Tameside and Glossop Integrated Care NHS Foundation Trust

Learning from Deaths Policy

‘LISTEN – LEARN – ACT TO IMPROVE’

EQUALITY IMPACT
The Trust strives to ensure equality and opportunity for all, both as a major employer and as a provider of health care. This policy has therefore been equality and impact assessed by the Clinical Audit and Effectiveness Group to ensure fairness and consistency for all those covered by it regardless of their individual differences, and the results are shown in Appendix 1.

Version:	1.1 Final
Authorised by:	Service Quality & Operational Governance Group
Date Authorised:	17th August 2017
Next review date:	December 2020
Document author:	Head of Clinical Audit and Effectiveness
Author designation:	Head of Clinical Audit and Effectiveness

VERSION CONTROL SCHEDULE

Version number	Issue Date	Revisions from previous issue	Date of approval by committee
1.0 (Draft)		Aligned to the Learning Candour and Accountability: A review of the way NHS Trusts review and investigate deaths of patients in England December 2016 and the National Guidance on Learning from Deaths – NHS England March 2017	
1.1 (Draft)	Aug 2017	Revised to incorporate Child Death Process	
1.1 (Final)	Aug 2019	Review time added to document, to allow review by MSG and incorporation of any changes to National Learning from Deaths Agenda. Review Date December 2020	

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1 Introduction – purpose

The National Quality Board (NQB) Learning from Deaths framework requires hospital trusts to adopt a standardised and transparent approach to learning from the care provided to patients who die.

The Trust started to complete mortality reviews in November 2014 as part of its Quality Improvement Programme, with a focus on learning from the care provided, as it is recognised that 'Reviews and investigations are only useful for learning purposes if their findings are shared and acted upon' (National Guidance on Learning from Deaths First Edition March 2017).

2 Purpose of this policy

There are three reasons for NHS Trusts to review and investigate a patient's death:

- identifying what care has been provided to **celebrate good practice** or to **ensure learning takes place** to improve and change the way care is provided to others in the future
- Being **Accountable** for our actions if failures are found, developing a culture of learning, transparency and openess
- **Duty of Candour** to share information with the bereaved family/carer
-

This policy is aligned to the National Guidance on Learning from Deaths (First Edition March 2017), the Trust Quality Strategy and the Patient Safety Programme. The policy provides guidance for all staff participating in the Mortality Review Process (Appendix 1) and sets out the parameters for planning, conducting and completing a mortality review.

As a Trust we peer review all in-hospital deaths using an agreed standardised mortality review proforma Adults (Appendix 2) paediatric deaths (Appendix 3).

With an aim of:

- Promoting organisational learning and improvement in quality care delivery from the outcomes of the completed mortality reviews
- Ensuring the delivery of quality of end of life care in accordance with NICE QS13
- Identifying and reducing 'avoidable' deaths across the Trust
- Identifying and minimising avoidable admissions
- Improving the experience of bereaved carer's and relatives by providing opportunities to feedback their experiences and concerns.

3 Scope

The Learning from Deaths Policy applies to deaths where the Trust has been involved in the care of the patient including deaths that have occurred outside of the organisation whereby shared care has been provided, and all patients that die in the hospital.
The scope of the policy may involve serious investigations, complaints, safeguarding concerns and coronial inquests, wherever possible an integrated approach will be adopted.

The Learning from Death Policy has been established by the Trust to provide guidance for those directly involved in the mortality review process, to ensure that as a Trust we learn from any deaths.

4 Mortality Review Process

The mortality review process provides a consistent and structured methodology for the completion of retrospective case reviews following a patient's death, incorporating the PRISM Study an evidence-based methodology (2015) and the Confidential Enquiry into Stillbirths and Deaths in Infancy (CESDI) grading Stratification Tool to support the clinicians in identifying potentially avoidable deaths, and to provide assurance on the delivery of quality of care leading up to the patient's death.

