Learning from Deaths Policy:

Developing a positive culture for learning and improvement

Solent NHS Trust policies can only be considered to be valid and up-to-date if viewed on the intranet. Please visit the intranet for the latest version.

Purpose of Agreement	This policy as well as informing staff of their role in relation to learning from deaths clarifies what is expected of them when a patient dies and how we should engage with bereaved families and carers.
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SUMMARY OF POLICY

This policy will inform the organisation of the staff roles and responsibilities relating to learning from deaths where a review indicates concerns about the quality of care provided or system-wide failures. In addition, where family/carers have raised concerns about the care provided or would like to ask questions about the patient's care and death staff will know how to support this process and promote a culture of learning and make improvements for future care.

As well as informing staff of their role in relation to learning from deaths this policy lays out what is expected of us when a patient dies and how we should engage with bereaved families and carers, to ensure there are accessible opportunities for them to discuss, or ask questions about, the care received by their loved one. Where a concern is expressed staff will actively seek to provide information in an open and honest way, identifying where lessons could be learned. This process should be led by the family/carers if this is what they want, making sure they are offered contact on multiple occasions. This takes into account where family/carers have stipulated that they do not want us to contact them.

This policy will be reviewed in 6 months to consider if there are any updates or amendments that are required following learning from a local and or national level.

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1. INTRODUCTION & PURPOSE

1.1 Following the publication of the 'Mazars Report' (Green et al, 2015) after an investigation into deaths that had occurred in Southern Health NHS Trust 2011-2015, all Trusts were required to take action and review practice and implement changes to ensure that lessons would be learned. In 2016 The Care Quality Commission (CQC) also reviewed the way Trusts review and published "Learning, Candour and Accountability".

Solent NHS Trust developed the 1st version of this policy in 2017 after considerable consultation and discussion with senior medical and non-medical colleagues in the organisation after recognising the need for a policy to ensure that learning from deaths was conducted in a positive and proactive manner. This introduced a reporting and governance process for the first time to enable assurance that poor quality of care or concerns that a death was avoidable would be highlighted, reported and acted upon.

The National Quality Board then later published the "National Guidance on Learning from Deaths" in 2017. This all contributed to the beginning of a standardised approach across the NHS in the way NHS Trusts report, investigate and learn from patient deaths, which it is anticipated will lead to better quality investigations and more embedded learning.

In 2019, CQC published "Learning from Deaths-a review of the first year of NHS Trusts implementing the national guidance, in which they identified 5 enablers and barriers to good practice. This policy addresses these to ensure a positive outcome, see below.

- Values and behaviours that encourage engagement with families and carers
- Clear and consistent leadership
- A positive, open and learning culture
- Staff with resources, training and support
- Positive working relationships with other organisations

These are also consistent with our HEART values of honesty, everyone counts, accountability, respect for others and teamwork.

1.2 This policy as well as informing staff of their role in relation to learning from deaths clarifies what is expected of us when a patient dies and how we should engage with bereaved families and carers. This is to ensure there are opportunities for them to discuss (or ask questions about) the care received by their loved one. Where a concern is expressed staff will actively seek to provide information in an open and honest way, identifying where lessons could be learned. This process should be led by the family/carers if this is what they want, making sure they are offered contact on multiple occasions and provided the Family Liaison Mangers details. This takes into account where family/carers have stipulated that they do not want us to contact them.

1.3 The purpose of this policy is to set out the Trust's expectation on the process when a patient has died and how we respond to and learn from deaths of patients where we are the main provider (or one of the main providers) of care or when there are concerns regarding the care we provided from family/significant others/carers or staff. When mistakes happen, we need to do more to understand the possible causes and ensure we work with our partners. This policy will help staff to understand that the purpose of reviews and investigations into patient deaths is to identify problems in care that

might have contributed to the end outcome, and are key to learning lessons in order to prevent a similar event happening again. It also provides an opportunity to review care, highlight and learn from good practice that has occurred.

2. SCOPE & DEFINITIONS

2.1 This policy applies to all Trust staff involved in caring for patients or those who have responsibility for the quality of patient care, to feel more confident in answering questions and reviewing deaths to identify how we can learn from them and improve care provided. This includes bank, locum, permanent and fixed term contract employees (including apprentices) who hold a contract of employment or engagement with the Trust, and secondees (including students), volunteers (including Associate Hospital Managers), Non-Executive Directors, governors and those undertaking research working within Solent NHS Trust, in line with Solent NHS Trust's Equality, Diversity and Human Rights Policy. It also applies to external contractors, Agency workers, and other workers who are assigned to Solent NHS Trust.

