EQUALITY IMPACT ASSESSMENT

Care Group / Corporate Service:	**Service:** ☐
Trustwide	**Policy:** √
Name of Service/Title of Policy or Strategy, Name of Event:	**Event:** ☐
Learning From Deaths Policy the right thing to do	**Strategy:** ☐
Equality Impact Assessment Undertaken by:	**Date undertaken:**
Sharon Greensill Trust Lead for Mortality, Inquests and Suicide Prevention	24/02/22

Questions

1. **What are the main aims and purposes of the Policy / Service / Event or Strategy?**

This policy sets out how the Trust has responded to, and will continue to respond to, the challenge of learning from patient deaths.

The core objectives of this policy are that:

- The Trust prioritises and enables meaningful engagement and compassionate support between families/carers and staff and compassionate support for families/carers that is open and transparent at all stages of the process. Families and carers should be encouraged to raise questions or share concerns about the care provided during all stages of the management of deaths process from notification of death, during the review process, and finally in seeing the lessons learned and actions taken.
- The Trust identifies positive practice as well as what can be improved upon in terms of service provision both to improve patient care and ultimately to reduce the probability of an avoidable death.
- The Trust maintains a standardised approach to logging, screening, reviewing, investigating and learning from deaths (LoSRIL) within the Trust and that the Trust receives robust assurance regarding this.
- Maintains the focus on engagement with partners across the local care system to:

    O Encourage “systems for learning’ with other stakeholders (eg acute Trusts, clinical commissioning groups, public health, safeguarding)

    o Agree joint reviews where appropriate with other Health and Social Care providers. This would include liaison with other organisations at the relevant Care Group Triumvirate level or Executive Director level to ensure that there was clarity regarding the lead responsibility for a serious incident investigation notification and where appropriate agreeing terms of reference.

    o Promote access to and sharing of broader data/information including clinical case reviews from other providers, information systems, epidemiological

information and the sharing of expertise within the law and in line with extant guidance

2. **Who is involved in delivering the service, implementing the policy or strategy / organising the event? (i.e., partnerships, stakeholders or agencies)**

Mortality Governance is a priority for Trust Boards and the March 2017 Learning from Deaths Framework places great emphasis on the importance of Board Leadership to ensure that learning from patient deaths becomes embedded in the organisation. Trust Boards are accountable for ensuring compliance with extant guidance which includes the National Guidance on Learning from Deaths, alongside NHS England's Serious Incident Framework 2015 and working towards achieving the highest standards in mortality governance. They are also responsible for ensuring quality improvement remains key by championing and supporting learning that leads to meaningful and effective actions to improve patient safety and experience, and which supports cultural change.

The Executive Medical Director is the Executive Lead for learning from deaths. The Trust also has a Trust Lead responsible for Mortality who works for the Executive Medical Director. Additionally a Non-Executive Director is nominated to take responsibility for oversight of progress and act as a critical friend holding the organisation to account for its approach in learning from deaths.

Both the Executive and Non-Executive Director leads and the Trust Lead for Mortality will have the capability and capacity to understand the issues affecting mortality in this Trust. They will challenge where necessary, to ensure high standards in mortality governance are maintained and that the care provided to patients who die is integral to the Trust's governance and quality improvement work.

In addition to the above, all of the **Non–Executive Directors** are responsible for:

- Ensuring that the processes in place focus on learning and can withstand external scrutiny, by providing challenge and support.
- Holding the organisation to account for its approach and attitude to patient safety and that there is evident learning from all deaths.

The Mortality Surveillance Group reviews data in relation to Trust deaths including all expected and unexpected deaths, homicides of patients currently in Trust care (and in addition within a 6 month period of discharge following mental health or learning disability care) service in line with the 'Learning from Deaths' Policy.

The Trust Mortality Lead/ Executive Medical Director will engage with relevant external regional and national bodies contributing to the management and improvement of quality learning in relation to mortality management and bring in relevant knowledge and skills into the organisation both to contribute to organisation learning and to cascade the Care Group Triumvirates and the Care Group Governance meetings.

3. **What information / data or experience can you draw on to provide an indication of the potential inclusive / exclusive results of delivering this service or event / implementing the policy or strategy to different groups of people and the different needs of people with protected characteristics in relation to this policy / service / event or strategy?**

Whilst the policy does not specifically reference protected characteristics it is relevant “to the death of **any patient** in receipt of services from the Trust”. The policy clarifies those deaths that are ‘out of scope; unless any care concerns are identified.

All ‘in scope deaths’ are reported into the Ulysses Mortality system and are reviewed by the Mortality Operational Group who will identify if the report can be closed, whether a Structured Judgment review is required or whether the death needs to be escalated to the Patient Safety team to consider if a Serious Incident Investigation is required.

The policy identifies deaths that may have ‘red flag ‘ categories and some of these will lead to an automatic SJR e.g a death of a person with a Learning Disability. In the case of a death of a patient with a Learning Disability a report also has to be made to the Learning Disabilities Mortality Review (LeDeR) Programme.