4.1 The mortality review process is applicable to

- All Adult in-hospital deaths in all specialties
- All learning disability deaths – incorporating LeDeR methodology
- Infant or child (under 18) reviews completed in accordance with T&GICFT Policy for the review of unexpected deaths in childhood within the Division of Paediatrics V3
- Perinatal or maternal deaths completed in accordance with Divisional process and reported Nationally to MBRACE
- Severe Mental Health needs
- Reviews of patients who did not die at the Trust but where care-management issues have been identified and for monitoring for example 30 Day Mortality reviews considered being in scope for review.
- Externally generated mortality outlier alerts Diagnosis groups identified in CQC/Imperial College Dr Foster Mortality Outlier Alerts reviewed and reported within the allocated timeframes provided by the Care Quality Commission and the relevant actions monitored by the Trust.
- Complaints received arising from death
- Areas identified for review by the Mortality Steering Group

4.2 End of Life Care - Expected deaths are reviewed by the End of Life Care Facilitator to review the provision and delivery of end of life care in accordance with NICE QS13 Standards

4.3 Bereaved Relatives and Carer's - The Trust bereavement pack incorporates information on the Trusts Mortality Review Process - Learning from Deaths – in that the Trust reviews all deaths as a matter of course. Contact details are provided to support the bereaved carer's and relatives to provide feedback or any concerns to the Trust for action. The pack also directs bereaved carer's and relatives to other support services and organisations that are available external to the Trust. The Trust is monitoring and will incorporate the National Supporting Bereaved Relatives and Carer's Guidance into the Policy once published by NHS England.

4.4 Investigation and Duty of Candour - For cases whereby Duty of Candour is required, information and the purpose of the investigation is provided and the bereaved carer or relative assigned a personal case contact. This will be co-ordinated by the Patient Safety Team in line with the Trusts Being Open (including requirements under duty of candour) Policy. Any investigations in relation to these will be managed in line with the Trust Incident Complaints and Investigation Policy.

4.5 Routine mortality surveillance benchmarked reports and alerts supplied by Dr Foster are reviewed and actioned and the results incorporated into the widely distributed Trust Weekly Performance – Key Performance Indicators Report.

5 Reporting & Learning

The Mortality Steering Group (MSG) has a central role in supporting services to achieve and maintain high standards of care and monitoring to ensure that the outcomes of the mortality reviews and subsequent actions are implemented and embedded.

A summary report will be provided to the Trust Board quarterly and an overall annual report reported in the Annual Quality Account.

The outcomes and the results of the mortality reviews, including the outcomes of MBRACE and CDOP will collectively provide assurance that the Trust is doing all it can to identify and learn from episodes of care where harm has occurred and drive improvements in clinical care and service delivery for future patients by reducing avoidable patient death and harm. Reporting mechanisms are in place to escalate any areas of concern and to widely distribute the themes from the mortality reviews through the Trusts Governance process from Board to Ward, e.g. Mortality News (MNEWS)

6 Roles and responsibilities

The Chief Executive is the accountable officer with overall responsibility for patient safety and quality in the Trust. They shall ensure, via the Medical Director that systems exist within the organisation for the delivery of the Mortality Review Process and compliance of monitoring and learning from mortality findings.

The Medical Director has overall responsibility for the Mortality Review Process and will report the outcomes and findings monthly to the Trust Board.

Named Non-executive director has a key role in ensuring their provider is learning from problems in healthcare identified through reviewing or investigating deaths. Processes are in place and focus on learning, and that the processes can withstand external scrutiny.

Mortality Steering Group The mortality steering group with defined Terms of Reference will receive mortality associated reports and assurance on the mortality review outcomes from specialties and divisions, and monitor the associated actions.

