Wirral Community Health and Care NHS Foundation Trust

Learning from Deaths Policy
GP58

TRUST WIDE HEALTH AND CARE POLICY

Document detail	
Policy Number	GP58
Version	Version 3
Approved by	Quality and Safety Committee
Effective from	October 2021
Date of last review	September 2021
Date of next review	September 2024
Lead Director	Medical Director
Responsible Lead	Deputy Chief Nurse
Superseded documents	Learning from Patient Deaths Policy 2020
Document summary	Reporting and learning from deaths standards

Document		
Version number	Comments	Approved by
1.	New September 2017	Quality and Safety Committee
2.	Revised for new Trust name – June 2019	No material changes made

Policy on a Page

The purpose of the Learning from Deaths Policy is to describe the process by which the deaths of people in our care, when no natural cause of death had been identified are reported, reviewed, and investigated. This policy supports the Trust to promote a just and open culture to continually improve safety systems and the delivery of safer care.

NHS England and the Trust have key reasons why we need to report, review, and investigate a death:

- Identifying care that has been provided to celebrate good practice or to highlight learning that needs to take place to improve and change the way care is provided to other people in the future
- Wirral Community Health and Social Care Services are required to report deaths that occur for people in receipt of care from Trust's services - where there is no natural cause of death
- This includes deaths that involve the police, coroner, and safeguarding concerns.
- All deaths will be reviewed that occur in the Community Integrated Care Centre
- Being open continually promotes our culture of learning and transparency
- Information sharing which is meaningful, caring, and compassionate for bereaved families and carers is in line with our Duty of Candour Standards. We need to keep families or carers updated and involved in investigations at a level they feel comfortable with, this enables their involvement, and provides opportunities to ask questions and raise queries
- We need to learn from deaths of people living with a learning disability, and these deaths are nationally reportable (LeDeR Programme Review 2019/2020). At times people living with a learning disability may die prematurely, as they may have had unidentified or unsupported health and care needs
- The Trust has a Mortality Review Group, which analyses key themes and reports into the Trust's Quality and Safety Committee and subsequently to Public Board. We also work with health and care partners to improve our care systems
- All reported deaths are notified automatically to senior managers for immediate review, and to support teams as required, depending on the nature of the reported death
- The Trust has a weekly Safety Huddle and Clinical Risk Management Group (CRMG) which review reported deaths in a timely manner to support teams when there are gaps in safety systems, as staff need to be provided with strong safety systems to do the right thing at the right time

Reporting Deaths Datix Pathway is on StaffZone to support you with any queries

SUPPORTING STATEMENTS

This document should be read in conjunction with the following statements:

SAFEGUARDING IS EVERYBODY'S BUSINESS

All Wirral Community Health & Care NHS Foundation Trust employees have a statutory duty to safeguard and promote the welfare of children and adults, including:

- being alert to the possibility of child/adult abuse and neglect through their observation of abuse, or by professional judgement made as a result of information gathered about the child/adult;
- knowing how to deal with a disclosure or allegation of child/adult abuse;
- undertaking training as appropriate for their role and keeping themselves updated;
- being aware of and following the local policies and procedures they need to follow if they have a child/adult concern';
- ensuring appropriate advice and support is accessed either from managers, *Safeguarding Ambassadors* or the trust's safeguarding team;
- participating in multi-agency working to safeguard the child or adult (if appropriate to your role; ensuring contemporaneous records are always kept and record keeping is in strict adherence to Wirral Community Health & Care NHS Foundation Trust policy and procedures and professional guidelines. Roles, responsibilities and accountabilities, will differ depending on the post you hold within the organisation;
- ensuring that all staff and their managers discuss and record any safeguarding issues that arise at each supervision session.

EQUALITY AND HUMAN RIGHTS

Wirral Community Health & Care NHS Foundation Trust recognizes that some sections of society experience prejudice and discrimination. The Equality Act 2010 specifically recognises the protected characteristics of age, disability, gender, reassignment, pregnancy and maternity, race, religion or belief, sex and sexual orientation. The Equality Act also requires public authorities to have due regard to the need to eliminate unlawful discrimination against someone because of their marriage or civil partnership.

