and staffing issues)?	
Please include immediate actions taken to mitigate risk if not detailed above.	
Have any other clinical or patient safety concerns been identified that require further investigation (including environmental factors and staffing issues)?	
Were any trainee doctors or dentists involved in the care and treatment of the patient?	**YES / NO**
If yes, please give the name of the trainee doctor(s) or dentist(s); this is so that the Director of Medical Education can make contact to offer support in advance of any investigation interviews *Trainee Doctor's (or Dentist's) Name:*	
<u>For patient deaths:</u> **State names and job titles of staff closely involved in the patient's care who may need to complete a witness statement for the Coroner.**	
Note: The names of the following individuals should be detailed as statements will be taken from the following staff: • *Last professional to have seen the deceased alive* • *Patient's Consultant* • *Care Coordinator or Support Worker* • *Any other relevant key individuals who made a decision around care.*	

STAFF NAME	Job Title

<u>Communication with Patient or Family/Carers:</u> **Please detail the evidence of following the Being Open Policy when a patient has been harmed whilst in receipt of care or treatment from BHFT (ORG072) and the Duty of Candour Process**
Our Duty of Candour is to the Patient. In cases where the patient lacks capacity or is deceased then Duty of Candour should be undertaken to the next of kin.
Ensure that you have documented on RIO a record of the incident and that Duty of Candour has been undertaken.

Was the patient known to Drug and Alcohol Services:	**YES/NO**
Have they been informed?	**YES/NO**

Details of other organisations/individuals notified
Details of any police or media involvement/interest

Report Completed By:	
Designation:	
Date / Time report completed:	

Please insert below a **brief** chronology of key events that have led to the incident from the past 12 months. Include key events/detail from previous years if relevant.

Date / Time	Event	Care Delivery Problems	Good Practice	Staff member involved from whom additional information

				may be required

For Deaths that are not progressing to full SI –this should be completed by Service Manager / Senior Clinician not involved in the direct care of the patient or Clinical Director

Overall assessment of care Please record your explicit judgements about the quality of care the patient received by the patient and whether it was in accordance with current good practice (for example, your professional standards/ NICE guidance/ expected Berkshire Healthcare protocols and policies). If there is any other information that you think is important or relevant that you wish to comment on then please do so
Please rate the care received by the patient

1 = very poor care 2 = poor care 3 = adequate care 4 = good care 5 = Excellent care Please circle only one score
Have any concerns/ complaints about the patients care been raised Yes / no If yes please give details below:

COMMENTS / FEEDBACK (This form can be photocopied as needed)

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Name _____ Date _____

Address _____

Return comments for consideration three months prior to review date to the designated Policy Lead or Governance Administration Manager, 2nd Floor, Fitzwilliam House, Skimped Hill Lane, Bracknell, RG12 1BQ.

Page: Paragraph:	
Page: Paragraph:	
Page: Paragraph:	
General comments:	

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

1. Title of policy/ programme/ service being analysed Mortality Review Policy and Procedure	
2. Please state the aims and objectives of this work and what steps have been taken ensure that Berkshire Healthcare has paid <u>due regard</u> to the need to eliminate discrimination, advance equal opportunities and foster good relations between people with protected characteristics. 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.	
3. Who is likely to be affected? e.g. staff, patients, service users Policy is relevant to all staff and is being implemented to improve patient care	
4. What evidence do you have of any potential adverse impact on groups with protected characteristics? **Include any supporting evidence e.g. research, data or feedback from engagement activities**	
4.1 Disability *People who are learning disabled, physically disabled, people with mental illness, sensory loss and long term chronic conditions such as diabetes, HIV)*	No adverse impact identified.
4.2 Sex *Men and Women*	*No adverse impact identified.*
4.3 Race *People of different ethnic backgrounds, including Roma Gypsies and Travelers*	*No adverse impact identified.*
4.4 Age *This applies to people over the age of 18 years. This can include safeguarding, consent and child welfare*	*No adverse impact identified.*
4.5 Trans *People who have undergone gender reassignment (sex change) and those who identify as trans*	*No adverse impact identified.*

4.6 Sexual orientation *This will include lesbian, gay and bi-sexual people as well as heterosexual people.*	*No adverse impact identified.*
4.7 Religion or belief *Includes religions, beliefs or no religion or belief*	*No adverse impact identified.*
4.8 Marriage and Civil Partnership *Refers to legally recognised partnerships (employment policies only)*	*No adverse impact identified.*
4.9 Pregnancy and maternity Refers to the pregnancy period and the first year after birth	*No adverse impact identified.*
4.10 Carers *This relates to general caring responsibilities for someone of any age.*	*No adverse impact identified.*
4.11 Other disadvantaged groups This relates to groups experiencing health inequalities such as people living in deprived areas, new migrants, people who are homeless, ex-offenders, people with HIV.	*No adverse impact identified.*

5 Action planning for improvement

5.1 Please outline what mitigating actions have been considered to eliminate any adverse impact?
N/A

5.2 If no mitigating action can be taken, please give reasons.

5.3 Please state if there are any opportunities to advance equality of opportunity?
N/A

An Equality Action Plan template is appended to assist in meeting the requirements of the general duty

Sign off

Name of person who carried out this analysis (Policy Lead): Amanda Mollett Head of Clinical Effectiveness

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