Mortality Clinical Lead will lead the delivery of the mortality review process and provide support and training to clinical colleagues involved in the mortality review process. Link with the Head of Clinical Effectiveness & Audit provide reports to the Mortality Steering Group incorporating review findings, learning points and actions for improvement. Support Clinical Coding Team where issues are identified

The Head of Clinical Effectiveness & Audit has delegated responsibility to support the implementation and further development of the Trust's Mortality Review Process throughout the organisation. They have operational responsibility for the application of the mortality review process, overseeing corporate learning from the mortality reviews and providing assurance reports to the Mortality Steering Group.

Head of Openness and Candour has delegated responsibility to ensure duty of candour requirements are implemented and appropriate investigations are undertaken were harm has been caused or suspected. The outcomes of these investigations will be managed in line with the Trusts investigation processes, and incorporated into the Learning from Deaths Reporting Dashboard and fed into the Mortality Steering Group for wider learning.

Mortality Review Team

- Will aim to review deaths within 14 working days of the death
- Grade the initial review of care management and escalate any concerns identified in line with the Trusts Mortality Review Process

Divisional Management Teams & Governance Leads

- Ensure engagement of the clinical teams in the Trust Mortality Review Process
- Receive mortality associated reports and outcomes from mortality reviews and ensure they are incorporated into the divisional/specialty meetings.
- Ensure the outcomes of the mortality reviews are widely distributed and that learning points are actioned, improvements implemented and monitored.
- Provide assurance of learning to the Mortality Steering Group for incorporation into the board report.

Clinical Staff

- All healthcare professionals should be involved in the mortality review process and, this may range from review and receipt of mortality outcomes such as the themes published bi-monthly in the Mortality News (MNEWS) or participation in the mortality review and the implementation of the actions/recommendations of shared learning.

Trust Information Team

- Generate and produce daily EIS update review
- Support the Head of Clinical Effectiveness and Audit with developing the electronic version of the Mortality Review Proforma
- Support the Head of Clinical Effectiveness and Audit with generating reports from the completed mortality reviews
- Generate mortality lists on request

Clinical Coding Team

- Participation in the mortality review process where coding issues have been identified
- Generating and distributing 30 day mortality patient lists
- Participation in the review of Dr Foster and externally received reviews and reports

Local LeDeR Representative/Learning Disabilities Team

In accordance with LeDeR all deaths of people with learning disabilities will receive a mortality review as part of the Trusts mortality Review Process, following initial triage a joint mortality review will be completed with the learning disability team.
Patients who meet the inclusion criteria for LeDeR following the joint review will be uploaded to the LeDeR reporting site and the local LeDeR representative informed.

Learning Disability Team

- Identify in collaboration with the Head of Clinical Effectiveness and Audit deaths of patients with a learning disability.
- Complete a joint mortality review of this patient group with the Trust mortality review team
- in collaboration with the Head of Clinical Effectiveness and Audit ensure good practice and learning from the outcomes of the mortality reviews are shared across organisations, and the Local LeDeR representative

Local LeDeR Representative

- Local LeDeR representative will have responsibility of co-ordinating investigations
- Member of the Mortality Steering Group providing feedback and outcomes of completed case reviews and LeDeR updates

7 Training

All staff completing mortality reviews at Trust level will receive training from the clinical effectiveness nurses and the Mortality Clinical Lead. The Trust will participate in the National training for the standardised judgement review process for mortality reviews delivered by the Royal College of Physicians.

8 Consultation, Dissemination and Implementation and review

The Learning from Deaths Policy has been widely distributed throughout the Integrated Trust teams, through the Divisional Quality and Safety Boards, Trust Mortality Steering Group, Local LeDeR Representative, Learning Disabilities Team, Service Quality and Operational Group, Quality Board. The completed document was ratified by the Service Quality and Operational Group, prior to uploading to the Trust Intranet Documents section. Awareness training will be delivered to the divisional governance forums, at point of care training to medical teams and nursing teams, awareness of the process provided to the Junior Doctors at their induction. The publication will be promoted through the Trust Team Brief and other communication channels.

