Wirral Community Health and Care NHS Foundation Trust

Learning from Deaths Policy
GP58

TRUST WIDE HEALTH AND CARE POLICY

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Document		
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1.	New September 2017	Quality and Safety Committee
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3.	Revised governance process in line with PSIRF	October 2021
4.	Updated text to bring into line with the governance framework defined by LFPSE and PSIRF.	Quality and Safety Committee June 2024

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 fair 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 and to highlight learning to make safety improvement

- Wirral Community Health and Care Foundation Trust is required to report deaths that occur for people in receipt of care from Trust services where there is no natural cause of death and may involve the police, coroner, and safeguarding concerns

- Caring, and compassion for bereaved families and carers is in line with our Duty of Candour Standards. We will keep families or carers updated and involved at a level they feel comfortable with, enabling their involvement, and providing opportunity to ask questions and queries

- Stage One – A mortality review form will be completed for all reported deaths and shared with the Clinical Risk Management Group (CRMG). Often no further action taken.
- Stage Two – when new learning has been identified or a request from Coroner or system partners, CRMG will request further incident review.

- We will learn from deaths of people living with a learning disability, and these deaths are nationally reportable (LeDeR Programme Review 2019/2020).

- All reported deaths on Datix and the online Learn From Patient Safety Events (LFPSE) service are shared with senior managers for timely review

- The Trust has a fortnightly Safety Incident Review Group (SIRG) 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

- The Trust has a quarterly 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

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.

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Learning from Deaths Policy

1. PURPOSE AND RATIONALE

1.1 The purpose of the Learning from Deaths Policy is to outline 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 Historically, nationally, there have been concerns about mortality, their reviews and learning from such serious incidents. This policy will enable learning and strengthen patient safety systems.

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 that involve the police, coroner, and safeguarding concerns.

- Any unexpected death not included in the 3 scenarios above.
- Deaths of people with a learning disability, are nationally reportable in line with the Learning from lives and deaths programme – people with a learning disability and autistic people (LeDeR) (NHS LeDeR Policy 2021)
- All deaths in in-patient beds that occur in the Community Intermediate Care Centre will be investigated.
- Deaths where concerns or complaints are raised by families, carers, staff and system partners.
- Deaths from natural causes, in which new learning for deteriorating, palliative and end of life care has been identified.

2.2 Child deaths are reviewed within the scope of the Merseyside Child Death Overview Panel (including Sudden Unexpected Deaths in Children SUDIC) and, for Cheshire East, by the Pan Cheshire Child Death Overview Panel. Further information about aspects of CDOP and SUDIC can be found in our StaffZone section for Child Health Procedures Child death procedures – StaffZone (wirralct.nhs.uk)

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 the complaints process.

3.2 Deaths will be systematically reviewed at the fortnightly Safety Incident Review Group coordinated by the Quality and Governance Service

3.3 The Safety Incident Review Group systematically reports into the fortnightly Clinical Risk Management Group for discussion in line with the Trusts Incident Safety Policy. They request the level of review / 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 and recorded on Datix
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 any learning or 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	A culture of fairness, openness and learning in the NHS by supporting staff 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.
Patient Safety Incident Response Framework	The Patient Safety Incident Response Framework (PSIRF) advocates a coordinated data driven response to patient safety incidents. It embeds patient safety incident response within a wider system of improvement and significant cultural shift towards systematic patient safety management. It has four key aims of compassionate engagement and involvement, proportionate response, system-based approaches and supportive oversight focused on strengthening response system functioning and improvement.
Learn From Patient Safety Events	Learn From Patient Safety Events (LFPSE) is national reporting system, supporting the PSIRF, to support the recording and analysis of patient safety events; including questions focused on learning and improvement, thereby allowing for greater depths of insight across the NHS.
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
Child Death Overview Panel (CDOP)	The CDOP process covers all child deaths from birth up to the 18th birthday (excluding still births and planned terminations). The CDOP considers the death of each child and is required to complete a proforma regarding its findings for each child. The proforma includes factors relating to the child and family, and service provision: categorization of the cause of death: a judgment regarding whether there were modifiable factors; learning points and recommendations; any new, ~~previously unidentified~~ ~~immediate~~ follow up actions for the family and whether the case should be referred to Local Safeguarding Children Partnership (LSCP) Chair for consideration of a Serious Case Review (SCR).
SUDiC	Sudden Unexpected Infant Death in Childhood. It refers to cases where a child dies unexpectedly, without a pre-existing medical cause of death being apparent.
ALTE	The Pan Merseyside and Pan Cheshire CDOP groups use the term ALTE for all life-threatening events for children 0-18 years and is associated with incidents where the child will not recover spontaneously and usually requires medical intervention.
BRUE	A BRUE is a brief resolved unexplained event used when a child, specifically under the age of 12 months, suddenly becomes floppy and unresponsive, or stops breathing briefly but then returns to normal. These episodes used to be recorded as ALTE but the term BRUE is now recommended.

