

Learning from Deaths Policy: The right thing to do

The key messages the reader should note about this document are:

- 1. The Trust will review and investigate deaths where care and service delivery problems occurred so that we can prevent recurrence.*
- 2. We make it a priority to work closely with families and carers of patients who have died and to ensure meaningful support and engagement with them at all stages.*
- 3. The Medical Director is the Board level Director with responsibility for learning from deaths and a named Non-Executive Director has lead responsibility for oversight of progress.*
- 4. The Mortality Review Group, chaired by the Medical Director, meets weekly to review all reported deaths and determine which require further investigation in accordance with this policy.*

Issue Date	08/04/2021	Review Date	18/04/2024
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This document has been approved and ratified. Circumstances may arise where staff become aware that changes in national policy or statutory or other guidance (e.g. National Institute for Health and Care Excellence (NICE) guidance and Employment Law) may affect the contents of this document. It is the duty of the staff member concerned to ensure that the document author is made aware of such changes so that the matter can be dealt with through the document review process.

NOTE: All approved and ratified policies and procedures remain extant until announcement of an amended version via Trust-wide notification, e.g. through the weekly e-Update publication or global e-mail or uploading to the appropriate section on BDCFT's Intranet (Connect).

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1 INTRODUCTION

It is important that the Trust learns from all deaths and must have a policy in place that sets out how it identifies, reports, investigates and learns from a patient's death. This should include the care leading up to the patient's death and considering if this could have been improved.

It is the right thing to do to review and investigate deaths where care and service delivery problems occurred so that we can learn and prevent recurrence in line with:

- Care Quality Commission (CQC) report Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England 2016;
- National Confidential Inquiry into Suicide and Safety in Mental Health;
- The Learning Disabilities Mortality Review (LeDeR) Programme;
- National Confidential Enquiry into Patient Outcome and Death;
- Healthcare Safety Investigation Branch;
- MBRRACE-UK: Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK;
- The National Quality Board (NQB) guidance on Learning from Deaths (2017)
- The Five Year Forward View for Mental Health

We will make it a priority to work more closely with families and carers of patients who have died and to ensure meaningful support and engagement with them at all stages, from the notification of the death of their loved one right through to actions taken following from an investigation (if deemed appropriate).

This policy informs the organisation of staffs' roles and responsibilities relating to learning from deaths and promotes a culture of learning lessons.

2 SCOPE

The purpose of this policy is to set out the Trusts expectation/principles on how it responds to deaths in our care and identifies the scope of review for each death and how the trust will learn from them.

This policy sets out how staff can support the involvement of families and carers when a death has occurred and how to engage with them to ensure there are easy opportunities to discuss or ask questions about the care received by their loved one to their preferred timescale.

This policy should be read in conjunction with

- Being Open Policy
- Serious Incident Policy
- Incident Reporting and Management Policy
- Investigation of Incidents, Complaints and Claims Policy

While a focus on process is important, everything that is done should place emphasis on the outcomes of learning from deaths and supporting families and carers.

The core objectives of this policy are:

- To prioritise and enable consistently effective, meaningful engagement and compassionate support between families, carers and staff that is open and transparent to allow them to raise questions about the care provided to their loved one.
- To help to identify what can be improved to ultimately reduce the inequality in the life expectancy of people with a serious mental illness/learning disability.
- To standardise approaches to reviewing deaths across the northern cohort of mental health trusts in order to share information and key learning.
- To enhance learning at a personal, team and organisational level.
- To ensure the Trust engages with other stakeholders (Acute Trusts, primary care, public health, safeguarding, Health and Wellbeing Boards etc.) to work collaboratively, sharing relevant information and expertise to maximize learning from deaths
- To standardize the approach for identifying, screening, reviewing, investigating and learning from deaths reported in the Trust support the evaluation of the Trust's approach to learning from deaths in line with the northern cohort of mental health trusts agreed principles.

3 Roles and Responsibilities

This policy applies to all Trust staff with a responsibility for patient care as set out below:

3.1 Board Members

Trust Boards are accountable for ensuring compliance with the 2017 NQB guidance on Learning from Deaths and working towards achieving the highest standards in mortality governance. They must ensure quality improvement remains key by championing and supporting learning that leads to meaningful and effective actions that continually improve patient safety and experience and supports cultural change. A key part of this is their responsibility to ensure that the involvement of a bereaved family or carer in the learning and investigation process following a death focus' on inclusivity, representation, non-discrimination, and empowerment.

The Medical Director has the lead responsibility at board for learning from deaths. The role of 'Patient Safety Director' is currently with Director of Nursing, Professions and Care Standards.