9 Policy Review

The policy will be reviewed by the Mortality Steering Group every two years, or following receipt of changes to National Policy or Processes from NHS England - National Quality Board, CQC – RCP etc.
Implementation of the Policy will be monitored by reviewing the process and outcomes by the Mortality Steering Group, and assurance reports generated for the Trust Board providing information on deaths of both adults and children (under 18).

The Quarterly Board Report will provide information on:

- Number of deaths in the Trusts care
- Number of deaths subject to case review
- All Learning Disability Deaths in Trust Care
- Number of deaths investigated under the Serious Incident Framework
- Number of deaths reviewed/investigated and identified with problems in care
- Themes and issues identified from review and investigation (including examples of good practice)
- Actions taken – planned and impact of actions taken.

The Trust will report annually in the Quality Account providing a detailed narrative account on the learning from reviews/investigations and the actions taken in the preceding year, including an assessment of their impact and actions planned for the next year.

10 References:

National Quality Board. 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. March 2017

CQC Learning, Candour and accountability: A review of the way NHS Trusts review and investigate the deaths of patients in England. December 2016

T&GICFT Incident Reporting, and Incident and Complaint Investigation Policy April 2016. http://tis/documents/IncidentReportingInvestigationPolicy.pdf

T&GICFT Being Open Policy (including requirements under duty of candour) V6 July 2016 http://tis/documents/BeingOpenPolicy.pdf

T&GICFT Policy for the review of unexpected deaths in childhood with the Division of Paediatrics V3 2017 http://tis/documents/UNEXPECTEDDEATHINCHILDHOOD.pdf

11 Bibliography

MAZAR Report - Independent review of deaths of people with a Learning Disability or Mental Health problem in contact with Southern Health NHS Foundation Trust April 2011- March 2015. December 2015

Healthcare Commission, Investigation into Mid Staffordshire NHS Foundation Trust. March 2009

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

NHSI, Implementing the Learning from Deaths framework: key requirements for trust boards July 2017