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

This group, chaired by the Medical Director, 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 meets 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

The Chief Nurse is responsible for working with the Medical Director to ensure appropriate reporting of any identified unexpected deaths in line with the Incident Reporting Policy and national reporting systems

5.7 Safety Incident Review Group

The Safety Incident Review group (SIRG) includes core members of the Quality and governance Service 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 Patient Safety Incident Investigations and monitoring completion of action plans StEIS reporting as needed. An After-Action Case Note Review is completed and would be progressed if significant learning has been identified at CRMG. The group is also responsible for monitoring of Duty of Candour. The minutes of the Group are submitted to the Quality and Safety Committee

5.9 Service Directors / Service Leads

Are responsible for implementing the Trust's responsibilities in relation to Mortality Review processes to improved patient care by:

- providing additional training that is service specific.
- providing clinical supervision, de-briefing meetings, and informal and formal support.
- supporting staff to request a debrief conversation, especially traumatic incidents.
- supporting staff to report unexpected deaths, within scope of the Trust's Mortality Review process.

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.

5.11 Medical and Healthcare staff

Senior clinical staff within services and our inpatient bed Community Integrated Care Centre (CICC) to be aware of the requirements of the Learning from Deaths Policy.

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, inequalities and 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.

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 is mandatory as part of the Learning Disability Death Review. (LeDeR) programme to learn and improve services

locally and nationally to improve the health of people with a learning disability and reduce health inequalities. The Trust will work with system partners as required.

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 required.

8.1 **Stage One**

All reported deaths which have occurred in a place where we are commissioned to deliver services, are discussed at both the fortnightly Quality and Governance Safety Incident Review Group (SIRG) and at the fortnightly Clinical Risk Management Group (CRMG). Further reviews and investigations are commissioned based on the events surrounding the death and the results of the Mortality Screening Tool. The principles around Duty of Candour are also overseen within this group. CRMG respond proportionately and at times no further action is required.

The Mortality Screening Tool considers whether a variety of factors were present. Examples include:

- Receipt of an End-of-Life advance care plan (PACA).
- Presence of a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) form.
- Association with failed visits.
- Association with rescheduled visits.
- Concerns raised by any party regarding the care provided prior to death.
- The involvement of other services involved prior to death.
- Medical Cause of death (if known).

Stage Two

When new learning has been identified, or families have raised concerns or questions CRMG will request further incident review. This also includes requests from the Coroner or system partners. An After-Action Review is undertaken and in line with the Trust's Patient Safety Incident Response Plan a patient safety incident investigation (PSII) may be requested. Shared learning is integral to the action plan, which is monitored by CRMG.

Patient and families are supported and informed at either stage one or two, to provide opportunities to ask or raise any queries. It is essential that family involvement is supported as part of a patient safety review as their insights of the patient's care supports further learning.

8.2 All reported deaths

All reported deaths are reviewed fortnightly at the Safety Incident Review Group and appropriate actions monitored. If aspects of the review are not completed, this is requested from the appropriate team. The findings from the initial review are shared at the fortnightly 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 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 (See 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. This includes any deaths reported by the Frailty Virtual Ward (FVW).

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 Networks 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 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 – See 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 GP08
15.2 The policy supports the implementation of the Duty of Candour Policy GP43
15.3 The policy supports the implementation of the Patient Safety Incident response plan GP60

16. REFERENCES / BIBLIOGRAPHY

- Care Quality Commission (2015) Regulation 20: Duty of Candour
- Learn From Patient Safety Events (LFPSE) LFPSE Online RPSE Service [Standard Access] - User Guidance (learn-from-patient-safety-events.nhs.uk)
- National Guidance on Learning from Deaths (2017) – A framework for NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in care. nqb-national-guidance-learning-from-deaths.pdf (england.nhs.uk)
- NHS (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
- NHS Improvement (2017) Implementing the Learning from Deaths framework: key requirements for Trust boards
- Wirral Community NHS FT Child Death Procedures – Trust StaffZone link Child death procedures – StaffZone (wirralct.nhs.uk)
- NHS England (2022) Patient Safety Incident Response Framework (v1 Aug 2022) B1465-1.-PSIRF-v1-FINAL.pdf (england.nhs.uk)
- NHS England (2022) Patient Safety Incident response Framework supporting guidance – Engaging and involving patients, families and staff follow a patient safety incident B1465-2.-Engaging-and-involving...-v1-FINAL.pdf (england.nhs.uk)