2.2 Solent NHS Trust is committed to the principles of Equality and Diversity and will strive to eliminate unlawful discrimination in all its forms. We will strive towards demonstrating fairness and Equal Opportunities for users of services, carers, the wider community and our staff.

2.3 Our Trust provides a wide range of clinical services across inpatient and community which can result in confusion as to who is responsible for the reporting and investigating of a patient's death. To support staff with this, the Trust only requires staff to report and investigate a death where we are one of the main providers of care-see below for guidance and refer to Appendix 1. However if there is any doubt staff are to contact their line manager for guidance. A monthly report is provided to each service line to cross reference all deaths that the trust is notified of and it is this data which informs the production of the trust mortality dashboard.

2.4 **Inclusion and Exclusion Criteria**

- **Reporting Unexpected Deaths**

As soon as the clinical service becomes aware of the death of a patient for whom we are the main provider of care that meets our inclusion criteria an incident form is to be completed. These are reviewed by the Quality and Safety team and arrangements are made for an incident review meeting when indicated.

- **Reporting expected deaths**

Expected deaths must be reported for all inpatient deaths. For all other expected deaths, an incident form must be submitted if there are any concerns from the family/carer or staff or other providers.

In summary:

To clarify a review <u>is</u> required in the following services as we are a main provider of care (or one of the main providers):

- All inpatient deaths-Adults Southampton and Portsmouth

- All patients who die within 6 months of accessing care in :
  Adult Mental Health and Older persons Mental Health (including up to 6 months post discharge or if the notification is delayed because it has not been possible to locate the patient and confirm

death)

- All patients who die within 1 month of accessing care in:

Adult Community teams

Primary Care (exceptions below)

Sexual Health-HIV positive patients only

Children's and Families service (please note the structured judgement tool is written for adults only)

A review is <u>not</u> required in the following services

OPMH Memory clinic

Tissue viability

Care home liaison

Community physiotherapy

Community Palliative Care team

Podiatry

Community Physiotherapy

Special Care Dentistry

Sexual Health (with the exception of patients with HIV)

Please note the above lists are guidance and not exhaustive. Other considerations in regards to this policy are:

1. Consider if there are any concerns about the quality of care that our Trust has provided and it is thought that this has contributed to the death of a patient, an incident review meeting must be held to determine next steps and actions required.
2. Consider that there may be other deaths which do not meet any of the above criteria but do require further review or investigation due to clinical complexity or other reasons.
3. In most cases we will review deaths that satisfy one of the following criteria:
    a. Was Solent the main (or one of the main) care providers for the patient at the time of death? For mental health services, this includes patients who were discharged up to six months prior to dying.
    b. Was the patient on a waiting list to be seen and is the cause of death related to the care they were likely to receive?

If the answer to the above considerations is yes, an incident review meeting is required.

3 PROCESS/REQUIREMENTS

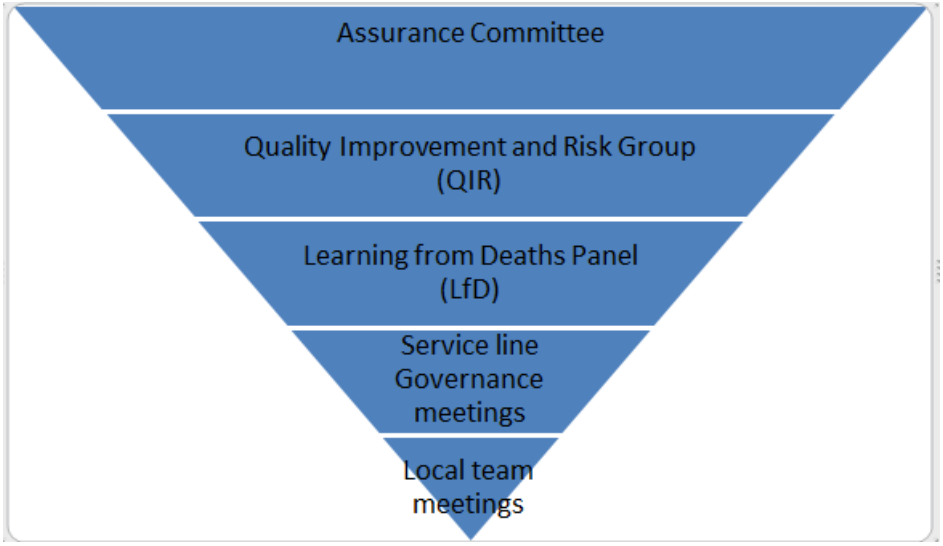
3.1 **Responding to and Learning from Deaths**

The NHS continues to evolve and our staff continue to work hard to deliver safe, high quality care in line with our HEART values. Unfortunately there are occasions when patients experience poor quality of care which is often due to system issues and or challenges. Our culture focuses on supporting staff to be confident in identifying what can be improved upon by openly and honestly reviewing the care/care pathways that the patient has been on. In doing so, we seek to improve future patient care and support of our staff. In addition the findings may support the Board to identify what future resources and investment may be required.

