NHS
Derbyshire Healthcare
NHS Foundation Trust

Learning from Deaths Procedure

See also:	Located in the following policy folder on the Trust Intranet
Untoward Incident Reporting and Investigation Policy and Procedure	Corporate and Risk Policies and Procedures
Handling Patient Feedback: Comments, Concerns, Complaints and Compliments Policy and Procedure	Corporate and Risk Policies and Procedures
Policy and Procedure for 'Duty of Candour and Being Open' Communicating openly with patients and their carers.	Corporate and Risk Policies and Procedures

Service area	Issue date	Issue no.	Review date	REGARDS Equality Impact Analysis (EIA) completed
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Ratified by	**Ratification date**	**Responsibility for review:**		
Quality Committee	Sept 2017	Medical Director		

Document published on the Trust Intranet under: Clinical Policies and Procedures

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ACCESSIBLE INFORMATION STANDARD

The Accessible Information Standard directs and defines a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of service users.

Ensure you have considered an agreed process for: sending out correspondence in alternative formats and appointments for patients / service users with communication needs, where this is applicable.

Better together

Learning from Deaths Procedure

Summary (Plain English) Summarise the main points of the policy below in a style that is clear and easy to understand. Ensure the whole policy is written in plain English, using simple language where possible and avoiding convoluted sentences and obscure words. The resulting policy should be easy to read, understand and use,
This procedure outlines how the Trust will respond to and learn from deaths of patients who die under its management and care.

Name / Title of policy/procedure	Learning From Deaths Procedure	
Aim of Policy	To outline the procedure that the Trust will respond to and learns from deaths of patients who die under its management and care	
Sponsor (Director lead)	Medical Director	
Author(s)	Lead Professional for Patient Safety and Experience/Mortality Technician	
Name of policy being replaced	New procedure	**Version No of previous policy:**

Reason for document production:	To meet requirements outlined in the *National Guidance on Learning from Deaths – A framework for NHS Trusts and NHS Foundation Trusts on identifying, Reporting, Investigating and Learning from Deaths in Care*
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Individuals or groups who have been consulted:	**Date:**	**Response**
Executive Director of Nursing, Medical Director, Deputy Director of Nursing	Aug 2017	Agreed
Mortality Group	31/08/2017	Agreed subject to final amendments
Quality Committee	Sept 2017	Approved
Board	Oct 2017	Agreed

Version control (for minor amendments)

Date	Author	Comment

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Learning from Deaths Procedure

1. Introduction

In line with the CQC's recommendations in its review of how the NHS investigates patient deaths, the National Quality Board published a new national framework for NHS Trusts *National Guidance on Learning from Deaths*[1] following the review undertaken by the CQC in response to the low numbers of investigation or reviews of deaths at Southern Health NHS Foundation Trust[2]. The purpose of the new framework is to introduce a more standardised approach to the way NHS Trusts report, investigate and learn from patient deaths, which should lead to better quality investigations and improved embedded learning.

The focus of the framework, and this subsequent procedure, is on improving governance processes around patient deaths. It includes: the Boards role in providing visible and effective leadership to ensure the Trust addresses any significant issues identified as a result of reviews and investigations; a new system of 'case record reviews'; quarterly reporting of specific information about deaths in care; and clarity as to how patients, families and others can raise questions or concerns in relation to the care provided through the *Handling Patient Feedback: Comments, Concerns, Complaints and Compliments Policy and Procedure.* This procedure, together with the linked *Untoward Incident Reporting and Investigation Policy and Procedure* and *Being Open/Duty of Candour Policy and Procedures* ensure the families/carers of patients who have died in care are properly involved at every stage.

For many people under the care of the NHS, death 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. The purpose of reviews and investigations of deaths is addressed in this procedure, which outlines the steps the Trust will take to identify issues that might have contributed to a death or opportunities to learn, in order to minimise the risk of recurrence. Reviews and investigations are only useful for learning purposes if their findings are shared and acted upon.