The Trust has a named Non-Executive Director for Learning from Deaths whose role it is to:

- ensure they receive appropriate levels of quality assurance.
- review quality standards; and take
- have lead responsibility for oversight of progress to act as a critical friend holding the organisation to account for its approach in learning from deaths.

Non-Executive Directors roles and responsibilities are to:

- understand the process: ensure the processes in place are robust and can withstand external scrutiny, by providing challenge and support.

- champion and support learning and quality improvement; and
- assure published information; ensure that information published is a fair and accurate reflection of the Trust's achievements and challenges

3.2 Medical Staff, Deputy Directors, General and Assistant General Manager and Service Managers

The responsibility of Senior Manager in the Trust is to ensure:

- all deaths are recorded within 24 hours of notification and initial operational reviews are completed within 48hrs.
- staff are supported to undertake Structured Judgement reviews allowing them time to carry out the process in a skilled way that will help to evidence learning opportunities.
- promote learning from deaths.
- sufficient time is assigned in local governance forums to outline and plan for any lessons learned, that the learning is acted on and that improvements are demonstrated; and that
- Staff are engaged with families to offer condolences, in line with Being Open and Duty of Candour when this applies.

3.3 Team Leaders and Ward Managers. and all Registered Nurses and Allied Healthcare Professionals

It is the responsibility of all staff to:

- familiarise themselves with this policy.
- understand the process for learning from deaths; and
- engage with families to offer condolences, in line with Being Open and Duty of Candour when this applies.

3.4 The Quality and Safety Committee

The is a subcommittee of Trust board. The Quality and Safety Committee will receive data on learning from deaths in the monthly dashboard.

3.5 The Mortality and Duty of Candour Review Group (MDCRG)

The primary role of the MDCRG is to provide assurance to the Trust Board on patient mortality and in particular how we are learning from deaths.. The meeting is chaired by the Medical Director. This group reviews data on patient deaths, including results and learning generated by Structured Judgment Reviews. They undertake an initial review of all deaths reported via Ulysses Safeguard and will identify if any deaths require further review either as a Serious Incident, a Learning Disability (LD) review, a Structured Judgement Review (SJR) or a detailed local review and receive the reports in order to identify actions to improve care. The Royal College of Psychiatrists toolkit supports the implementation of the Structured Judgement Review (SJR) process to effectively review the care received by

patients who have died. This will in turn allow learning and support the development of quality improvement initiatives when problems in care are identified.

4 PROCESSES

4.1 Identifying and Reporting Deaths

The Trust has systems that identify and capture the known deaths of its patients on SystemOne (S1) on the incident management system, Ulysses Safeguard reporting system. This is to help ensure that the Trust Board has a comprehensive picture of the deaths of all services users and the opportunities to learn from them.

Trust staff must report deaths for whom we are the main provider of care, within 24 hours of being informed of the death and provide the cause of death where known. This should be recorded on the Ulysses Safeguard reporting system (IrE). The initial review should be completed by a Senior Manager within 24 hours (or next working day). This should be submitted to the General Manager for review and approval prior to sign off by the Director of Nursing, Professions and Standards.

If it is considered that the death is a suspected suicide then the SI Team is automatically informed via the IrE reporting system and will report this on StEIS (this is detailed fully in the Serious Incident Policy).

Where the cause of death is unclear, the SI team will liaise with HM Coroner.

Once the incident report is completed staff should attempt to engage with the family and or carers unless otherwise instructed.

This applies to the deaths of all patients open to BDCFT mental health or learning disability services.

4.1.1 Death of a Patient with a Learning Disability

For patients with learning disabilities there is the national Learning Disabilities Mortality Review (LeDeR) programme which has been running since 2016, as well as the internal BDCT review process. As part of the internal review process, a notification is made to the LeDeR programme and the death is reported via the Ulysses Safeguard system by one of the team members in the community team. BDCT are not responsible for managing LeDeR reviews – there is a local area contact (LAC) within the CCG who reports on the LeDeR process across Bradford district and hold accountability for this, working closely with BDCFT and LD Matrons. However, BDCT has agreed to provide some staff time so members of the LD community team can be involved as LeDeR reviewers on occasions and support with undertaking a small number of local LeDeR reviews throughout the year. All deaths are reported to LeDeR by the Community Matron for Adults with a Learning Disability.

4.1.2 Death of a Child

- The death of a person under 18 (where the Trust is the lead provider of care) will be subject to the Child Death Review Process (2018 and is reportable to the Coroner. Where we are the lead provider, a Serious Incident or Structured Judgement Review will be undertaken.

4.1.3 Deaths which are reportable to the Coroner

The following deaths are reportable to HM Coroner.