3.2 **Encouraging a 'learning from deaths' culture**

To enable us to learn from deaths of patients we are providing care to, we require a clear and robust governance process. The Trust has a "no blame" approach to learning and this should encourage all staff to engage in an open and honest manner. The aim of this review process is to learn specific lessons and to develop and improve future care provision to minimise the risk that this could occur again. Any emerging themes/trends that are identified will be shared across the organisation and actions taken to ensure that they are appropriately reviewed and acted upon. The Trust learning framework is how we acknowledge the learning and make sustainable changes to improve future care provision. Staff will be able to view learning and improvements that have been implemented by accessing the learning zone on the intranet.

The governance structure in place to enable this is below:



The Learning from Deaths (LfD) panel meets monthly and reviews any serious incidents (SI's)that have been raised as a result of a patient death, service line reports on mortality, structured judgement tools (SJT), learning from coroners inquests and the monthly mortality dashboard. The main purpose of this panel is to share and disseminate lessons learned from reports (negative and/or positive) and support actions to ensure that as a Trust we learn, share and develop to improve our future care provision and delivery of care. The panel also reviews any National reports or reported trends and guidance to continue to develop and improve best practice. Feedback is disseminated across the Trust by the panel members through internal governance processes.

The panel reports to the Quality Improvement and Risk Group (QIR) and The Board Assurance Committee on a quarterly basis within the Patient Safety Report which includes the mortality dashboards. If any emerging themes are identified consideration is given to the need to review staff training to ensure we have a competent and responsive clinical workforce.

Within the Patient safety report the following is documented:

- total number of deaths reported
- total number of deaths that were subject to a structured review (if a patient has a known learning disability this will be as per the LeDeR review process) or reviewed by another provider
- total number of deaths that were subject to a serious incident (SI) investigation
- learning that has been identified from investigations and reviews.
- what changes have occurred as a result of our learning.

For every death that is subject to a serious incident investigation staff involved in the patient's care will receive direct feedback on the investigation findings and recommendations.

Staff may also require support following the death of a patient and team leaders should ensure that they are offered support and given opportunities to discuss this at varying intervals in time.

3.3 **Family engagement**

When staff are aware that a patient has died, it is important to make direct contact with the family as soon as possible to offer condolences. Staff should refer to the 'Being Open' process as a minimum. For more detailed guidance staff should refer to the Trust's 'Being Open and Duty of Candour "policy.

3.4 **Inpatient Services**

For all deaths within inpatient services the family/carer must be contacted at the point the patient has died by a staff member to inform them of the death. Condolences are to be offered. If appropriate, and it is known that their loved ones care is to be reviewed, the family/ carer is to be given the opportunity to be involved in this process and their preferred method of future contact regarding this should be established. If not appropriate (or it is not known initially that a review is required) further contact will be required (where possible this should be within 7 working days).

This is a sensitive situation and families/carers may respond differently to the loss of a loved one and the information offered at that initial contact. Staff may need to offer the opportunity for a follow up call and provide the Family Liaison Manager (FLM) contact details (refer to SolNet page for details). It is important that we directly engage with families/ carers to find out if they have any concerns regarding the care of their loved one or any previously unanswered questions. This will help guide the review and decision making process.

3.5 **Community Services**

Within the community services often notification of the patient's death will either come directly from the patient's family/carer or another agency such as the Police or HM Coroner's office. If the notification comes via another agency the lead for that patient's care or another staff member who knew the patient should make contact with their relative/carer and follow the advice as noted above.

3.6 **Being Open and Duty of Candour**

The principles of being open are to be applied following all deaths. The statutory 'Duty of Candour' is triggered when patient safety incidents are reported and validated as moderate harm or above-as identified through the Serious Incident process. Refer to the Trust's "Being Open and Duty of Candour" policy" and "Serious Incident" policies for full guidance on SolNet.