This procedure has been reviewed against the 'Template Learning from Deaths Policy'[3] and is compliant with all aspects of the template that are required to be included.

2. New requirements

Under the *National Guidance on Learning from Deaths*, Trusts are required to:

[1] National Guidance on Learning from Deaths. National Quality Board. March 2017

[2] Learning, candour and accountability. A review of the way NHS trusts review and investigate the deaths of patient in England. Care Quality Commission. Dec 2016

[3] Template Learning from Deaths policy. NHS Improvement. Sept 2017

Publish an updated policy by September 2017 on how their organisation responds to and learns from deaths of patients who die under their management and care, including:

- how their processes respond to the death of an individual with a learning disability, severe mental illness, an infant or child death, a stillbirth or a maternal death
- their evidence-based approach to undertaking case record reviews
- the categories and selection of deaths in scope for case record review (and how the organisation will determine whether a full investigation is needed)
- how the trust engages with bereaved families and carers, including how the trust supports them and involves them in investigations
- how staff affected by the deaths of patients will be supported by the trust.

Collect specific information every quarter on:

- the total number of inpatient deaths in an organisation's care[4]
- the number of deaths the trust has subjected to case record review (desktop review of case notes using a structured method)
- the number of deaths investigated under the NHS's Serious Incident Framework (and declared as Serious Incidents)
- of those deaths subject to case record review or investigated, estimates of how many deaths were more likely than not to be due to problems in care
- the themes and issues identified from review and investigation, including examples of good practice
- how the findings from reviews and investigations have been used to inform and support quality improvement activity and any other actions taken, and progress in implementation.

Publish this information on a quarterly basis from December 2017 by taking a paper to public board meetings.

This policy sets out Derbyshire Healthcare Foundation Trust approach to meeting these requirements

3. Scope

This policy applies to all staff whether they are employed by the trust permanently, temporarily, through an agency or bank arrangement, are students on placement, are party to joint working arrangements or are contractors delivering services on the Trust's behalf.

4. Purpose

Derbyshire Healthcare NHS Foundation Trust will implement the requirements outlined in the Learning from Deaths framework[5] as part of the organisation's existing procedures to learn and continually improve the quality of care provided to all patients.

This procedure sets out the procedures for identifying, recording, reviewing and investigating the deaths of people in the care of Derbyshire Healthcare NHS Foundation Trust

It describes how the Trust will support people who have been bereaved by a death at the Trust, and also how those people should expect to be informed about and involved in any further action taken to review and/or investigate the death. It also describes how the trust supports staff who may be affected by the death of someone in the trust's care.

It sets out how the trust will seek to learn from the care provided to patients who die, as part of its work to continually improve the quality of care it provides to all its patients.

This policy should be read in conjunction with policies and procedures outlined on the front page of this document.

5. Roles and responsibilities

This section describes the specific responsibilities of key individuals and of relevant committees under this policy.

Role	Responsibilities
Chief Executive	Overall responsibility for the implementation of the policy
Medical Director (Board level lead	Responsible for acting as patient safety

[5] National Guidance on Learning from Deaths. National Quality Board. March 2017

with responsibility for leading the learning from deaths agenda)	director to take responsibility for the learning from deaths agenda.
Non-Executive Directors	Responsible for ensuring they: • understand the review process: ensuring the processes for reviewing and learning from deaths are robust and can withstand external scrutiny • championing quality improvement that leads to actions that improve patient safety • assure published information: that it fairly and accurately reflects the organisation's approach, achievements and challenges.
Executive Director of Nursing and Patient Experience	Responsible for ensuring that there are processes and procedures are in place to ensure that timely, compassionate and meaningful engagement with bereaved families and carers in relation to all stages of responding to a death. Work with commissioners to review and improve their respective local approaches
Learning disability lead	Responsible for ensuring that the Learning from Deaths Procedure is adhered to in the event of a death
Head of Safeguarding Children	Will ensure that child deaths will be reviewed under CDOP and reported as untoward incidents
All staff	To read, understand and take any action to meet the requirements of the learning