- Suspected suicide of an in-patient;
- Sudden, unexplained deaths;
- The death of a patient who is detained under the Mental Health Act 1983, or where the Mental Capacity Act applies; and
- The death of a patient under the age of 18 who the Trust are lead provider of care for.

4.2 Engaging with families

Working with families/carers of patients who have died offers an invaluable source of insight and opportunity to improve services. Therefore, there is a need to ensure appropriate support is provided at all stages of the review process and that there is an understanding that treating bereaved families/carers as equal partners in the process is vital.

We will reinforce the importance of family engagement following deaths by dealing respectfully, sensitively, and compassionately with families and carers when someone has died. This is crucial to our values and to the involvement of families in the learning from deaths process. . At times families may have questions, and/or concerns they would like answers to in relation to the care and treatment their loved one received, but they do not always want to make a complaint. We must listen with compassion and provide as much information about the care and treatment of their loved one as we can, in line with Duty of Candour.

When a service user dies, staff will often be the first to offer condolences and support and to give appropriate information.

They also need to ask if the families/carers have any comments they may wish to make about the care provided. This early discussion supports ensuring that deaths where families raise concerns are reviewed or investigated. If there are any concerns this must be reported on the incident reporting system (Safeguard).

When staff contact families and carers, they should ensure they follow the Being Open Policy which includes Duty of Candour when this is required.

What the family can expect from the Trust

The family or carer of a deceased person can expect their needs and views to be considered in full. They can expect to be treated in line with the Trust's Being Open policy. They should also expect to receive information about local and national support available e.g., local and national support groups, including specialist support.

If you are reading this as a family member or carer of someone who has recently died, and they received care from our Trust and you have anything you would like to discuss, you can contact the clinical team involved to discuss or you can contact the Patient Advice and Complaints Department on 01274 251440. Please remember that it is your right to raise concerns about the quality of care provided to your loved one and this information will be used to inform decision making about the level of investigation required.

If you want involvement in the investigation on any level, you should know that the Trust is committed to clear, honest, compassionate, and sensitive responses to any request or challenge you make. We will make every effort to ensure that you are treated as an equal partner in the investigation and we will keep you informed about decisions, outcomes etc, in line with your wishes. Families can choose how they wish to be involved and this may include:

- contributing and directing lines of enquiries in reviews and SJR's where they may have concerns or highlighting good practice;
- providing evidence / contributions to the review or investigation e.g. a time-line of events, review of the draft report, providing a summary of their view of care; and
- commenting on a draft report.

Families/carers should also be given the option of seeing final reports to ensure they are aware of any findings. Ideally this should be undertaken in a face to face meeting with a staff member talking the family member / carer through the report. It is recognised, however, that this is not always possible.

If the family member / carer decides they do not want to be involved in the review process staff should make it clear they can contact us at any time should their decision change and that any relevant information can still be shared. If the family does not want contact at all about the process or findings, this should be honoured, and staff should record their wishes.

Staff should be prepared for the types of questions that families may have such as:

- Why is there an investigation?
- Can I access the records for my relative?
- Can I speak to the staff who were caring for my relative?

One way to ensure that answers are provided to the questions that families / carers have is to ask them at an early stage what they want to know and to involve them in writing the terms of reference of any review or investigation. Further information and support can be accessed by the Serious Incident team as this is already in practice in serious incident investigations.

There are some circumstances where the Trust may find out about the death of a service user after some delay. In these circumstances a discussion should take place between the Mortality Review Group and the clinical team involved to determine the best approach.

4.2.1 Confidentiality

Patients have a right to confidentiality, and this persists after death. They may have made it very clear that they did not want their families to know anything about their clinical presentation and this should be respected. BDCFT may hold sensitive information that a patient may not wish to be shared with family/carers. In any communication with family this should be considered in line the BDCFT Information Governance policies. It is acknowledged that there may be occasions in which consideration should be given to the disclosure, in line with the patient's wishes. Any member of staff engaging in such discussions should discuss with their line manager in the first instance. Where further guidance is required the Information Governance Team should be contacted.

Confidentiality will be considered in all aspects of Being Open with families and communications of patients wishes with external agencies e.g. HM coroner.

4.3 Review of Deaths procedure

The Trust collects data on all known deaths and has a process in place to determine the scope of deaths which require further review or investigation. The information below sets out these processes in addition to the existing Serious Incident Framework.