3.7 **Providing written information to relatives/carers**

The death of a close family member or friend is can be devastating and people are often unsure what to do next or where they can get support from. Information can and should in the first instance be provided verbally but they may not always retain this information at that time. The Trust appointed a Family Liaison Manager (FLM) in late 2018 who is able to provide bereaved families with additional support and guidance through this difficult time after it was recognised that this was an important way to ensure that family, significant others and carers are supported. There are resources which can be accessed to support staff to help bereaved families on the SolNet pages and the contact details of the FLM. See Appendix 2 for the referral guidance. Consideration must also be given to ensure that we share all information in an accessible way-refer to SolNet for more information on accessible information.

3.8 **How to engage meaningfully and compassionately with bereaved families and carers**

When it is identified that the death of a patient is to be reviewed, initial contact with families and carers should be undertaken by one of the lead staff members involved in the patients care and continue to be the service point of contact. Families and carers are to be contacted via their preferred method of contact if this has already been established. If the preferred method of contact is not known a letter should be sent, this will then enable the relative/carer time to consider what they wish to do. A template letter is available for staff to use in Appendix 3 and this is to be personalised to reflect the individual circumstances of each family/carer.

If the letter is not acknowledged or the offer of involvement is declined staff should respect this whilst being aware that they may change their mind at a later date. If this happens, staff will be open to this. When a family/carer confirm they want to be involved in any review or investigations, staff will treat the family/carer as a valued partner in the process from the beginning and explain that the purpose is to review the quality of care provided and if there are any lessons which can be learned and shared to improve future care provision. It is important to ask if they have any specific questions that they wish to be asked. If an Serious investigation is to be undertaken, it may be that some questions relate to other providers and as the main provider of care, we will make contact and invite them to be part of the process to enable the bereaved family/ carers to have one single report. If the care is to be reviewed as per the structured judgement tool, it will be useful to provide a copy of the template to help them to understand what the review involves and provide them with the opportunity to ask any additional questions. Preferred method of contact needs to be established and timeframes confirmed with the family/carers.

If the family/carer decides they do not want to be involved in the review process it needs to be made clear they can contact the service at any time should they change their mind. If the family does not want contact at all about the process or findings, this will be honoured and recorded on the electronic records of the patient and the incident reporting system.

All contact with the family member/carer must be recorded on the electronic care record and electronic reporting system (for the latter when it relates to duty of candour).

For any family/carer where their first/preferred language is not English staff are to refer to their local guidance and arrangements.

In some cases a family member/carer may wish to seek independent legal advice. This should be respected and not seen as threatening and does not lead to an automatic involvement of legal representation on behalf of the Trust. If any staff member within the Trust receives a communication from a legal professional, this must be discussed with their line manager and the Head of Risk and Litigation must be informed.

3.9 **Patients right to confidentiality following death**

The Department of Health, General Medical Council and other clinical professional bodies have acknowledged that the duty of confidentiality continues beyond death and this is reflected in their guidance. Staff should be mindful of this when talking to bereaved families/carers where patients have not wanted sensitive information shared.

This can be difficult when trying to support the bereaved family/ carers in an open and transparent way. Therefore any staff unsure should:

- Refer to the Trust Access to Health Records Policy.
- Speak with their immediate line manager.
- Contact the Trust Information Governance team for advice.
- Contact the Trust Caldicott Guardian.

3.10 **Where the patient is under the age of 18**

In the case of any death where the patient is under the age of 18 this will be subject to the Child Death Review process (Department of Health and Social Care and Department of Education, 2018). These reviews are separate to the Trust processes and the service involved will engage and provide support as required. The local Safeguarding Children Boards lead on this process and seek to promote action to prevent future deaths and support wider aspects of inter-agency working to safeguard children and promote child welfare in the future. In some circumstances, the service may declare a Serious Incident or undertake a structured judgement review if it is felt that there are any immediate concerns relating to this death (this is because the Child Death Review process can be an extended process and as a Trust we want to ensure that if there is any immediate learning or action required that this is undertaken promptly without delay).

3.11 **Where the patient has a Learning Disability (LD)**

In the case of a death within the Learning Disability services a report also has to be made to the Learning Disabilities Mortality Review (LeDeR) Programme. An incident form is to be completed and the LeDeR Notification of Death on-line form is to be completed and submitted (http://www.bristol.ac.uk/sps/leder/notify-a-death/).

A LD structured judgement tool is to be completed following the completion of the LeDeR process and submitted to service line governance.
Completed templates are then to be sent to the Quality and Safety team for inclusion on the LfD panel for discussion and noting.

All templates are located on the trust intranet on the Business zone under templates.