Committee	**Responsibilities**
Trust Board	Responsible for for ensuring: an identified board level leader and non- executive director are in place to provide oversight of progress; the learning from deaths paying particular attention to the care of patients with a learning disability or mental health needs. Ensuring that the Trust has:

	• A systematic approach to identifying those deaths requiring review • Adopts a robust and effective methodology for case record reviews • Ensures case record reviews and investigations are carried out to a high quality • Ensures that mortality reporting in relation to deaths, reviews , investigations and learning is regularly reported to the Board • Ensures learning from reviews and investigations is acted on to sustainably change clinical and organisational practice and improve care and reported in annual Quality Accounts Shares relevant learning and ensures that there are sufficient nominated staff have appropriate skills to review and investigate deaths.
Mortality Review Group	See Section 10 and Appendix A: Terms of Reference
Quality Committee	Board Committee with responsibility for assuring the Board that their responsibilities are being met with respect to the learning from deaths agenda and that it is being progressed

6. Definitions

The following definitions apply for the purpose of this policy:

The *National Guidance on Learning from Deaths* includes a number of terms. These are defined below.

Death certification
The process of certifying, recording and registering death, the causes of death and any concerns about the care provided. This process includes identifying deaths for referral to the coroner.

Case record review

A structured desktop review of a case record/note, carried out by clinicians, to determine whether there were any problems in the care provided to a patient. Case record review is undertaken routinely to learn and improve in the absence of any particular concerns about care. This is because it can help find problems where there is no initial suggestion anything has gone wrong. It can also be done where concerns exist, such as when bereaved families or staff raise concerns about care.

Mortality review

A systematic exercise to review a series of individual case records using a structured or semi-structured methodology to identify any problems in care and to draw learning or conclusions to inform any further action that is needed to improve care within a setting or for a particular group of patients.

Serious Incident

Serious Incidents in healthcare are adverse events, where the consequences to patients, families and carers, staff or organisations are so significant, or the potential for learning is so great, that a heightened level of response is justified. Serious Incidents include acts or omissions in care that result in unexpected or avoidable death, unexpected or avoidable injury resulting in serious harm – including those where the injury required treatment to prevent death or serious harm – abuse, Never Events, incidents that prevent (or threaten to prevent) an organisation's ability to continue to deliver an acceptable quality of healthcare services, and incidents that cause widespread public concern resulting in a loss of confidence in healthcare services. See the Serious Incident framework for further information.[6]

Investigation

A systematic analysis of what happened, how it happened and why, usually following an adverse event when significant concerns exist about the care provided. Investigations draw on evidence, including physical evidence, witness accounts, organisational policies, procedures, guidance, good practice and observation, to identify problems in care or service delivery that preceded an incident and to understand how and why those problems occurred. The process aims to identify what may need to change in service provision or care delivery to reduce the risk of similar events in the future. Investigation can be triggered by, and follow, case record review, or may be initiated without a case record review happening first.

[6] https://improvement.nhs.uk/resources/serious-incident-framework/

Death due to a problem in care
A death that has been clinically assessed using a recognised method of case record review, where the reviewers feel that the death is more likely than not to have resulted from problems in care delivery/service provision. (Note, this is not a legal term and is not the same as cause of death'). The term 'avoidable mortality' should not be used, as this has a specific meaning in public health that is distinct from 'death due to problems in care'.

Quality improvement
A systematic approach to achieving better patient outcomes and system performance by using defined change methodologies and strategies to alter provider behaviour, systems, processes and/or structures.

Patient safety incident
A patient safety incident is any unintended or unexpected incident which could have led or did lead to harm for one or more patients receiving NHS care.