The trust is committed to equality of opportunity and anti-discriminatory practice both in the provision of services and in our role as a major employer. The trust believes that all people have the right to be treated with dignity and respect and is committed to the elimination of unfair and unlawful discriminatory practices.

Wirral Community Health & Care NHS Foundation Trust also is aware of its legal duties under the Human Rights Act 1998. Section 6 of the Human Rights Act requires all public authorities to uphold and promote Human Rights in everything they do. It is unlawful for a public authority to perform any act which contravenes the Human Rights Act.

Wirral Community Health & Care NHS Foundation Trust is committed to carrying out its functions and service delivery in line with a Human Rights based approach and the FREDA principles of **F**airness, **R**espect, **E**quality **D**ignity and **A**utonomy.

Contents Page

Learning from Deaths Policy

1. PURPOSE AND RATIONALE

1.1 The purpose of the Learning from Deaths Policy is to describe the process by which the deaths of people in our care, where no natural cause of death had been identified, are reported, recorded, reviewed, and investigated. This clinical governance process provides a consistent framework to improve the quality of the care we provide to patients, and people who need our health and care services and their families.

1.2 Nationally, there are concerns about mortality, their reviews and learning from such serious incidents. This policy will allow us to establish if the care that has been provided, contributed in any way to an adverse outcome and how we can learn from such incidents to prevent a recurrence for patients and people who need our services.

1.3 The principles within the policy outlines the need for Trust services to engage meaningfully and compassionately with bereaved families and carers.

1.4 The policy promotes the psychological safety of staff following reported deaths as all staff are offered a de-briefing meeting with their line manager. Additional support is provided, as needed, for each team in proportion to the nature of the incident.

2. SCOPE OF THIS POLICY

2.1 Deaths, where no natural cause of death has been identified will be reviewed as outlined in the scope of this policy:

Reported deaths for those patients who have had contact with community health and care services in the last 30 days and where the Trust is the main care provider. This includes:

- Deaths that involve the police, coroner, and safeguarding concerns
- Deaths of people with a learning disability, need to be reported on Datix and will be reviewed and are nationally reportable (NHS LeDeR Policy 2021)
- All deaths in-patient beds that occur in the Community Intermediate Care Centre will be investigated
- Deaths which have occurred, and associated with staff concerns as part of the Trust's open and transparent culture
- Deaths where concerns or complaints are raised by families or carers

2.2 Child deaths are reviewed within the scope of the Merseyside Child Death Overview Panel (including Sudden Unexpected Deaths in Children SUDIC)

2.3 The contents of the policy apply to all staff whether they are employed by the Trust

permanently, temporarily, through an agency or bank arrangement. This includes students on placement, are party to joint working arrangements or are contractors delivering services on the Trust's behalf.

3. OUTCOME FOCUSED AIMS AND OBJECTIVES

A structured review of deaths provides a process for analysing concerns, identifying themes and ways to strengthen safety systems and minimise similar incidents occurring again. The Trust's objectives are to:

3.1 Clinically review reported deaths on Datix or reported via complaints

3.2 Deaths will be systematically reviewed at the weekly Safety Huddle coordinated by the Quality and Governance Service

3.3 The Safety Huddle systematically reports into the weekly Clinical Risk Management Group for discussion in line with the Trusts Incident Safety Policy request the level of investigation needed when learning is identified or Serious Investigation can be requested

3.4 The Mortality Review Group, analyses themes and learning on a quarterly basis, which then reports to the Quality and Safety Committee and then to Public Board.