4.3.1 Scope of deaths reviewed

The NQB National Guidance on Learning from Deaths provides the context to the review or investigation of deaths and establishes a number of circumstances where investigation is mandated. These include:

1. all deaths where bereaved families and carers, or staff, have raised a significant concern about the quality of care provision;
2. all in-patient, out-patient and community patient deaths of those with learning disabilities;
3. all deaths in a service specialty, particular diagnosis, or treatment group where an 'alarm' has been raised;
4. all deaths in areas where people are not expected to die, for example in relevant elective procedures;
5. deaths where learning will inform the provider's existing or planned improvement work, for example if work is planned on improving sepsis care, relevant deaths should be reviewed, as determined by the provider. To maximise learning, such deaths could be reviewed thematically;
6. a further sample of other deaths that do not fit the identified categories so that providers can take a strategic overview of where learning and improvement is needed. This does not have to be a random sample and could use practical sampling strategies such as taking a selection of deaths from each weekday etc.

The NQB guidance requires that all inpatient, outpatient and community patient deaths of people with severe mental illness (SMI) should be subject to a Structured Judgement Review or Serious Incident investigation.

In relation to this requirement, there is currently no single agreed definition of which conditions/criteria would constitute SMI. The term is generally restricted to the psychoses, including schizophrenia, bipolar disorder, delusional disorder, unipolar depressive psychosis, and schizoaffective disorder.

Further national guidance is expected to clarify expectations about mortality review in mental health and community services in the future however in the meantime, Trusts have been asked to use the above description of SMI. The MDCR will review all deaths where we are the main provider of care at the time of death. The MDCR will also receive notifications of deaths where other provider organisations may be involved and are the lead organisation.

In order to support consistency in determining the scope of deaths for further review, the cohort of Northern Mental Health Trusts has identified a number of potential triggers for a Review / Investigation. These include deaths:

1. where family / clinical staff / risk management staff flag or raise a concern;
2. where medication with known risks such as Clozapine was a significant part of the treatment regime;

3. from causes or in clinical areas where concerns had already been flagged – (possibly at Trust Board level or via complaints or from data);
4. where they had been subjected to a care intervention where death would not have been an expected outcome e.g. ECT, rapid tranquilization;
5. where the service user had no active family or friends and so were particularly isolated e.g. with no-one independent to raise concerns;
6. where there had been known delays to treatment e.g. assessment had taken place or a GP referral made but care and treatment not provided, or where there was a gap in services; and
7. associated with known risk factors / correlations.

Also:

8. particular causes of death e.g. epilepsy;
9. deaths in distress which might include: drug and alcohol deaths, or deaths of people with an historic sex offence e.g. people who might not be in crisis but need support and from whose experience there may be learning from a thematic review;
10. where a proactive initial assessment of a death has potentially identified that there was a deterioration in the physical health of a service user which was not responded to in a timely manner; and
11. Random sampling of 10% of deaths.

The following are services where the Trust is not classed as the main provider of care but contributes to a wider care package. Whilst these would be out of scope, the MDCR may request a further review:

- District Nursing Services including Community Matrons;
- Speech and Language Therapy;
- Dental Services;
- Children's 0-19 services (excluding CAMHS); and
- Podiatry.

4.4 Review Processes

All deaths recorded on the Safeguard Ulysses system will be reviewed in MDCR. The exception will be deaths which have already been reported in StEIS, and these are reviewed in the Serious Incident panel.

A report is generated by the Risk Team on a weekly basis and includes details of all newly reported deaths. This report is reviewed in the MDCR.

Decisions made in the MDCR will be recorded by the Serious Incident & Complaints Officer on the Safeguard Ulysses system.

The Trust has adopted the following levels of scrutiny

1. Death Certification;
2. Initial Review;
3. Structured Judgement Review; or
4. Serious Incident Investigation

4.4.1 Certification

If the death has been certified by a doctor as a natural death and they have not reported the death to the Coroner, no further review will usually be necessary. This is unless the Trust is aware of any concerns expressed by family and clinical staff or through governance processes. The clinical team will normally review the case.

Of note is that once the reform of death certification comes into place, the medical examiners will be mandated to give bereaved relatives a chance to express any concerns and to refer to the Coroner any deaths appearing to involve serious lapses in clinical practice or patient safety.

Any Coroner requests which are received by the Trust, where the patient may have had contact previously but are out of scope for a serious incident, will be recorded on the Safeguard Ulysses system to ensure they are reviewed in MDCR.

4.4.2 Initial Review

All unexpected deaths will require an initial review completed by the team. Where the death is suspected suicide, this will follow the Serious Incident process. For all other deaths, the initial review will be completed by the team and signed off by the General Manager for review and discussion in the MDCR.