7. The process for recording deaths in care

The process relies on the NHS Spine system as its main source of information as well as Trust systems such as Paris and SystmOne.

The Trust employs a Mortality Technician who is responsible for extracting the data from the NHS Spine on a daily basis (Monday to Friday), regarding deaths of patients who are currently open to services, or have been open to services within the last 6 months. From this, a Trust mortality database is populated. Each case is assessed by the Mortality Technician using the 'red flags' for incident reporting and mortality review, to determine if the death should be reported as an untoward incident or should be subject to scrutiny by the Mortality Review Group. If the death meets the criteria for reporting as an untoward incident, the Mortality Technician will cross check with Datix to ensure the incident form has been submitted. For deaths which need to be reported as an incident (see Section 9), an incident form must be completed within 24 hours of the death, or of staff becoming aware of the death (See section 5.2 of the *Untoward Incident Reporting and Investigation Policy and Procedure*). If not submitted the technician will escalate to the Lead Professional for Patient Safety and Patient Experience to determine further action and escalation. Each death is also cross checked against complaint data to identify if there has been a complaint raised by the patient or family member/carer within 6 months prior to their death. If so, the clinical team will be asked to report as an untoward incident and the *Untoward Incident Reporting and Investigation Policy and Procedure* will be followed.

The Mortality Database provides the basis for enabling the Trust to identify trends and learning going forward. The Trust is currently using Excel as the central database for the Mortality Work but will explore further packages as the work expands over time.

8. Mortality Dashboard

The National reporting dashboard template has been adapted for local use. This suggested dashboard is a tool to aid the systematic recording of deaths and learning from the care provided by NHS Trusts. The dashboard will be used to record relevant incidents of mortality, deaths reviewed and lessons learnt to encourage future learning and the improvement of care.

9. Selecting Deaths for Case Record Review

The Mortality Review Group have identified a list of 'red flags' to determine which deaths should be reported as an untoward incident (through Datix) and which should be considered for review by the Mortality Review Group.

'Red flags' for deaths to be reported as untoward incidents (Datix)

An incident form (Datix) must be completed if the death meets any of the following criteria listed below. In these cases the process outlined in the *Untoward Incident Reporting and Investigation Policy and Procedure* must be followed:

Any patient open to services within the last 6 months who has died and meets the following:

- Homicide – perpetrator or victim. (This criteria only relates to patients open to services within the last 6 months)
- Domestic homicide - perpetrator or victim (This criteria relates to patients open to services within the last 6 months)
- Suicide/self-inflicted death, or suspected suicide
- Death following overdose
- Death whilst an inpatient
- Death of an inpatients who died within 30 days of discharge from a DHCFT hospital
- Death following an inpatient transfer to acute hospital
- Death of patient on a Section of the Mental Health Act or DoLs authorisation
- Death of patient following absconsion from an inpatient unit
- Death following a physical restraint
- Death of a patient with a learning disability
- Death of a patient where there has been a complaint by family/ carer/ombudsman, or staff have raised a significant concern about the quality of care provision
- Death of a child (and will likely be subject to scrutiny by the Child Death Overview Panel)
- Death of a patient open to safeguarding procedures at the time of death, which could be related to the death

- o Death of a patient with historical safeguarding concerns, which could be related to the death
- o Death where a previous Coroners - Regulation 28 has been issued
- o Death of a staff member whilst on duty
- o Death of a child under the age of 18 of a current or previous service user who has died in suspicious circumstances
- o Where an external organisation has highlighted concerns following the death of a patient whether they were open to the Trust at time of death or not

10. Mortality Review Group

(See Appendix B for Terms of Reference)

To meet the requirements set out in guidance, the Trust has implemented a Mortality Review Group (MRG). The aim of this Group is to:

- Receive an overview of deaths recorded of patients within our care on a monthly basis
- To then determine through the application of a rolling review programme of categories of 'mortality flags' those deaths which require further scrutiny, either through review of death certification; case record review; or investigation in line with *Untoward Incident Reporting and Investigation Procedure*.
- To identify themes and actions resulting from these reviews. There will also be a focus on systems and processes used by our services with cross reference to the recommendations and learning from the Serious Incident Group
- To share overall learning across the Trust

In undertaking this process, the Group will provide estimates of how many of the deaths subject to review were judged more likely than not to have been negatively influenced by aspects of our care.