4. MORTALITY ASSOCIATED DEFINITIONS

Patient	In this policy the term refers to all users of Trust services
Mortality Review	The process of reviewing the quality of care and assessing if the incident of patient death was avoidable
Case Note Review	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
Serious Incident	Is defined as an incident that occurred in relation to NHS-funded services and care resulting in one of the following: Acts or omissions in care that result in; unexpected or avoidable death. injury required treatment to prevent death or serious harm, abuse.
Never Events	Never Events are serious incidents that are entirely preventable because guidance or safety recommendations providing strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers. The list is subject to updates – the list explains what they are and how staff providing, and commissioning NHS-funded services should identify, investigate and manage the response to them. It is relevant to all NHS-funded care.
Just Culture	The fair treatment of staff supports a culture of fairness, openness and learning in the NHS by making staff feel confident to speak up when things go wrong, rather than fearing blame
Psychological Safety	For all staff to work at their best, adapting as the environment requires, they need to feel supported within a compassionate and inclusive environment. It means staff do not feel the need to behave defensively to protect themselves and instead opens the space in which they can learn

NHS Patient Safety Strategy 2019	The NHS is developing a new Patient Safety Framework, to improve safety measurement across the whole system, involving patients and families, introducing a new patient safety syllabus.
Unexpected Death	A death may be described as unexpected if it was not anticipated to occur in the timeframe in which the individual died, **and** no natural cause identified
Duty of Candour	Health and Social Care Act 2008 Regulation 20. The intention of this regulation is to ensure that providers are open and transparent with people who use services and other 'relevant persons' (people acting lawfully on their behalf) in general in relation to care and treatment. It also sets out some specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong.
Structured Judgement Review:	is and independent review, conducted by an independent individual, trained in SJR.
Death certification	The process of certifying, recording and registering death, the causes of death and any concerns about the care provided. The process includes identifying cases for referral to the Coroner
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 same as 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.
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

5. Duties

5.1 Chief Executive

The Chief Executive is responsible for the statutory duty of quality and safety and takes overall responsibility for this policy

5.2 Trust Board

The Trust Board has overall responsibility for ensuring that the standards within this policy are followed.

NHSI guidance (July 2017) states that the Board has responsibility to ensure that the following takes place:

- Robust systems are developed for recognising, reporting and reviewing or investigating deaths where appropriate
- Teams learn from problems identified in health and care provided from reviewing different sources of information
- Effective, sustainable action is taken where key issues are identified
- Provision of visible, effective leadership to support staff to improve

- Ensure that needs and views of patients and the public are central to how the Trust operates.

5.3 Medical Director

The Trust's Medical Director has executive responsibility for ensuring that the Trust has a structured process to review deaths and have oversight of the appropriate reporting of deaths in line with national reporting systems. They are also responsible for ensuring that people who have been bereaved by a death at the Trust are supported and kept informed and involved in review or investigation into the death in line with the Duty of Candour.

The Medical Director will also ensure the Trust supports staff who may be affected by the death of someone in the Trust's care.

The Medical Director is responsible for oversight and implementation of learning from the care provided to patients who die, as part of the Trusts work to continually improve the quality of care it provides to all its patients. This includes the dissemination of any learning both internally and externally across the system as appropriate.

An identified non–executive lead is responsible to the Board for providing assurance of the implementation of the national guidance.

5.4 Quality and Safety Committee

The Quality and Safety Committee receives a mortality quarterly report from the Medical Director as well as an Annual Report which identifies learning, themes and actions taken to sustain improvements internally and with safety system partners. The Medical Director provides assurance to the Trust Board that the Trust is meeting its obligations and reports any areas of concern.

5.5 Mortality Review Group – Chair Medical Director

This group is responsible for the oversight of all aspects of mortality review including initial data, the outcome of the initial screening process and any investigations undertaken. This group will meet quarterly to ensure timely review of data and learning and reports to the Quality and Safety Committee.