Appendix One

Engaging and involving patients, families and staff following a patient safety incident

The PSIRF recognises that learning and improvement following a patient safety incident can only be achieved if supportive systems and processes are in place. It supports the development of an effective patient safety incident response system that prioritises compassionate engagement and involvement of those affected by patient safety incidents (including patients, families, and staff). This involves working with those affected by patient safety incidents to understand and answer any questions they have in relation to the incident and signpost them to support as required.

We are firmly committed to continuously improving the care and services we provide. We want to learn from any incident where care does not go as planned or expected by our patients, their families, or carers to prevent recurrence.

This document has two parts:
Part A: Creating the right foundations describes the systems and processes that establish strong foundations on which an effective involvement process can be built. This guidance is for those responsible for PSIRF implementation and those in system oversight roles.

Part B: Engagement and involvement process describes a process for engaging those affected by patient safety incidents and supportively involving them throughout a learning response, and while it focuses on patient safety incident investigation (PSII) it can be applied to other learning response methods. This practical guidance is aimed at those working directly with people affected by patient safety incidents (e.g. learning response leads and family liaison officers).

Engagement principles
Alongside the advice in parts A and B, nine principles should inform the design of an organisation's systems and processes for engaging and involving those affected by patient safety incidents. Due to the range of incidents that can occur, and the different needs of individuals affected, the principles should be flexibly applied when engaging with or involving those affected by patient safety incidents in an investigation.

1. Apologies are meaningful
Apologies need to demonstrate understanding of the potential impact of the incident on those involved, and a commitment to address their questions and concerns. Ideally, an apology communicates a sense of accountability for the harm experienced, but not responsibility for it ahead of investigation. Getting an apology right is important – it sets the tone for everything that follows. Apologising is also a crucial part of the Duty of Candour.

2. Approach is individualized
Engagement and involvement should be flexible and adapt to individual and changing needs. These needs could be practical, physical, or emotional. Engagement leads should recognise that every response might need to be different, based on an understanding of the different needs and circumstances of those affected by an incident.

3.Timing is sensitive
Some people can feel they are being engaged and involved too slowly or too quickly, or at insensitive times. Engagement leads need to talk to those affected about the timing and structure of engagement and involvement, and any key dates to avoid (e.g. birthdays, funeral dates, anniversaries), particularly where someone has lost a loved one.

4. Those affected are treated with respect and compassion
Everyone involved in a learning response should be treated respectfully. There should be a duty of care to everyone involved in the patient safety incident and subsequent response, and opportunities provided for open communication and support through the process. Overlooking the relational elements of a learning response can lead to a breakdown of trust between those involved (including patients, families, and healthcare staff) and the organisation.

5. Guidance and clarity are provided
Patients, families, and healthcare staff can find the processes that follow a patient safety incident confusing. Those outside the health service, and even some within it, may not know what a patient safety incident is, why the incident they were involved in is being investigated or what the learning response entails. Patients, families, and healthcare staff can feel powerless and ill-equipped for the processes following a patient safety incident. Therefore, all communications and materials need to clearly describe the process and its purpose, and not assume any prior understanding.

6. Those affected are 'heard'
Everyone affected by a patient safety incident should have the opportunity to be listened to and share their experience. They will all have their individual perspective on what happened and each one is valid in building a comprehensive picture to support learning. Importantly, the opportunity to be listened to is also part of restoring trust and repairing relationships between organisations and staff, patients, and families.

7. Approach is collaborative and open
An investigation process that is collaborative and open with information, and provides answers, can reduce the chance litigation will be used as a route for being heard. The decision to litigate is a difficult one. Organisations must not assume that litigation is always about establishing blame – some feel it is the only way to get answers to their questions.