11. 'Red flags' for deaths to be reviewed by the Mortality Review Group

If a death does not meet the criteria for reporting under the *Untoward Incident Reporting and Investigation Policy and Procedure* (is detailed above), the scrutiny of the death will be undertaken in line with this Procedure.

'Red flags' for mortality review are as follows:

- o Referral made, but patient not seen prior to death
- o Patient referred to services, then assessed and, discharged without referral onto other mental health services (including liaison team)
- o Patient diagnosed with a severe mental illness
- o Death of patient on Clozapine
- o Death of patient on Olanzapine
- o Anti-psychotic medication
- o Substance misuse death
- o Patient only seen as an Outpatient

- Patient with a long term physical condition
- Patient in chronic pain
- Deaths up to 6 month post-discharge
- Patient on end of life pathway, subject to palliative care
- Patient who have died and were on an out of area transfers
- Patients whose care plan was not reviewed in the 6 months prior to their death
- Patient whose risk plan and or safety plan was not in place or updated as per policy, prior to death
- Death listed for review at inquest
- Death of a patient with an Eating Disorder

12 .Process for the review of deaths by the Mortality Review Group

See Appendix A for flowchart of process

13. Scrutiny of mortality data

The Mortality Review Group will choose four mortality 'red flags' to review in each six month period, as part of a rolling programme of review and scrutiny. These will be determined by the Mortality Review Group based on a literature review and knowledge of areas of concern.

The Trust has three levels of scrutiny that may be undertaken following the notification of a death that meets the 'Red flags' for deaths to be reviewed by the Mortality Review Group.

- **Review of Death certification** – undertaken through scrutiny of all available data provided by the Coroner's Office or other sources such as GP, to determine cause of death and if further case record review or investigation is required
- **Case Record Review** – to identify learning through case record review or if investigation is required in line with the *Untoward Incident Reporting and Investigation Policy and Procedure.*
- **Investigation** – through *Untoward Incident Reporting and Investigation Policy and Procedure* as previously outlined

To ensure objectivity, case record reviews and investigations should be conducted wherever possible by clinicians other than those directly involved in the care of the deceased. If the specific clinical expertise required only resides with those who were involved in the care of the deceased the review process should still involve clinicians who were not involved in order to provide challenge and objectivity. The Trust will pilot both the Structured Judgement Review (SJR) methodology and also the PRISM review form to determine whether there were any problems in the care provided to a patient within a particular service.

- Following scrutiny, if further information is provided by other sources such as the Safeguarding Team or the Coroner's Office, the death will be re-opened to scrutiny and appropriate process followed. The Mortality Group will liaise with the coroner if there are concerns identified due to problems in care following the review of care.

Following scrutiny of the deaths by the Mortality Review Group, the Trust will categorise the outcome as either;

- **Expected / unavoidable** (end of life care) - the focus in this category is getting end of life care right and providing patients and their families and carers with a good experience.
- **Unexpected / unavoidable**
- **Unexpected / avoidable** – the focus within this category is to maximise learning from deaths that may be the result of problems in care.

14. Selecting deaths for investigation

Where a review carried out by the trust under the process above identifies patient safety incident(s) that require further investigation, this will be managed in line with the Trust's *Untoward Incident Reporting and Investigation Policy and Procedure*.