The Trust will also report annually in the Quality Report providing a mortality narrative 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

5.6 Chief Nurse

They are responsible for working with the Medical Director to ensure appropriate reporting any identified unexpected deaths in line with the Incident Reporting Policy and national reporting systems

5.7 Safety Huddle

The safety huddle includes core members of the Quality and Governance Service, Quality Lead for Adult Social Care, member of Safeguarding Team and Risk and Governance Manager

5.8 Clinical Risk Management Group

The purpose of the group is to ensure there is a robust quality assurance process is in place for the approval of Serious Incidents, complaints, inquests, and litigation prior to the report being shared. This group is responsible for the review and approval of all RCA's

investigations, reviews and reports completed in response to Serious Incidents. This includes all incidents reported on StEIS (including never events) and internal RCA/complaints reports completed. The group is also responsible for the approval of local review reports, the monitoring of Duty of Candour in the Trust and for overview of serious complaints, complaints response performance, claims and inquests. The minutes of the Group are submitted to the Standards Assurance Framework for Excellence (SAFE) Steering Group for approval

5.9 Service Directors / Heads of Services

They are responsible for understanding the Trust's responsibilities in relation to Mortality Review and support the collation of this information and address actions identified through this process that will lead to improved patient care. They must make themselves aware of the relevant policies and guidance to ensure that all staff within their teams has access to:

- The appropriate means of recording a death that falls within the scope of the Trust's Mortality Review process and understanding of how to ensure this data is captured
- Additional relevant training that is service specific
- Clinical Supervision, de-briefing meetings and informal and formal support
- All staff have the option to request a debrief conversation on all incidents raised

5.10 Service Leads, Team Leaders, Team Managers

Are responsible for following the standards within this policy and providing psychological support for staff when incidents occur in line with the Trust's just and learning culture

6. LEARNING FROM DEATHS NATIONAL GUIDANCE

6.1 For many people death under the care of the NHS is an inevitable outcome and they experience excellent care from the NHS in the months or years leading up to their death.

6.2 However, some people experience poor quality provision resulting from multiple contributory factors, which often include system-wide failures. Trust staff work tirelessly to deliver safe, high-quality healthcare. When incidents happen, providers work with their system partners, when appropriate, to understand the causes and potential gaps in safety systems. Reviews and investigations are only useful for learning purposes if their findings are shared and acted upon

6.3 In December 2016, the CQC Report Learning, Candour and Accountability detailed concerns about the way NHS Trusts investigate and learn from the deaths of people in their care, and the extent to which families and carers are involved in the investigations process.

6.4 In 2017 the National Quality Board issued new guidance on Learning from Deaths to create learning cultures, listen to families and carers and drive quality improvements in cases where significant learning has been highlighted. Subsequent national reports continue to guide NHS Trusts to make significant improvements in systematically investigating, and learning from deaths to reduce health inequalities in the provision of care, including people living with a learning disability, autism, and mental illness

7. LEARNING DISABILITIES AND MENTAL HEALTH

7.1 People with a learning disability or mental health problems often have poorer health than other people and may face barriers to accessing health and care to keep them healthy. Too many people with a learning disability or mental health problems are dying earlier than they should, many from conditions which could have been treated or prevented.

7.2 The learning from deaths of people with a learning disability (Learning Disability Death Review. LeDeR) programme was set up as a service improvement programme to look at why people are dying and what we can do to change services locally and nationally to improve the health of people with a learning disability and reduce health inequalities. By finding out more about why people died we can understand what needs to be changed to make a difference to people's lives.

7.3 The new LeDeR policy (2021) aims to set out for the first time for the NHS, the core aims and values of the LeDeR programme and the expectations placed on different parts of the health and social care system in delivering the programme from June 2021. It will serve as a guide to professionals working in all parts of the health and social care system on their roles in delivering LeDeR. By 1 April 2022 all changes within the LeDeR Policy must be implemented by integrated care systems.

7.4 The Mazars Report (April 2011-March 2015) identified the key areas applicable across Trusts when reviewing the deaths of people with a learning disability or mental health problems to conduct reviews and investigations in a systematic structured way to promote learning that is equitable, open and fair to provide safe person-centred care.