3.12 **Incident Review**

See Appendix 1 for process to guide decision making regarding incident reporting and process.

In addition to this, for information the following deaths are reportable to the Coroner and an incident review meeting is indicated in all cases.

- Suspected self-harm of an inpatient.
- Suspected self-harm of a person within 6 months of discharge from service.
- Death of a patient who is detained under the Mental Health Act 1983, including patients subject to a Community Treatment Order.

- Death of a patient under the age of 18.
- If the death is as a result of an occupational injury / disease.
- Homicide.
- Unexplained death.

3.13 **Outcomes of the incident review meeting**

Serious incident (SI) investigation

Staff should refer to the SI policy which explains the process in full and are to ensure that the principles in this policy are followed in undertaking the investigation.

Structured Judgement tools

To ensure these are undertaken in an open and impartial way, the structured judgement tool review will be undertaken by senior clinicians not involved directly in the care provision of that patient or through a multi-disciplinary meeting with senior staff who have not had direct patient care involvement and attached to the electronic incident form. The Clinical Director and Professional Lead will review the completed form and confirm that no further action is required and it is then to be submitted to the Quality and Safety team for discussion at the Learning from Deaths panel. If further action is required, this will be referred to the Quality and Safety team who will organise an incident review meeting.

Where possible the structured review should be completed within 20 working days of the patient's death.

To locate these tools please refer to the Business zone on the intranet.

3.16 **Outcomes from Structured Judgement tool review**

- **When learning is identified** this needs to be highlighted and discussed at the LfD panel regarding next steps.
- **If notable practice is identified:** this needs to be reported at the LfD panel and staff encouraged to complete a learning from excellence form which can be submitted via the reporting zone on the intranet.
- **If no learning is identified and no further action is required** these will be reported to the LfD panel for noting.

- **If it is concluded that there are concerns regarding quality of care and/or avoidability outcome for the patient** the Quality and Safety team are to be informed and an incident review meeting will be held and a decision will be made regarding next steps.

4. ROLES & RESPONSIBILITIES

The Chief Executive Officer

The Trust recognizes it is accountable for ensuring compliance with the National Guidance on Learning from Deaths, alongside NHS England's Serious Incident Framework 2015 (update awaited in spring 2019) and working towards achieving the highest standards in mortality governance. The Board is also responsible for ensuring quality improvement remains key by championing and supporting learning that leads to meaningful and effective actions that improve patient safety and experience, and supports cultural change.

The Executive Director

Within Solent NHS trust this is our Chief Medical Officer and is responsible for:

- Ensuring the learning from deaths process is delivered as noted in this policy
- Provide challenge when necessary
- To ensure high standards in mortality governance are maintained and that lessons learned from the care provided to patients who die is integral to the Trust's governance and quality improvement work.

The Non-Executive Director

Is responsible for:

- oversight of the progress
- acts as a critical friend holding our Organisation to account for its approach in learning from deaths and will challenge where necessary
- Ensuring that the processes in place focus on learning and can withstand external scrutiny, by providing challenge and support.
- Holding the Organisation to account for its approach and attitude to patient safety and that there is evident learning from all deaths.
- Ensuring fellow Non- Executive Directors understand, and can participate in, the process

Clinical Directors, Professional Leads, Lead Consultants, Medical Staff, Service Managers, Modern Matrons, Ward and Team Managers, all Registered Nurses and Allied Healthcare Professionals

It is the responsibility of the above staff:

- To promote an open culture of responding to the deaths of patients who die in or under our care and ensure staff reporting deaths have the skills and training to support the review process.
- To support families or carers during a difficult and emotional time.
- To participate in the review and investigation of patient deaths
- Support staff to review and investigate deaths ensuring they have the time to carry this process out in skilled way to a high standard.
- Ensure staff have the right level of skill through training.
- To promote learning from deaths through facilitating and giving focus to the review, investigation and reporting of deaths.
- To ensure that all learning from the process of review and investigation is shared across the trust (and consideration to sharing this outside the trust) and learning is acted upon.

Head of Patient Safety

The Head of Patient Safety is responsible for ensuring that:

- Data is collected and published to monitor trends in deaths with Board level oversight of this process.
- Ensuring the incident reporting system is used to its full potential to record deaths and the

circumstances of individual deaths.

- Information is processed consistently, precisely and in a meaningful way to fulfil the governance processes required to ensure that high standards in mortality governance are maintained. To continue to promote and embed an open learning culture.
- Learning is identified and monitored through the trust learning framework and changes are shared across the trust and with families/carers and other partner organisation's when applicable.