15. Reporting

The Mortality Review Group will provide on a quarterly basis, a report to the public session of the **Board of Directors** a report that includes the following data:

- Number of inpatient deaths
- Number of deaths subject to case record review
- Of the deaths subject to review, an estimate of how many deaths were judged more likely than not to have been due to problems in care

This report will be considered by the Quality Committee on a quarterly basis as part of the Serious Incident Report, prior to submission to Board.

This data will be summarised in the Trusts Quality Account from 2018, including evidence of learning and action as a result of this information and an assessment of the impact of actions that the Trust has taken.

The Mortality Technician will provide a monthly report to the Mortality Review Group on the numbers of deaths in the reporting month, broken down by Directorate and Division where required. The report will also contain information on;

- Numbers of deaths reported through Datix
- Numbers of deaths reported through the Spine

- Numbers of causes of death requested that month
- Numbers of causes of death received that month
- Trends in causes of death
- How many Serious Incidents are identified through cause of death information
  (Although this data will be presented monthly it will contain data spanning the duration of the project which means we could receive cause of death for someone from previous months, but we will record the month of death in the data)

16. Staff Training

The Trust will provide for the members of the Mortality Review Group to participate in the training provided nationally following the publication of the *National Guidance on Learning from Deaths*.

17. Involving families/carers

The Trust has a duty to engage meaningfully and compassionately with bereaved families and carers in relation to all stages of responding to and investigating a death in line with the 'Being Open/Duty of Candour' Policy and Procedures.

Guidance on informing, supporting and involving families is also detailed in the *Untoward Incident Reporting and Investigation Policy and Procedure* (Section 5.4)

18. Learning

The Trust will derive learning from the reviews and investigations and will act on this learning within the Trust, and across the wider health community.

Across our services: Incident investigations and case record reviews will generate action plans which are discharged through the operational arm of the Trust and will be monitored to ensure completion of these actions, by the Mortality Review Group.

In addition to individual and team learning, organisational high level lessons will be identified to inform the development of our systems and processes including education and training. There will be reciprocal learning between the Research and Development Department and the Mortality Review Group, particularly around the prevention of self-harm and suicide.

The following internal learning and sharing mechanisms have been identified:

- Feedback intelligence Group (FIG)
- Serious Investigation Group (SIG)
- Mortality Review Group (MRG)
- Quality Committee (QC)
- 'Blue Light Information'
- Practice Matters

Regionally: The Trust will continue to attend Regional Mortality Meetings to share learning.

Nationally: The Trust will continue to share learning in the national virtual workspace known as SLACK. Where a patient safety incident is identified this is reported to the National Reporting System (NRLS) which periodically distributes lessons to be learnt.

The Trust contributes data to the National Enquiry Into Suicide and Homicide and is also part of the enquiries national benchmarking system, the status of which is regularly reported through the Quality Committee.

Coroners: Regulation 28 reports where lessons can be leant to avoid future deaths, will be considered by the Mortality Review Group and will also be integral to the Trusts system to support learning within and across the organisations and local partners

The Trust will seek to compare performance across specialities and divisions but also across health economies regionally and nationally and provide assurance to the Trust Board that the organisation has a robust culture of clinical excellence and processes in place to deliver and act on learning from the review of patient deaths in our care.

Where a case record review identifies a problem in care that meets the definition of a patient safety incident then this should be reported via the National Reporting and Learning systems (NRLS)

The following external reporting mechanisms have been identified:

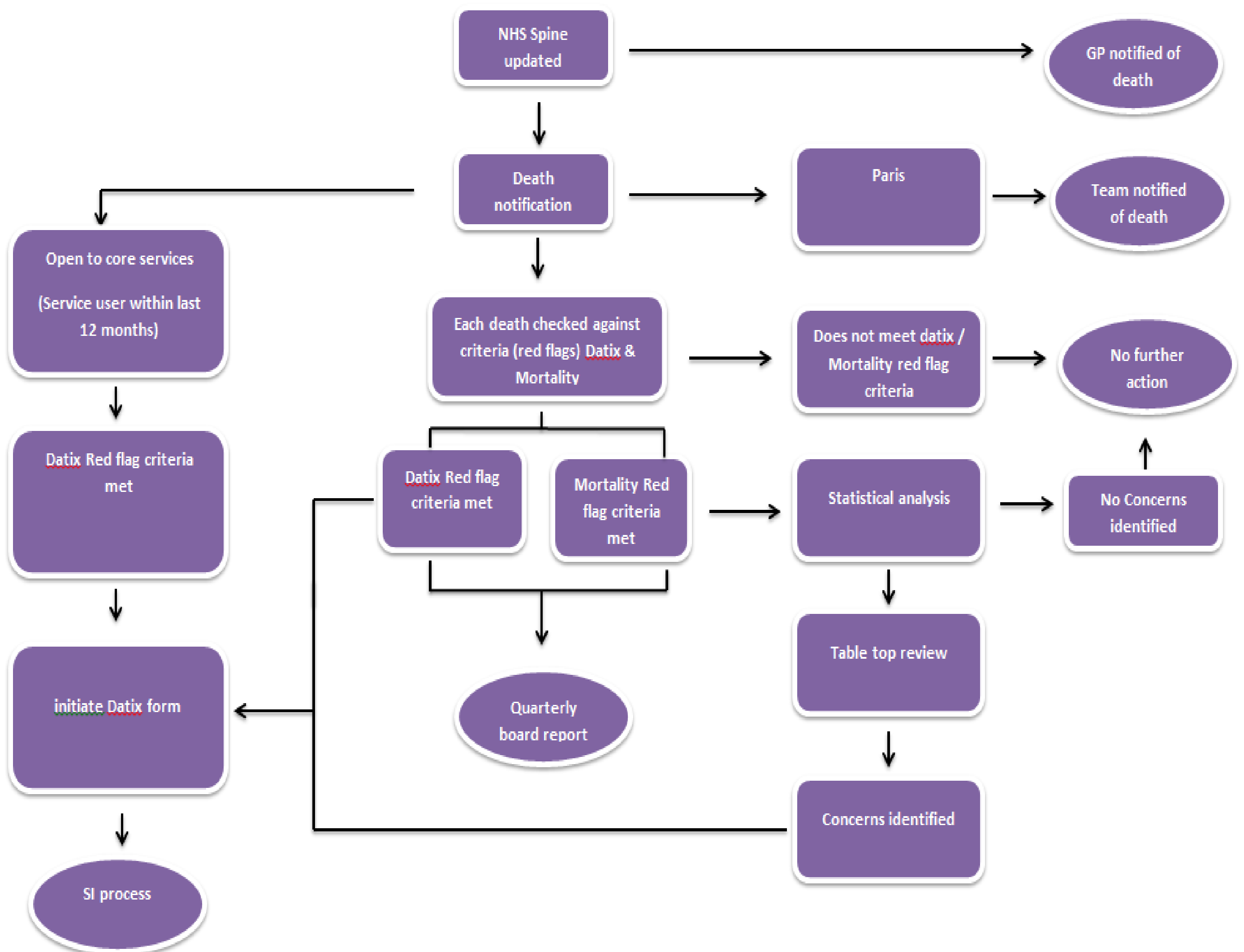
- Care Quality Commission
- National Reporting and Learning System

19. Supporting and involving staff

As a caring organisation we would want to protect our staff from distress and trauma arising from risks associated with the nature of their work. The Trust values its staff and appreciates that it needs to ensure staff have appropriate support following any traumatic or stressful incident.

Please refer to the *Untoward Incident Reporting and Investigation Policy and Procedure* Appendix K: Guidance for supporting staff following traumatic or stressful incidents, for further information

Appendix A: Process



Appendix B: TERMS OF REFERENCE FOR THE MORTALITY GROUP

Introduction:

In line with the CQC's recommendations in its review of how the NHS investigates patient deaths, the National Quality Board published a new national framework for NHS Trusts *National Guidance on Learning from Deaths*[7]. The purpose of the new framework is to introduce a more standardised approach to the way NHS Trusts report, investigate and learn from patient deaths, which should lead to better quality investigations and improved embedded learning.