The MDCR may request a full Structured Judgement Review, particularly where there are concerns noted

4.4.3 Structured Judgment Review Process

The Trust has adapted the Royal College of Psychiatrists Structured Judgement Review (SJR) Tool (2018) which is in itself based on the Structured Judgement Review process developed by the Royal College of Physicians, a process embedded within most acute hospitals in England.

Where a death is reported, the clinical teams will be asked to complete the initial review. This will be reviewed by the MDCR who will determine the level of investigation required. The tool identified 'red flags' which will automatically lead to an SJR. These red flags can be modified by the Trust through the MDCR. The static red flags are:

- Family, carers, or staff have raised concerns about the care provided;
- Diagnosis of psychosis or eating disorders during the last episode of care;
- Psychiatric inpatient at time of death, or discharged from inpatient care within the last month; and/or
- Under Crisis Resolution and Home Treatment Team (or equivalent) at the time of death.

The Trust has also identified the following red flags:

- Where the patient has disengaged from services
- If the patient has a current diagnosis of personality disorder
- If the patient was prescribed Clozapine or a high dose of antipsychotic
- Where insulin was administered by our staff
- Learning Disability (specifically where the cause of death is as result of respiratory or abdominal difficulties)

The MDCR will also select cases at random which do not meet the above criteria.

The key task of the SJR is to determine if there were problems in care. This may trigger a Duty of Candour process. At any stage of the review process this may be escalated to a StEIS reportable investigation. Any escalations will be agreed in MDCR panel. This will then sit within the serious incident reporting framework.

Once the decision has been made to undertake a SJR then the family will be notified of this in writing by the Director of Nursing, Standards and Professions. This letter will include details of the reviewer and how they can contribute. A summary of the findings will be sent to the family on completion on the review, including responses to any questions they may have.

4.4.4 Serious Incidents

Serious incidents are managed in line with the Serious Incident policy and the report reviewed in the Serious Incident panel.

4.5 *Sharing Learning*

The Trust will continue to educate staff and encourage an open culture of listening to the views and opinions of families and carers following all deaths. Staff will become more confident in identifying what can be done differently and improve systems and share systems and processes that are working well.

The Trust will ensure that lessons learnt result in change in organisational culture and practice by identifying themes and trends in formal meetings, and escalating issues to the Patient Safety and Learning Group who have a responsibility to escalate issues to the Quality and Safety Committee. An annual thematic review will also be undertaken.

Completed initial reviews and SJR's, identifying any lessons to be learned will be presented to the Mortality Review Group as a standard agenda item to be reviewed and approved. Where the incident has been reported on StEIS, this report will be reviewed in the Serious Incident Panel. Any actions required would be agreed and monitored in the first instance through the Mortality Review Group and cascaded through the operational management structure as appropriate.

We will ensure learning is cascaded to frontline clinical staff and divisions on a regular basis by use of

- 1) The Learning Hub; and
- 2) Feedback of findings and discussion and monitoring of action plans to QUOPS.

Learning from deaths is not limited to the trust. Where the learning is of significance or has implications that go beyond the trust we will ensure this is shared by

- 1) Encouraging joint investigations of deaths where this is appropriate;
- 2) Sharing the outcomes of our reviews of deaths with other services where there is learning that is relevant to them; and
- 3) Discussing the outcome of reviews of deaths at system forums such as the System Quality Committee

4.6 Data reporting

Trusts are required to publish information on deaths, reviews and investigations via a quarterly agenda item and paper to its public Board meetings.

When counting 'total number of deaths in scope' and 'total number of deaths reviewed' it should be possible to see what percentage of deaths has been reviewed in a particular period. In other words, the number of deaths reviewed should be reported as a percentage of the number of deaths. To do this means that it is helpful to have a time lag in the reporting period - for example Q1 data would be reported at the end of Q2.

The dashboard will include:

- Total number of deaths on the safeguard system;
- Total number of deaths reviewed in MDCR;
- Total number of deaths reviewed under the SJR methodology;
- A breakdown of the structured judgement review, indicating:
 - the number of deaths likely to be as a result of a problem in care
 - the number of deaths likely than not to have; and
- Total deaths referred to LeDeR.

Understanding the data around the deaths of our patients is a vital part of our commitment to learning from all deaths.

5 DEFINITIONS

Definitions of terms significant to this policy are set out in the table below.