The Learning from Deaths panel

The panel meets on a monthly basis and is responsible for:

- Having oversight of the review of deaths within the Trust including all expected / unexpected deaths, of patients currently in Trust care (and in addition within a 6 month period of discharge following mental health or LD care).
- Reviewing mortality data for patients and service users
- Engaging with relevant external regional and national bodies contributing to the management and improvement of quality learning in relation to mortality management.
- Acting as the Trust's expert advisory group in terms of reviewing for and consideration of national guidance and other relevant documentation.

5. TRAINING

It is acknowledged that some staff have already been trained to undertake structured judgement tools based on the previous policy. It is recognised that further training is required to implement the updated version. This will be undertaken by providing the following:

- Bespoke training sessions to be led by the Quality and Safety team and the Learning and Development team will be informed to update on staff records.
- The e learning module available through the Royal college of Physicians

Staff will be made aware of this policy through:

- Team Brief
- Team meetings
- Local Induction

6. EQUALITY IMPACT ASSESSMENT AND MENTAL CAPACITY

In accordance with the Equality Act 2010 equality and diversity issues have been considered in the development of this policy and no equality issues were identified. This policy has been assessed against the requirements of the Mental Capacity Act (MCA) 2005 during policy development. (Refer to Appendix 4).

7. SUCCESS CRITERIA / MONITORING EFFECTIVENESS

The success criteria for this implementation and adherence to the policy will be that:

- Deaths fulfilling the criteria for review or investigation are appropriately identified, reviewed and/or investigated and reported
- random case note reviews are completed
- In accordance with the Learning from Deaths Panel Terms of Reference where actions resulting from learning are required these are undertaken in a timely manner and that sustainable quality improvement results from this learning
- What has changed as a result of learning will be recorded on the trust framework database for all staff to view

There are no additional monitoring needs in relation to this policy as all monitoring and reporting is undertaken via the Learning from Deaths panel and Quality Improvement and Risk.

8. REVIEW

This document may be reviewed at any time at the request of either staff side or management, but will automatically be reviewed 3 years from initial approval and thereafter on a triennial basis unless organisational changes, legislation, guidance or non-compliance prompt and earlier review

9. REFERENCES AND LINKS TO OTHER DOCUMENTS

Trust policy: Being Open and Duty of Candour Policy.

Trust policy: Incident Reporting Policy.

Trust policy: Serious Incident Policy.

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, 2017).

Implementing the Learning from Deaths framework: key requirements for trust boards (July 2017)

Child Death Review process (Department of Health and Social Care and Department of Education, 2018).

Learning, Candour and Accountability (The Care Quality Commission (CQC), 2016).