To meet these requirements, the Trust has implemented a Mortality Review Group (MRG).

Purpose:

The aim of the Mortality Review Group is to:

- Receive an overview of deaths recorded of patients within our care on a monthly basis
- To then determine through the application of a rolling review programme of categories of 'mortality flags' those deaths which require further scrutiny, either through review of death certification; case record review; or investigation in line with *Untoward Incident Reporting and Investigation Procedure*.
- To identify themes and actions resulting from these reviews. There will also be a focus on systems and processes used by our services with cross reference to the recommendations and learning from the Serious Incident Group
- To share overall learning across the Trust

In undertaking this process, the Group will provide estimates of how many of the deaths subject to review were judged more likely than not to have been negatively influenced by aspects of our care.

The Executive Director lead for mortality review is Dr John Sykes, Medical Director. The Non-Executive Director is Dr Anne Wright.

Terms of Reference:-

1. Provide overview and scrutiny of mortality data including analysis with reference to geographical location/team/individual practitioners, diagnosis and cause of death

2. Establish a level of scrutiny for each death based on identified mortality 'red flags' .

3. Ensure reports completed in line with all relevant national guidance on reporting of deaths

4. Members of the Group to be trained in the use of the structured judgement review as a method to scrutinise case records and cascade training as required

[7] National Guidance on Learning from Deaths. National Quality Board. March 2017

5. Determine themes including organisational high level actions and learning

6. Implement appropriate methods for dissemination of learning for the Trust (including training and education), and services across the wider health economy such as independent health care and social care services.

7. Monitor Regulation 28 reports and actions, and any learning from inquests or claims to support learning within and across the Trust and local system partners

8. Review of nationally available data to benchmark against local information.

9. Scrutiny of Public Health data against other regional information in comparator trusts.

Frequency of Meetings

Monthly

Membership

Core Members

Chair: John Sykes
Dept. Chair: Dr Paul Rowlands
Consultant: Dr Arthita Das
Mortality Tech: Aneesa Akhtar
Audit Lead: Rubina Reza
Nurse Consultant: Sam Kelly
Patient Safety: Rachel Williams
Deputy Director of Nursing and Quality Governance: Darryl Thompson
CCG Representation: Phil Sugdan
Investigator Facilitator: Bhavnita Bunawah/ Debbie Scott

Other individuals may be invited to attend the group ad hoc when specialist opinion is required.

REGARDS EIRA: Assessing Equality Relevance (Stage 1)

1. Name of the service / policy / project or proposal (give a brief description):

Learning From deaths Procedure- this procedure outlines the action the Trust will take in response to learning from deaths of patients within their care

2. Answer the questions in the table below to determine equality relevance:

	Yes	No	Insufficient data / info to determine
Does the project / proposal affect service users, employees or the wider community, and potentially have a significant effect in terms of equality?		x	
Is it a major project / proposal, significantly affecting how functions are delivered in terms of equality?		x	
Will the project / proposal have a significant effect on how other organisations operate in terms of equality?		x	
Does the decision/ proposal relate to functions that previous engagement has identified as being important to particular protected groups?		x	
Does or could the decision / proposal affect different protected groups differently?		x	
Does it relate to an area with known inequalities?		x	
Does it relate to an area where equality objectives have been set by our organisation?		x	

3. On a scale of high, medium or low assess the policy in terms of equality relevance.

	Tick below:	Notes:
High		If ticked all 'Yes' or 'Insufficient data'
Medium		If ticked some 'Yes' and / or 'Insufficient data' and some 'No'
Low	x	If ticked all 'No'

EIRA completed by: Rachel Williams
Date: 30/08/2017