12 Evidence based studies incorporated into the Mortality Review Process

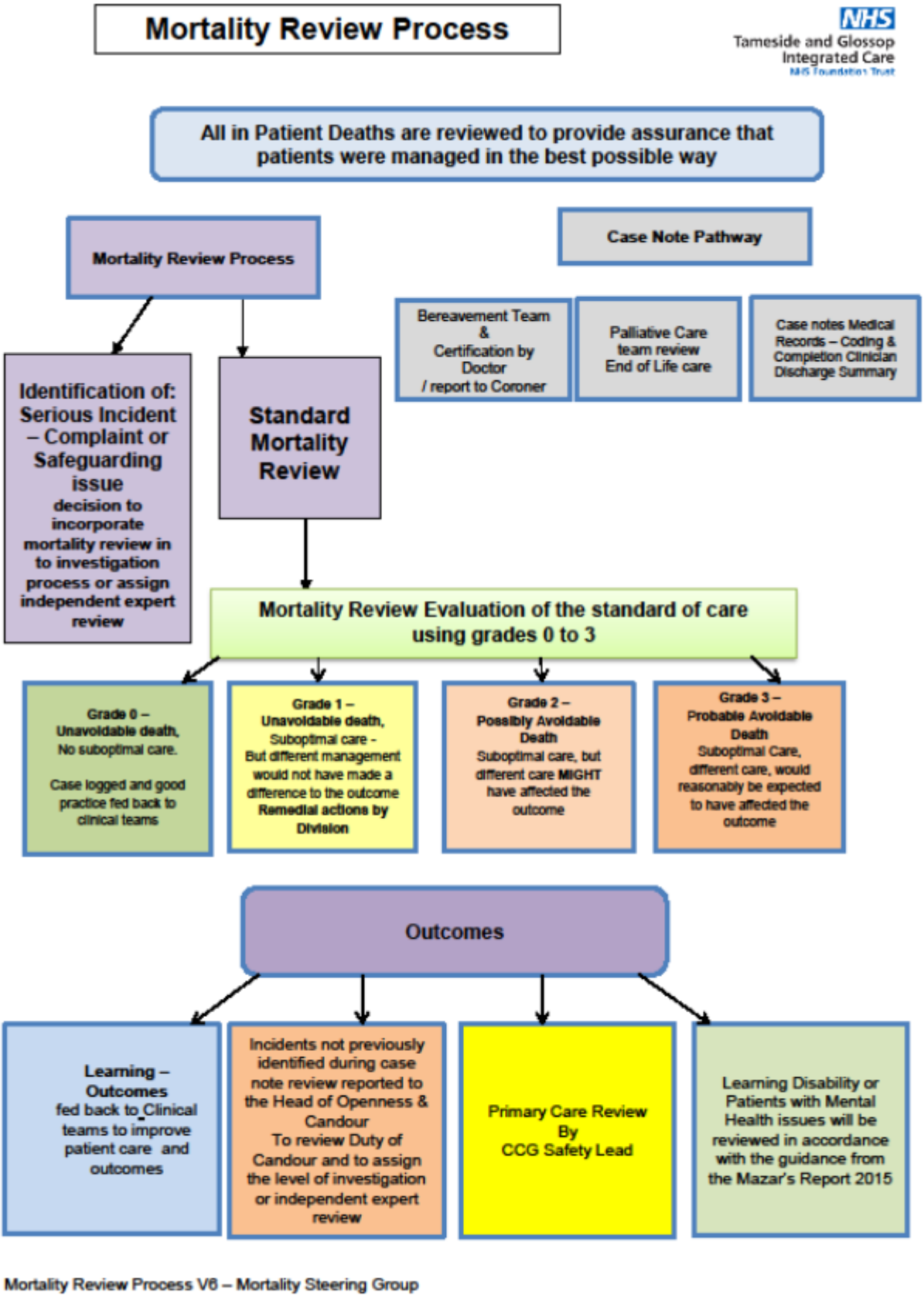
PRISM 2 - Avoidability of hospital deaths and association with hospital-wide mortality ratios: retrospective case record review and regression analysis
BMJ 2015; 351 doi: https://doi.org/10.1136/bmj.h3239 (Published 14 July 2015)
Cite this as: BMJ 2015;351:h3239

PRISM2 Study Avoidability of hospital deaths and association with hospital-wide mortality ratios: retrospective case record review and regression analysis
http://www.bmj.com/content/351/bmj.h3239

Horgan H, Healey F, Neale G, et.al. Preventable deaths due to problems in care in English acute hospitals: a retrospective case record review study. BMJ Quality and Safety (2012)

Confidential Enquiry into Stillbirths and Deaths in Infancy (CESDI) Risk Stratification Tool
http://www.pi.nhs.uk/rpnm/CE_SB_Final.pdf

13 APPENDIX 1 – MORTALITY REVIEW PROCESS



14 APPENDIX 2 TRUST MORTALITY REVIEW PROFORMA

Mortality Review Proforma V6

NHS
Tameside and Glossop
Integrated Care
NHS Foundation Trust

1.	Name	
2.	NHS Number	
3.	Date of Birth	
4.	Age	
5.	Date of Death	
6.	Discharge Ward	
7.	Is this patient's care subject to a Serious Incident/SI Review/Complaint of Safeguarding Case? If so discuss with Head of Openness and Candour prior to completing the review	
8.	Which Division was the patient under the care of	
9.	Were there unnecessary/ inappropriate transfers between wards? If yes, please detail	
10.	Date of Standard Mortality Review	
11.	Reviewer	
12.	Admission Source (Nursing/ care home or own home)	
13.	Nursing Care Home Name	
14.	Type of Admission (Emergency/Elective)	
15.	Could this admission have been avoided with better care planning? If yes, please detail	
16.	Did the patient have a Learning Disability or Mental Health Condition? – requires review in accordance with Mazar's Report.	
17.	Admitting Presentation/ Diagnosis	
18.	Diagnosis on Discharge Letter	
19.	Main Condition Treated	
20.	Cause of Death	