Term Used	Definition
StEIS	Strategic Executive Information System is the national system for reporting Serious Incidents (SI) that enables electronic logging, tracking, and reporting of Serious Incidents with NHS Improvement
Deaths in Scope	Deaths that the Northern Mental Health Trusts and the Trust for general community services have determined require further review under this policy.
LeDer	The Learning Disabilities Mortality Review (LeDeR) programme has been commissioned by NHS England to support local areas in England to review the deaths of people with a learning disability to: <ul style="list-style-type: none">• identify common themes and learning points; and• provide support to local areas in their development of action plans to take forward the lessons learned.
Structured Judgment Review	a Mortality Review Tool that will support Mental Health Trusts in securing learning through reviewing the deaths of patients who are or have recently been under their care.
Safeguard Ulysses	The incident management system used by the Trust
Serious Incident	An incident where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations

Term Used	Definition
	are so significant, that they warrant using additional resources to mount a comprehensive response.
QUOPS	Operational Services Quality, Operations meetings

6 EQUALITY IMPACT ASSESSMENT

The Trust has no intent to discriminate and endeavours to develop and implement policies that meet the diverse needs of our workforce and the people we serve, ensuring that none are placed at a disadvantage over others. Our philosophy and commitment to care goes above and beyond our legal duty to enable us to provide high-quality services. Our Equality Analysis and equality monitoring is a core service improvement tool which enables the organisation to address the needs of disadvantaged groups. The aim of Equality analysis is to remove or minimise disadvantages suffered by people because of their protected characteristics.

An impact assessment has been undertaken to consider the need and assess the impact of this Policy document and is evidenced at Appendix B.

7 TRAINING NEEDS ANALYSIS

The Trust is committed to high quality targeted training and effective communication to support this policy document. The Trust recognises that training capacity can fluctuate and will depend on resources available. As such, based on an assessment of capacity and risk, the training needs analysis will identify the high priority groups for training. The objective is to implement this policy document and meet the training needs of these groups over the time frequency stated. The focus of Trust monitoring will be on this group over the agreed period or lifetime of the policy document.

8 MONITORING COMPLIANCE AND EFFECTIVENESS

Criteria	Evidence identified to indicate compliance with policy	Method of monitoring, i.e. how/where will this be gathered?	Frequency of monitoring	Lead responsible for monitoring
<i>Interim Review of policy</i>	BDCFT Dashboard	Report	Annually	Mortality Review Group

9 REFERENCES TO EXTERNAL DOCUMENTS

- NATIONAL QUALITY BOARD (2017). National Guidance on Learning from Deaths: A Framework for NHS Trusts and Foundation Trusts on identifying, Reporting, Investigating and Learning from Deaths in Care.
- National Quality board (2018) Learning from deaths Guidance for NHS trusts on working with bereaved families and carers <https://www.england.nhs.uk/wp-content/uploads/2018/08/learning-from-deaths-working-with-families-v2.pdf>
- NHS IMPROVEMENT. National Guidance on Learning from Death: Information and resources for trust boards. <https://improvement.nhs.uk/resources/learning-deaths-nhs/>

10 ASSOCIATED INTERNAL DOCUMENTATION

In respect of this policy, specific related Policy documents / Trust documents are:

- Serious Incident Policy 2021
- Incident Reporting and Management Policy 2018
- Investigation of Incidents, Complaints and Claims 2018
- National Quality Board: National Guidance on Learning from Deaths 2017
- NHSE Serious Incident Framework 2015: Supporting learning to prevent recurrence

11 APPENDIX A: DOCUMENT PRODUCTION DETAILS

Title:	<i>Learning from Deaths Policy: The right thing to do.</i>
Version:	<i>2-01 Draft</i>
Name and Title of Responsible Director:	<i>David Sims – Medical Director</i>
Name and Title of Responsible Deputy Director/ General Manager:	<i>Sarfaraz Shora, Deputy Medical Director</i>
Name and Title of Author:	<i>Louise Hussain – Serious Incident Lead</i>
Title of Responsible Committee / Group (or Trust Board):	<i>Trust Board</i>
Persons/Groups/Committees consulted:	<i>List of all persons, groups, committees, or external agencies consulted during the production of the Policy document. Where individuals are named then only their work titles must be recorded.</i>
Service User, Patient and Carer consultation:	<i>Does the content of the Policy document impact on service users, patients, or carers? If so, have they been consulted with in its development or review? Please state who has been consulted and how they have been consulted. The service user/ patient involvement team may be able to help with this.</i>
Target Audience:	<i>Frontline clinical staff and managers within operational services. Staff within the Nursing Governance directorate</i>
Approved by:	<i>The Mortality and Duty of Candour Review Group</i>
Date Approved:	<i>Insert the date of the group or committee meeting at which the Policy document was approved in dd/mm/yyyy format, e.g. 12/04/2017.</i>
Ratified by:	<i>Insert the name of the group or committee that will ratify the Policy document for implementation. All BDCFT policies must be ratified by the Executive management Team (EMT).</i>
Date Ratified:	<i>Insert the date of the meeting at which the Policy document was ratified for implementation by EMT in dd/mm/yyyy format, e.g. 12/04/2017.</i>
Date Issued:	<i>Insert the date on which the Policy document is issued for use by Trust staff in dd/mm/yyyy format, e.g. 12/04/2017. This will normally be added by the person disseminating the Policy document or at the time it is uploaded to the Trust's Intranet (Connect).</i>
Review Date:	<i>Insert the date by which the Policy document must be reviewed in dd/mm/yyyy format, e.g. 11/04/2016. This is normally 3 years following the date on which the Policy was last ratified.</i>
Frequency of Review:	<i>Every 3 years unless national changes dictate difference requirements</i>
Copies available from:	<i>Trust's Intranet (Connect), e.g. Connect on BDCFT Intranet.</i>