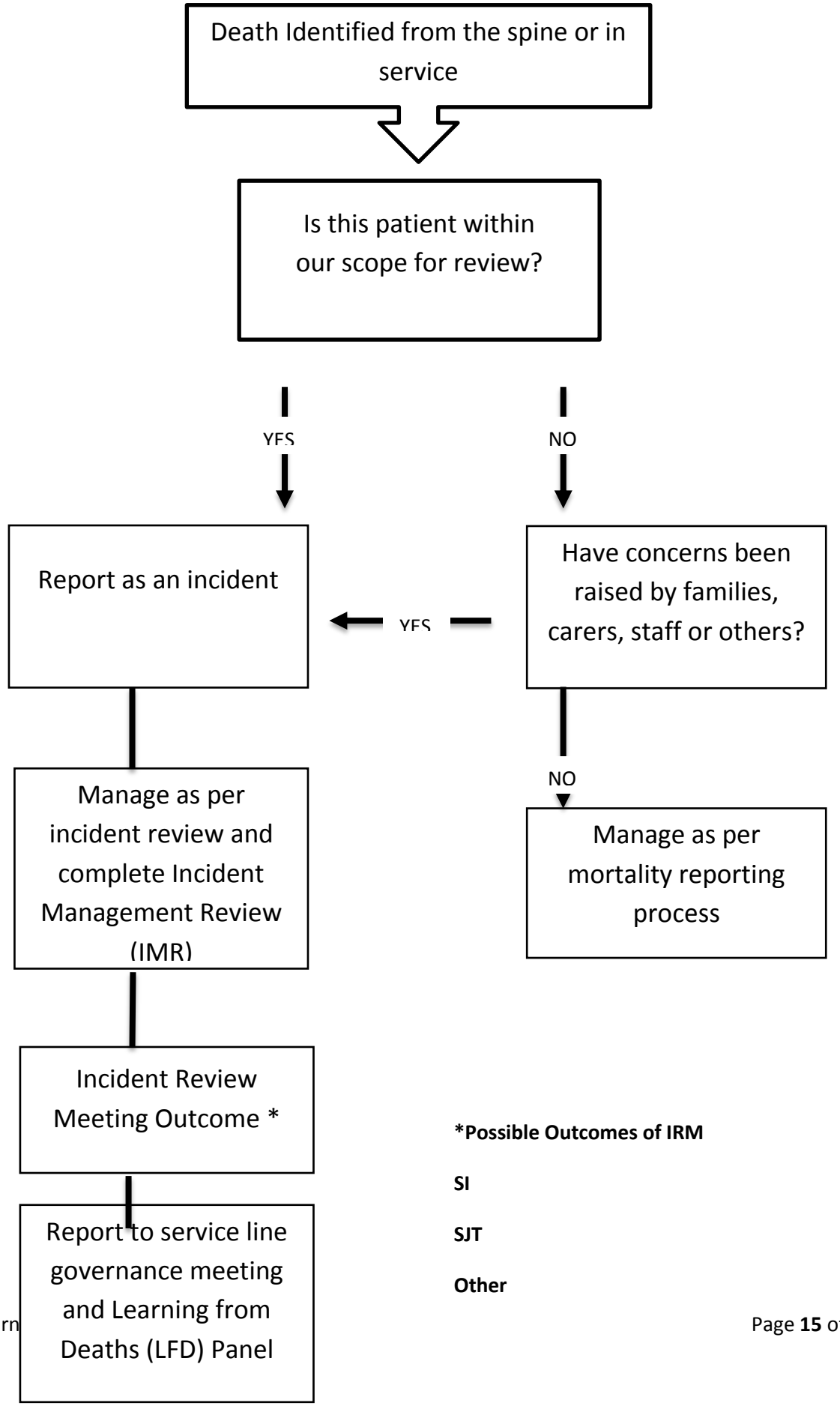
Mazars Report-An investigation into Southern Health deaths 2011-2015 (Green et al, 2015)

Learning from Deaths-a review of the first year of NHS Trusts implementing the national guidance, (CQC, 2019).