21.	**Did any of the following cause harm:**		Incident Number
22.	Did a procedural complication cause harm? If yes, include in case summary		
23.	Is there evidence of harm from anaesthesia? If yes, include in case summary		
24.	Did an inpatient fall cause harm? If yes, include in case summary		
25.	Did a hospital acquired pressure ulcer occur or worsen? If yes, include in case summary		
26.	Did a medication error cause harm? If yes, include in case summary		
27.	Was there a health care acquired infection (HCAI)? If yes, include in case summary, eg HAP, C-Diff etc		
28.	Did the admission result from harm before hospitalisation? If yes, please detail		
29.	Did patient go to theatre or endoscopy?		
30.	Delays in diagnosis, investigations, delivery of care or treatment? If yes, please detail		
31.	Poor Communication between members of the MDT (including medical, nursing staff and AHPs) If yes, please detail		
32.	Lack of regular review by a suitable doctor? If yes, please detail		
33.	Lack of regular reviews by nursing staff? If yes, please detail		
34.	Failure to escalate care or respond to NEWS? If yes, please detail		
35.	Observations completed according to NEWS – minimum 12 hours? If no, please detail		
36.	Was there involvement from MacMillan/ Marie Curie/ Palliative team? If yes, please detail		
37.	Is there a DNACPR decision documented & correctly completed form filed in the Alerts section of the medical notes?		
38.	Is there documented evidence of discussion of DNARCPR with patient/ relatives?		
39.	Is there a documented decision for End of Life Care? If yes was an Individualised End of Life Care Plan completed?		
40.	Poor medical or nursing documentation? If yes, please detail.		

41.	Missing Documentation If yes, please list missing documentation	
42.	Good Practice Identified? If yes, please detail	
43.	Were any of the following care bundles in use for this admission:	Aspiration Pneumonia (AP) Asthma Central venous catheter (CVC) insertion Chronic Obstructive Pulmonary Disease (COPD) Community Acquired Pneumonia Fractured Neck of Femur Heart Failure Hospital Acquired Pneumonia (HAP) Non-invasive ventilation Sepsis Stroke
44.	Standard Mortality Review Case summary	
45.	Initial Mortality Review CEDI Mortality Classification banding (Above 0 requires further review by Mortality Team or report to Head of Duty of Candour)	
46.	Further review requested? If yes, please provide reasons	
47.	Mortality Team Further Review summary	
48.	Mortality Team Completing further review	
49.	Mortality Team final CEDI Mortality Classification banding	
50.	Additional Comments	
51.	Incident Form Completed - details	
52.	Handed over to Head of Openness & Candour / Date	

Mortality Review Proforma V6

NHS Tameside and Glossop Integrated Care NHS Foundation Trust

Evaluation of the standard of care - CEDI Mortality Classification bandings

CEDI Grade	Avoidable Death?	Care Provision	Yes/No
Grade 0	Unavoidable death	No suboptimal care	
Grade 1	Unavoidable death	Suboptimal care, but different management would not have made a difference to the outcome	
Grade 2	Possibly avoidable death	Suboptimal Care, different care **MIGHT** have affected the outcome	
Grade 3	Probable avoidable death	Suboptimal Care, different care, **WOULD** reasonably be expected to have affected the outcome	

15 APPENDIX 3 UNEXPECTED DEATH IN CHILDHOOD REVIEW PROFORMA

NHS
Tameside and Glossop
Integrated Care
NHS Foundation Trust

Unexpected Death in Childhood Review

Name of Patient **DOB** **NHS number**

Date of death **Time of death**

Cause of Death (as noted on death certificate)
1a
1b
2

Date of review

Reviewers present

Summary of case

Background

In-patient management

Observations

- **Frequency**
- **PEWS**
- **Monitoring**

Medications

Identified drug errors **Yes/No**
Post mortem findings

Identified Issues with care

- **Clinical Management**
- **Resuscitation**
- **Communication (parents, other specialties)**