8. MORTALITY REVIEW PROCESS

Reported deaths on Datix are automatically shared at the time the incident with nominated senior leads for timely oversight and for immediate actions as require.

8.1 Initial mortality screening

Reported deaths have a mortality review completed, including child deaths, and a SBAR (Situation, Background, Assessment and Recommendations) completed on Datix (incident reporting system). If an immediate safety concern is highlighted a 72-hr review is requested.

8.2 All reported deaths

All reported deaths are reviewed each week by the Safety Huddle and appropriate actions monitored. If aspects of the review are not completed, this is requested from the appropriate team. The notes of findings from initial review are shared each week with the Clinical Risk Management Group. If a death from natural causes is reported on Datix, a rationale can be provided, and the coding changed to "no harm caused".

8.3 The Clinical Risk Management Group (CRMG)

The Clinical Risk Management Group – review the initial outcomes of the review process and in line with the Incident Reporting Policy take the appropriate actions to investigate deaths in which no natural cause has been identified. If significant learning had been identified and the Trust is not the main provider of care, the incident may still progress to an investigation or Rapid learning Review to strengthen wider safety systems.

8.4 CRMG receive all final draft reports for Serious Investigations (RCAs Root Cause Analysis) for final review and approval.

8.5 Divisions are accountable for monitoring action plans that result from investigations to strengthen safety systems and oversight of completed actions is monitored by the Clinical Risk Management Group

9. BEREAVED FAMILIES AND CARER INVOLVEMENT (Appendix One)

9.1 The Trust will actively promote and work with staff to enable them to fully engage with the family, where appropriate, when a family member has died whilst receiving care to ensure that they are able to contribute to the investigation process as an equal partner. The approach that is expected from staff includes the following:

- Adopting a compassionate, open and honest approach including early apology in line with Duty of Candour CQC Regulation 20 and the Trusts Duty of Candour Policy (on StaffZone)
- Include the family / carers in all appropriate aspects of the investigation including and explain the purpose of the investigation i.e. to identify learning so that improvements can be made
- Keep the family / carers informed throughout the process by nominating a named lead for families to contact with any queries or questions they may have
- Offer the opportunity for the family / carers to ask questions, raise concerns and raise a complaint if this is their choice
- Ensure that a coordinated approach is undertaken if the investigation involves several agencies.

10. CROSS SYSTEM MORTALITY REVIEWS AND INVESTIGATIONS

10.1 Where problems are identified relating to other NHS Trusts or organisations, the Trust should make every effort to inform the relevant organisation so they can undertake any necessary investigation or improvement.

10.2 All such incidents should be reported on Datix, our incident management system and reviewed at the Clinical Risk Management Group, to monitor progress and undertake joint investigations when needed.

10.3 The Trust should ensure that every effort is made to work collaboratively with neighbouring NHS organisations within the Integrated Care System (ICS). Inclusive of commissioner leads for Care Homes, and Domiciliary Care, together with the Primary Care Network in relation to the National Mortality Agenda. The sharing of personal identifiable information will be underpinned by an Information Sharing Agreement signed by each organisation in order to observe the duty of confidentiality owed to service users and protect their personal information and encourage learning and improvement at an ICS level.

11. CONSULTATION

11.1 The Clinical Risk Management Group has noted updates needed for the policy and an overview of the requirements needed for the updated learning from Deaths Policy has been agreed at The Mortality Review Group.

12. TRAINING AND SUPPORT

12.1 The NHS has developed a national patient safety syllabus for Patient Safety Leads. This will be implemented across Trusts in line with NHS timeframes.

12.2 Senior staff who undertake serious investigations currently have a range of skills for undertaking lead investigation, including an understanding of the science of human factors, just culture, advanced quality improvement skills, and clinical skills. Nomination of leads relates to the nature of the serious investigation. Leads are supported and guided by experienced staff in the Quality and Governance Service, subject experts, the Deputy Chief Nurse and Medical Director, when indicated.