Where is previous copy archived (if applicable):	<i>Z Drive: MDCR</i>
Amendment Summary:	There are minor changes to the policy following changes to the Trust structures and review processes. Is a <i>major/ minor</i> revision to an existing Policy document.

Amendment detail:

Amendment number	Page	Subject
1	5	<i>Clarification of Board Members responsibilities</i>
2	7	<i>Revised text on LeDeR process and responsibility for reporting</i>
3	8	<i>Clarification of what families can expect from the Trust</i>
4	12	<i>Revisions to red flags</i>
5	13	<i>Escalation route of Patient Safety and Learning Issues</i>
6	13	<i>Inclusions of annual thematic review</i>
7	24	<i>Revision to flow chart to reflect PSLG to receive findings</i>

12 APPENDIX B: EQUALITY IMPACT ASSESSMENT (EQIA)

Area	Response
Policy/Procedure	Learning from Deaths
Manager	Dr David Sims, Medical Director
Directorate	Governance
Date	
Review date	12/01/2020
Purpose of Policy	Working with families/carers of patients who have died offers an invaluable source of insight to improve services. Therefore there is a need to ensure appropriate support is provided at all stages of the review process and an understanding that treating bereaved families/carers as equal partners in this process is vital. In line with the National Quality Board guidance on Learning from Deaths, every Trust must have a policy in place that sets out how it identifies, reports, investigates and learns from a patient's death. This should include the care leading up to the patient's death and considering if this could have been improved.
Associated frameworks e.g. national targets NSF's	CQC review December 2016, Learning, candour and accountability
Who does it affect	Families and Carers
Consultation process carried out	The Trust has worked with a northern alliance of other trusts to develop this policy. A national policy regarding involving families is to be produced this year so the policy will be reviewed in light of this. A recognised national figure ran a workshop with the northern alliance. The Trust has also consulted with staff and families in developing policy and resources for undertaking investigations. All of the key recommendations have been added in this policy.
QA Approved by	Patient Safety and Learning Group

Equality protected characteristic	Impact Positive	Impact Negative	Rationale for response
Age		No	
Disability		No	
Gender Reassignment		No	
Race		No	
Religion or Belief		No	
Pregnancy & Maternity		No	
Sex		No	
Sexual Orientation		No	

Equality Analysis SIGN - OFF		
Have any adverse impacts been identified on any equality groups which are both highly significant and illegal?		No
Are you satisfied that the conclusions of the EqIA Screening are accurate? The Trust will publish a summary of the impact analysis carried out to meet the duty and make this available to the public on the Trust Internet site.		Yes
Completed by Manager		
Q A approved		
Director approved		

POLICY DOCUMENT COMPLIANCE CHECKLIST (NOT AN APPENDIX AND WILL BE REMOVED FROM FINAL VERSION OF POLICY WHEN ISSUED)

The Policy Document Compliance Checklist is available to the author to ensure a uniform approach to its development and management and should be utilised as a source of assurance by them and the responsible director or deputy director for it to ensure that all requirements are met.

The Policy Document Compliance Checklist will not be included in the final version of the policy and should be removed from the final version of it and filed separately by the author or policy lead.

Failure comply with BDCFT’s standard policy template may mean that the policy cannot proceed to approval and ratification.