Unexpected death in childhood review Proforma – Policy for the review of unexpected deaths in childhood within the Division of Paediatrics V3 2017 – Latest Version Trust Intranet

- **Documentation**

Areas of Good Practice

Actions to address Issues identified

Escalation to Red incident investigation	**Yes/No**
Safeguarding Concerns	**Yes/No**
Coroners Inquest	**Yes/No**

Parental Consultation/Bereavement Support

16 APPENDIX 4 MORTALITY ASSOCIATED DEFINITIONS

Mortality – for the purpose of this document, mortality relates to any in-hospital death, or any death occurring within 30 days of discharge selected for review e.g. Stroke, Endoscopy and patients discharged to the local hospice

Case Record Review – A structured review of case records carried out by clinicians to determine whether there were any problems in the care provided to a patient and to identify good practice. Case record review is undertaken routinely in the absence of any particular concerns about care, to learn and improve.

Investigation – A systematic analysis of what happened, how it happened and why, with an aim of identifying what might need to change to reduce the risk of similar events in the future, investigation can be triggered following a mortality review or may be initiated without a mortality review happening first.

Death due to a problem in care – A death that has been clinically assessed and the reviewers feel the death is more likely than not to have resulted in problems in care delivery/service provision. (Not the 'cause of death' or 'avoidable mortality').

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.

MSG – Mortality Steering Group – Multi-disciplinary meeting chaired by Medical Director as executive lead – receiving assurance on the mortality review process and learning, receipt of mortality associated reports, and benchmarking mortality data

Avoidable/Preventable/Amenable Deaths – terms used interchangeably in the NHS

- **Amenable** death is amenable (treatable) deaths from that cause (subject to age limits if appropriate) could be avoided through good quality healthcare
- **Avoidable deaths** Avoidable mortality, which is based on the concept that premature deaths from certain conditions should be rare, and ideally should not occur in the presence of timely and effective health care, is used as an indicator to measure this contribution
- A death is **Preventable** if, in the light of understanding of the determinants of health at time of death, all or most deaths from that cause (subject to age limits if appropriate) could be avoided by public health interventions in the broadest sense

CESDI Stratification Tool - Confidential Enquiry into Stillbirths and Deaths in Infancy (CESDI) Stratification Tool used to evaluate and grade the outcomes of the mortality reviews assisting in the identification of Amenable/Avoidable Deaths.

Crude Mortality – total number of deaths as a percentage of the total number of hospital spells

HSMR – The Hospital Standardised Mortality Ratio (HSMR) is an indicator of healthcare quality that measures whether the mortality rate at a hospital is higher or lower than you would expect

SHMI - The Summary Hospital-level Mortality Indicator (SHMI) is an indicator which reports on mortality at trust level across the NHS in England using a standard and transparent methodology.

Dr Foster Intelligence is a provider of healthcare information in the United Kingdom, monitoring the performance of the National Health Service and providing information to the public.

CUSUM Alerts - The Dr Foster Intelligence HSMR CUSUM chart provides an early warning system for changing mortality rates. CUSUM = statistical quality control or cumulative sum control chart

RCP – Royal College of Physicians

CDOP – Child death overview panel

MBRACE - Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK

17 APPENDIX 5 EQUALITY IMPACT ASSESSMENT

Analysis of Effects Assessment (AoE) Part 1: Initial screening template

Title of Policy /Procedure / Project / Strategy / Service to be assessed: Learning From Deaths Policy

Short description of Policy / Procedure / Project / Strategy / Service (aims, objectives and purpose) The National Quality Board (NQB) Learning from Deaths framework requires hospital trusts to adopt a standardised and transparent approach to learning from the care provided to patients who die. As part of this process the Trust is required to publish a Learning from Deaths Policy. This policy is aligned to the National Guidance on Learning from Deaths (First Edition March 2017), the Trust Quality Strategy and the Patient Safety Programme. The policy provides guidance for all clinical staff participating in the Mortality Review Process, and the process for involving bereaved relatives and carer's in the mortality review process. **Date of assessment:** 21st August 2017 **Person responsible for assessment:** Head of Clinical Effectiveness & Audit