Reference is noted to “Any death which meets the following criteria is also reportable to the Coroner and will be actioned by the RDaSH Coroners Liaison Service: The policy clarifies the categories of deaths that are reportable to the HM Coroner.

Protected Characteristics	Positive Impact	Negative Impact	Reasons for Impact
Age	√	☐	The referenced Trust “Duty of Candour policy” notes that the reporting of all Serious Incidents and communication with families/carers is irrespective of age. Also refer to section 3.
Disability	√	☐	The referenced Trust “Duty of Candour policy” notes that vulnerable patients/ service users with disability are protected through the reporting, investigation and communicating with their carers or families. Also refer to section 3.
Gender reassignment	√	☐	This policy is relevant “to the death of **any patient** in receipt of services from the Trust and is therefore gender neutral and does not discriminate. Also refer to section 3.
Marriage and civil partnership	√	☐	This policy does not discriminate on anyone based on their relationship or personal choices. Also refer to section 3.
Pregnancy and maternity	√	☐	This policy does not discriminate on anyone on their maternal/paternal circumstances.

Protected Characteristics	Positive Impact	Negative Impact	Reasons for Impact
			Also refer to section 3.
Race	√	☐	This policy does not discriminate on anyone based on their race, colour, culture or life styles Also refer to section 3.
Religion or belief	√	☐	This policy does not discriminate on anyone based on their faith, belief system or life style Also refer to section 3.
Sex	√	☐	This policy does not discriminate on the basis of gender, lifestyle or personal orientation Also refer to section 3.
Sexual Orientation	√	☐	This policy does not discriminate on anyone based on their sexual orientation or life styles. Also refer to section 3.
Disadvantaged groups	√	☐	This policy does not discriminate on anyone based on their personal circumstance, background, life styles or situation. Also refer to section 3.

4. **What positive impacts are there for this policy / service / event or strategy to better meet the needs of people with protected characteristics?**

All cases of reported deaths will be logged, reviewed by the Mortality Operational Group and closed or a Structured Judgment Review/Serious Incident Investigation will be undertaken where required. Lessons learnt will be shared to enable improvements to be made to care and service delivery.

Section 5.4.3 refers to the **Duty of Candour (Being Open and Duty of Candour Policy)** which states that when a death is considered an incident, it is crucial that communication with family and/or carers is sensitive, empathetic and open.

The **Learning from Deaths Policy notes at Section 5.6 "A patient's right to confidentiality following death"** that "during conversations with bereaved families/carers there will be occasions when they ask very specific questions in relation to the care and treatment their relative was receiving. Whilst in most cases this will not pose an issue, there may be circumstances where we hold sensitive information that the patient may not have wished to be shared, or where sharing of information could negatively impact on the emotional wellbeing of the family member/carer to whom it is being disclosed. In answering such questions staff need to be mindful of the fact that current extant guidance is that confidentiality obligations owed by health professionals continue even after death.

Additionally the Department of Health, General Medical Council and other clinical professional bodies have long accepted that the duty of confidentiality continues beyond death and this is reflected in their extant guidance".

5. **What action would be needed to ensure the policy / service / event or strategy overcomes:**
   - Discriminatory negative impacts
   - Exclusion

Failure to meet the needs of people from across the protected characteristics and opportunities for promoting equality and inclusion are maximised.

Duty of Candour will be triggered when the harm threshold is reached and the death is considered an incident. The Duty of Candour policy will guide the reporter through the process. Continuous monitoring will be undertaken through the quality checking of all reviews and investigation reports for robustness, effective implementation and timely delivering of learning . This is monitored through a corporate function

6. **Recommended steps to avoid discrimination and ensure opportunities for promoting equality and inclusion are maximised. Include:**

Options for action	Explanation if no further action is required	Lead responsible for overseeing actions	Timescales	Costs (where applicable)
The "Learning From Deaths" process will maintain its inclusive approach "to the death of **any patient** in receipt of services from the Trust".	On-going as required.	Executive Medical Director Trust Lead for Mortality, Inquests' and Suicide Prevention.	On-going as required.	
Monitoring process for Serious Incident investigation reports and related complaints or claims.	On-going as required. Refer to Incident Management Policy.	Trust Patient Safety Lead	On-going as required.	

7. **Monitoring and reporting arrangements of EIA, for policies and strategies refer to section 7 of the Procedural Documents (Development and Management) Policy.**

For services / events please include the following:

Refer to all prior information for relevance to the Learning from Deaths Policy.

- How the equality impact of the service will be monitored

- Frequency of monitoring
- How the monitoring results will be used and where they will be published;
- Who will be responsible for reviewing monitoring results and initiating further action where required
- Any changes that have been made to remove or reduce any negative impacts as a result of conducting the equality impact assessment?
- Any action points should be included in Care Group / Corporate action plans, with monitoring and review processes.

Is further work / consultation required? If yes, please explain how this is to be carried out and the time frame for completion.

Yes √ No ☐

The Equality Impact Assessment will be reviewed in line with changes to services, client or staff groups, legislation or policy review.

Name:	
Sharon Greensill	
Designation:	
Trust Lead for Mortality, Inquests and Suicide Prevention	
Signature:	**Date:**
	24 February 2022