8. Subjectivity is accepted
Everyone will experience the same incident in different ways. No one truth should be prioritised over others. Engagement leads should ensure that patients, families, and healthcare staff are all viewed as credible sources of information in response to a patient safety incident. 10 | Engaging and involving patients, families and staff following a patient safety incident

9. Strive for equity
Organisations may differ from patients, families, and healthcare staff in what they consider is the appropriate response to a patient safety incident. The opportunity for learning should be weighed against the needs of those affected by the incident. Engagement leads need to understand and seek information on the impact of how they choose response types on those affected by incidents and be aware of the risk of introducing inequity into the process of safety responses

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
Mortality Data is analysed and reported quarterly to the Quality and Safety Committee	Mortality Review Group	Medical Director	Quarterly	Divisions	Quality and Safety
All case reviews of reported deaths are summarised in the Patient Safety Incident Review paper	Clinical Risk Management Group	Quality and Governance – Patient Safety	Fortnightly Meeting	Divisions	Quality and Safety
Oversight for completion of action plans from After Action Reviews and Patient Safety Investigations	Clinical Risk Management Group	Medical Director	Fortnightly	Divisions	Quality and Safety

Appendix Three

Stage 1 Quality and Equality Impact Assessment (QEIA) template

Initiative/Project/Change Title	Policy				
Department/service	Trust wide		**Lead Name & Job Title**	Medical Director	
Rationale for completion	Updated Policy ✓	Change to an existing strategy or policy	Change to a service or function	A new service or function	Other
Initiative/Project/Change Description *Describe current status followed by any changes that stakeholders would experience*.	Updates to the existing Learning From deaths Policy aligns to the Patient Safety Incident Response Framework 2022 and NHSE Learning From Deaths guidance. A revised governance process to review reported deaths as stage one and a stage two process has been included.				
Who is likely to be impacted?	Patients/service users/carers ✓	Workforce ✓	Organisation ✓	Partners ✓	Other

Quality Impact

This looks at the project as a whole and asks how it will impact patients/service users, staff and the organisations involved and how any identified risks or negative impacts could be mitigated.

If the risk score is greater than 10 in any area, this will require a more detailed impact assessment to be carried out and shared for Executive approval Standard Operating Procedure - template (wirralct.nhs.uk)

	Positive/ Neutral/Negative impact	**Negative Risk Score (L x C)**	**Mitigations for impacts**
Patient/Staff Safety – will the scheme have a positive/negative or neutral effect on the aim to treat and care for people in a safe environment and protect them from avoidable harm?	Positive		
Clinical Effectiveness – will the scheme have a positive/negative or neutral effect on the aim to apply knowledge that is based on research, clinical experience and patient preferences, to achieve optimum processes and outcomes of care for patients/service users?	Positive		
Patient/Staff/Organisation Experience – will the scheme have a positive/negative or neutral effect on patients' experience of care, based on all interactions, before, during and after delivery of the care? How will it affect staff experience and the portrayal of the organisation as a whole?	Positive		

Equality Impact - Who may be affected by this activity?

	Positive/Negative/ Neutral impact description	Negative risk score (L x C)	Mitigations
Protected characteristics (Equality Act 2010)			
• **Age** • **Disability** • **Race** • **Gender reassignment** • **Marriage & civil partnership** • **Pregnancy & maternity** • **Religion & beliefs (including no belief)** • **Sex** • **Sexual orientation**	Neutral		
In addition, consider the following vulnerable groups:			
• **Armed forces/veterans/reservists** • **Carers** • **Digital exclusion** • **Domestic abuse** • **Education (literacy)** • **Gypsy Roma Travellers** • **Homeless** • **Looked after children** • **Rural/urban areas** • **Socioeconomic disadvantage** • **People with addiction or substance misuse problems** • **People on probation** • **Prison population** • **Undocumented migrant, refugees, asylum seekers** • **Sex workers** • **Neurodiversity** • **Other (please describe)**	Neutral		

If the risk score is greater than 10 in any area, this will require a more detailed impact assessment to be carried out and shared for Executive approval Standard Operating Procedure - template (wirralct.nhs.uk)

Approval activity

Approval Group Name	**Quality and Safety Committee**		
Group Chair		**Date**	
Decision/outcome	**Approved**	**TBC**	
	Not Approved	**TBC**	
	Full QEIA required		

	Learning from Deaths Policy
What is being considered?	Update of existing policy to reflect national guidance on Learning from Deaths - incorporating criteria for review of unexpected deaths and update of LFPSE and PSIRF
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 [✓]

Please ensure the QIA/EA is added to the SAFE quality tracker

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

- 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