Is this a proposed new policy/proposal? **YES** **Is this a review of an existing policy/proposal?** **NO**

1. Who is responsible for the policy/proposal?	Mortality Steering Group
2. Who are the main stakeholders in relation to the policy/proposal?	All persons identified in Section 6 of the Policy Roles and Responsibilities

3. What outcomes are expected / desired from this policy/proposal?	National and Trust Requirement The Policy is designed to promote equality

4. The following section requires you to assess the likely negative impact and positive impact of your policy/proposal on the nine Protected Characteristics as defined by the Equality ACT as follows. Please support any answers with evidence.

Protected Characteristics	**Answers to:** **What likely adverse impact will this Policy / Service have on the public or staff, giving particular regard to potential impacts negative and positive in relation to:**	**Evidence:** ***(What is your evidence for this answer? Consider; both quantitative and qualitative existing data.)***
a. Race	None	The Learning from Deaths Policy is applicable to all deaths identified in the scope of this policy
b. Disability	None	The Learning from Deaths Policy is applicable to all deaths identified in the scope of this policy
c. Sex	None	The Learning from Deaths Policy is applicable to all deaths identified in the scope of this policy
d. Religion and belief	None	The Learning from Deaths Policy is applicable to all deaths identified in the scope of this policy

e. Sexual orientation	None	The Learning from Deaths Policy is applicable to all deaths identified in the scope of this policy
f. Age	None	The Learning from Deaths Policy is applicable to all deaths identified in the scope of this policy
g. Carers	None	The Learning from Deaths Policy is applicable to all deaths identified in the scope of this policy, incorporating the involvement of carers
h. Gender Reassignment	None	The Learning from Deaths Policy is applicable to all deaths identified in the scope of this policy
i. Marriage & Civil Partnership	None	The Learning from Deaths Policy is applicable to all deaths identified in the scope of this policy
j. Pregnancy & Maternity	None	The Learning from Deaths Policy is applicable to all deaths identified in the scope of this policy
K. Human Rights	None	The Learning from Deaths Policy is applicable to all deaths identified in the scope of this policy
5. Is there any further evidence / data that you would consider relevant or necessary in order to answer the above question? If so, please detail. *	No	

6. Are any of the above impacts (detailed in 4a – K) justifiable, valid or legal? Please explain?	**N/A**
7. Is this policy/proposal missing a valid opportunity to promote equality of opportunity for one or more of the groups (see 4a) concerned? Please expand.	**No**
8. Does this policy/ proposal promote the Trusts Values and Behaviours (see below) for all of the protected characteristics:	**Yes**
8a. Respect: Does your policy promote treating everyone with dignity and respect at all times?	Yes
8b. Learning: Does your policy promote and encourage learning?	Yes
8c. Care: Does your policy offer support and understanding and promote understanding of privacy and confidentiality?	Yes

8d. Communication: Does your policy encourage listening and welcome feedback (engagement)?	Yes
8e. Safety: Does your policy outline responsibilities and improve quality for all.	Yes

9. Based on the above, do you consider that this policy/proposal now requires a full impact assessment?	**NO**	
If NO, no further assessment is required. Ensure that findings are published as 'Part 1 Analysis of Effects'. **If YES, complete question 9 and proceed to full impact assessment and action plan**		
10. Who will be responsible for carrying out the full Analysis of effects: part 2?	**N/A**	

Responsible Manager for Policy/proposal Head of Clinical Effectiveness & Audit

Date: 21st August 2017

Ratified: Service Quality & Operational Governance Group August 2017

Hyperlinks to: **Analysis of Effects Assessment Guidelines**