<i>Insert title of document being reviewed</i>		Yes/No/ Unsure	Comments
1.	Title		
	Is the title clear and unambiguous?	Yes	
	Is it clear whether the document is policy, procedure or strategy?	Yes	
2.	Rationale		
	Are reasons for development of the procedural document stated, e.g. in the Introduction or Scope sections?	Yes	
3.	Development Process		
	Is the method described in brief e.g. in the Introduction, Scope sections or Appendix A?	Yes	
	Are people involved in the development identified, e.g. in the Production and Review Details (Appendix A)?	Yes	
	Do you feel a reasonable attempt has been made to ensure relevant expertise has been used?	Yes	
	Is there evidence of consultation with stakeholders, service users, patients or carers, e.g. in the Production and Review Details (Appendix A)?	Yes	
	Have the requirements of the following been taken into account where applicable: Mental Health Act Mental Capacity Act Care Programme Approach (CPA) Guidance	Yes	
4.	Content		
	Is the objective of the document clear, e.g. in the Scope section?	Yes	

<i>Insert title of document being reviewed</i>	Yes/No/ Unsure	Comments
Is the target population clear and unambiguous, e.g. in the Scope section or Appendix A?	Yes	
Are the intended outcomes described in the Core Content section?	Yes	
Are the statements clear and unambiguous?	Yes	
Are any amendments compared to a previous version of the document summarised or where appropriate listed in more detail in the Production and Review Details (Appendix A)?	Yes	
The Trust is transitioning services to agile working: please consider and include implications for agile workers and the management of agile within all policies and procedures.	Yes	
<p>Accessible Information Standard. All organisations that provide NHS or adult social care are legally required to meet the standard law (Section 250 of the Health and Social Care Act 2012) and to ensure that people who have a disability, impairment or sensory loss are asked if they have any accessible information needs and if they do that these needs are met. This might include making sure that people get information in different formats if they need it, for example in large print, braille, easy read or via email or that people get support with communication that they need, for example support from a British Sign Language (BSL) interpreter, deafblind manual interpreter or advocate. Under the Standard organisations must do the following five things. So please consider when writing your policy and any associated procedures how you will:</p> <ol style="list-style-type: none"> 1. Ask people if they have any information or communication needs and how these needs might be met. 2. Record those needs clearly and in a set way in the appropriate clinical system. 3. Highlight or flag the person's file or notes so it is clear that they have information or communication needs and how to meet those needs. 	Yes	

<i>Insert title of document being reviewed</i>	Yes/No/ Unsure	Comments
<p>4. Share information about people's information and communication needs with other providers of NHS and adult social care, when they have consent or permission to do so.</p> <p>5. Take steps to ensure that people receive information which they can access and understand, and receive communication support if they need it.</p> <p>For more information and support with the Accessible Information Standard contact Fiona Sherburn, Deputy Director of HR & Workforce Development.</p>		
<p>Information Governance Information governance and GDPR has been considered in terms of information sharing. For more information about Information Governance contact: Gaynor Toczek, Information Governance & Security Manager, Administration.</p>	Yes	
5. Evidence Base		
Is the type of evidence to support the document identified explicitly throughout and in the References to External Documents, Associated Internal Documentation sections and Appendices?	Yes	
Are key references cited?	Yes	
Are supporting documents referenced?	Yes	
6. Approval and Ratification		
Does the document identify which committee/group will approve it, e.g. in the Production and Review Details (Appendix A)?	Yes	
If appropriate has the joint Human Resources/Staff Side Committee (or equivalent) approved the document and is this stated in the Production and Review Details (Appendix A)?	Yes	
Does the document identify which committee/group will ratify it in the Production and Review Details (Appendix A)?	Yes	
7. Dissemination and Implementation		
This should be done as per the guidance on the Policy and Trust-Wide Procedure Development and Management Policy.	Yes	

<i>Insert title of document being reviewed</i>		Yes/No/ Unsure	Comments
	Does the plan include the necessary training/support to ensure compliance, e.g. in the Training Needs Analysis section?	Yes	
8. Document Control			
	Does the document identify where it will be held in the Production and Review Details (Appendix A)?	Yes	
	Have archiving arrangements for superseded documents been addressed, in the Production and Review Details (Appendix A)?	Yes	
9. Process to Monitor Compliance and Effectiveness			
	Are there measurable criteria, standards or KPIs to support the monitoring of compliance with and effectiveness of the document in the Monitoring Compliance and Effectiveness section?	Yes	
	Is there a plan to review or audit compliance with the document in the Monitoring Compliance and Effectiveness section?	Yes	
10. Review Date			
	Is the review date identified in the Production and Review Details (Appendix A)?	Yes	
	Is the frequency of review identified in the Production and Review Details (Appendix A)? If so is it acceptable?	Yes	
11. Overall Responsibility for the Document			
	Is it clear who will be responsible for co-ordinating the dissemination, implementation and review of the document, in the Production and Review Details (Appendix A)?	Yes	

Author Approval

The Author should complete, sign and date this Policy Document Compliance Checklist to show they have applied it.

Author		Date	
Signature			

13 APPENDIX D: LEARNING FROM DEATHS FLOWCHART

When there is to be a structured case review under the Learning from Deaths process