13. MONITORING

13.1 See Appendix Two

14. EQUALITY IMPACT ASSESSMENT – Appendix Three

14.1 EIA's support organisations to avoid discrimination on any grounds including age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex or sexual orientation. Carers are also protected from discrimination, as they are associated with people with a protected characteristic i.e. disabled people. Should staff become aware of any exclusions that do not comply with this statement they would need to complete an incident form and an appropriate action plan put in place

15. LINKS TO OTHER KEY POLICIES- on Trust StaffZone

15.1 The policy supports implementation of the Incident Reporting Policy

15.2 The policy supports the implementation of the Duty of Candour Policy

16. REFERENCES / BIBLIOGRAPHY

- Care Quality Commission (2015) Regulation 20: Duty of Candour
- National Quality Board (NQB 2017) National Guidance from Learning from Deaths
- NHS (March 2021) Learning from Lives and Deaths – People with a learning disability and autistic people (LeDeR) policy 2021
- NQB (2018) Learning from Deaths – Guidance for NHS Trusts on working with bereaved families and carers
- NHS (2019) Just Culture Guide
- Mazar Report - Independent review of deaths of people with a Learning Disability or Mental Health problem in Southern Health NHS Foundation Trust April 2011- March 2015. December 2015
- NHS Improvement (July 2017) Implementing the Learning from Deaths framework: key requirements for Trust boards

Appendix One: Guidance for NHS Trusts on working with bereaved families and carers

Learning from Deaths
NQB (2018) Learning from Deaths – Guidance for NHS Trusts on working with bereaved families and carers.

Guiding principles
NQB's guidance set the principles that families can expect Trusts to follow the death of someone in NHS care – see below. Families who helped develop this guidance asked that these principles be expanded; and for more detail to be included, to reflect their feedback and experiences.

Key principles that bereaved families can expect will be followed:

1. Bereaved families and carers should be treated as equal partners following a bereavement
a. Trusts should be mindful of the imbalance of power represented by the finances, resources, information, and knowledge available to them compared to families.
b. Trusts should try to lessen this inequality by ensuring families and carers are listened to. They should use plain, understandable language to engage families. And they should provide information on how to apply for access to medical and other records.
c. Trusts should have a clear policy for engaging with bereaved families and carers. This should include a commitment to welcoming their questions or sharing concerns about the quality of care their loved one received.

2. Bereaved families and carers must always receive a clear, honest, compassionate and sensitive response in a sympathetic environment
a. Families only receive the news of a loved one's death once. A human rather than clinical approach to communication is important at this time.
b. They should be treated with respect, kindness, care and compassion.
c. It is important to recognise that families are grieving; all communications with families should be person-centred. Challenge from families should be received positively.
d. Trusts should make it a priority to support bereaved families and carers. They should ensure a consistent level of timely, meaningful and compassionate engagement at every stage, including notification of the death (and of the instigation of an investigation, lessons learned, and actions taken, where relevant).

3. Bereaved families and carers should receive a high standard of bereavement care which respects confidentiality, values, culture and beliefs, including being offered appropriate support. This includes providing, offering or directing people to specialist suicide bereavement support
a. Some families that helped develop this guidance never received information about services that could support them, including how to gain access to counselling inside or outside the Trust.
b. The investigation or complaints process is stressful and damaging for families on top of their grieving. They should be offered counselling services appropriate to their needs or directed to organisations that may help them through these processes.
c. All families should receive a letter from the trust following the death of a family member in its care. They should also receive information about bereavement support, including points of contact for questions or concerns.

4. Bereaved families and carers should be informed of their right to raise concerns about the quality of care provided to their loved one
a. Families should be told about the different ways they can raise concerns, and the processes involved should be explained.

b. Trusts should adopt a learning culture that encourages families to raise concerns, as they may highlight issues that may not otherwise be identified.

5. Bereaved families' and carers' views should help to inform decisions about whether a review or investigation is needed

a. Families felt they were a lone voice when seeking to have a death investigated and that organisational culture placed corporate defensiveness above concern for the truth.
b. Families often have useful information the trust may not be aware of.
c. Where an investigation may not be pursued despite a family's concerns, the family should be involved in discussions about why, before the trust reaches a final decision. Families should be told about their options to appeal the decision or raise the issue elsewhere.

6. Bereaved families and carers should receive timely, responsive contact and support in all aspects of an investigation process, with a single point of contact and liaison

a. Families need consistent and clear communication from a senior representative with authority to take decisions on the trust's behalf. The communication should be transparent, open and honest.
b. Timescales should be agreed with families and kept to, with any missed deadlines explained, where possible in advance.
c. Trusts should provide families with easy-to-understand guides and checklists to explain processes and procedures.
d. Families should be given contact details for organisations providing advocacy, advice, information, and support, in addition to support available within the trust
.

7. Bereaved families and carers should be partners in an investigation to the extent, and at whichever stages, that they wish to be involved, as they offer a unique and equally valid source of information and evidence that can better inform investigations

a. Some families said they had to become detectives, seeking information through their own initiative and determination, and learning how processes work.
b. Families should be central in investigations and treated as equals. This includes being involved in setting the terms of reference and agreeing from the outset how they can be actively involved in any investigation(s).
c. Families' views should be welcomed and received positively. The Trust should aim to respond fully to points raised; where it cannot, it should explain why

8. Bereaved families and carers who have experienced the investigation process should be supported to work in partnership with Trusts in delivering training for staff in supporting family and carer involvement where they want to

a. Trusts should use families' experiences in developing training programmes and materials. This gives staff an opportunity to hear families' voices and experiences first hand.
b. Trusts should aim to involve families in staff training. Families can tell staff about the impact of poor engagement. This can help staff interact positively with families in future.
c. Families can help share learning from one Trust to another, particularly when they belong to networks of other families in similar situations.
d. Trusts should recognise that reviewing and investigating deaths offers an opportunity for learning and a key way to improve the quality of care for all patients.
e. Where Trusts receive feedback, including positive and negative comments from bereaved families about the care and support they provide, they are encouraged to share these so others can learn from it.

Appendix Two: Monitoring Compliance with the process described in the policy

Requirement to be monitored	Process for monitoring	Responsibility	Frequency	Responsibility for screening and action plans	Responsible Committee
The total number of deaths with no natural cause notified to the Trust with outcome of the screening tools completed	Mortality Review Group	Medical Director	Quarterly	Divisions	Quality and Safety
Number of deaths with no identified natural cause of death that trigger a Serious Investigation (RCA)	Clinical Risk Management Group	Medical Director	Weekly Meeting	Divisions	Quality and Safety
Oversight for completion of action plans from Serious Investigations (RCA's)	Clinical Risk Management Group	Medical Director	Monthly	Divisions	Quality and Safety

Appendix Three: Equality Impact Assessment

Title	Learning from Deaths Policy
What is being considered?	Update of existing policy to reflect national guidance on Learning from Deaths
Who may be affected?	Patients [✓] People who need Trust care services [✓] Partner agencies [✓] Families and carers [✓]

Is there potential for an adverse impact against the protected groups below? Age, Disability, Gender Reassignment, Marriage and Civil Partnership, Pregnancy and Maternity, Race, Religion and Belief, Sex (gender), Sexual Orientation or the Human Rights articles?	No [✓]

On what basis was this decision made? (Please complete for both 'yes' and 'no').

- Learning from Deaths Policy is based on NHS guidance and associated national reporting structures
- No evidence of potential adverse impact identified from incident death analysis by the Trust's Mortality Review Group
- No evidence of adverse impact from NHS best practice principles, which have been added to the policy for patients with a Learning Disability and Autism

If 'No' equality relevance, sign off document below and submit this page when submitting your policy document for approval. If 'Yes' Please complete pages 2-3.

Regarding the general duty of the Equality Act 2010, the above function is deemed to have no equality relevance.

Equality relevance decision by: Mortality Review Group
wcnt.inclusion@nhs.net