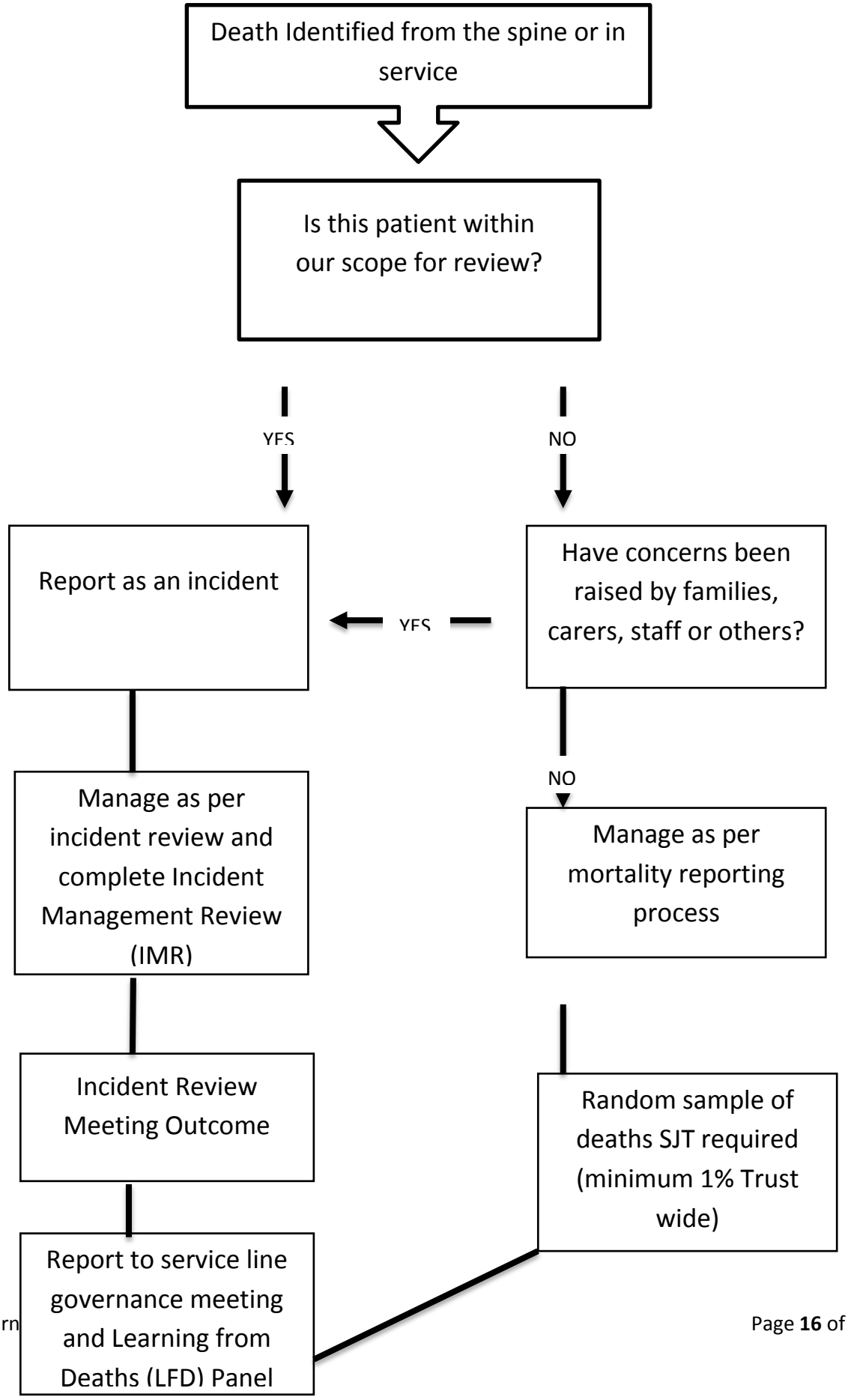
10. GLOSSARY

Abbreviation/ Acronym	
SI	Serious Incident
QIR	Quality Improvement and Risk Group
LD	Learning Disability
LeDeR	Learning Disability Mortality Review
LfD	Learning from Deaths panel
MR	Mortality Review
IR	Incident Report
ILDS	Integrated Learning Disabilities Service
SJT	Structured Judgement tool
IMR	Incident Management Review

Appendix 1 UNEXPECTED DEATH PROCESS



EXPECTED DEATH PROCESS



Appendix 2

Role of the Family Liaison Manager and the referral process for Solent NHS Trust

Key Relationships

Patients, Families and Carers
Investigating Officers
Head of Patient Safety
Complaints and PALS Team
Service Line Professional Leads
Clinical Service Leads
Chief Nurse
Chief Medical Officer

Trust Family Liaison Manager-Sarah O'Neill
Quality and Safety Team
Solent NHS Trust Headquarters
Highpoint Venue

Contact: sarah.o'neill@solent.nhs.net
Tel: 07393 006046

What type of cases should be referred to the FLM and when the FLM can't assist

The role of the Family Liaison Manager (FLM) is primarily to support families, carers and people known to them, throughout the investigation process, following a **serious incident or complex complaint, relating to Trust services**. This is where significant errors, harm or death has been caused to a service user. The family or carers must also consent to being supported by the FLM, on behalf of the Trust.

The FLM will also be available to support bereaved families, carers and people known to the service user, throughout a Coroner's Inquest, should the deceased have been known to the Trust as a service user and where the Coroner has a duty to investigate.

In the event that the Police are involved with any case and the family are supported by the Police Liaison Service, then the Trust FLM will not be involved. The FLM is also unable to be involved in cases where the Police are investigating the family for any reason.

The role of the FLM, when and how to refer

The purpose of this role is to ensure families and carers are treated fairly in an open and honest way, being mindful of their needs and inviting them to be actively involved and consulted during any investigation, also signposting them to other support services as required.

The FLM should be notified, as soon as possible, by the service, when an incident is recognised that may reach the criteria for their involvement, in line with the detailed information above, relating to cases that are eligible for referral.

The FLM referral can be made to the FLM in person, email or telephone, or via Ulysses Safeguard, the Trust reporting system, where there is a tab for incidents that require a referral to the FLM, by any member of staff. The FLM will also liaise

closely with the Quality and Safety Team to identify possible cases that reach the referral criteria and will be invited to all incident review meetings where a death or serious incident has been noted, to consider support for the family/carers.

The FLM will then contact the family/carers to introduce the role and gain agreement for involvement in the case. Once this has been agreed, the FLM will attend the initial incident/complaint review meeting and any other subsequent planning meetings, as appropriate.

The FLM will contact the family and/or carers and liaise closely with the person/s investigating the incident or complaint, for the duration of the investigation. This will include agreeing methods and timing of communication with family members, this may include face to face meetings, telephone calls and email correspondence, to ensure that the family's needs are met with regard to the provision of timely, open and accurate information during the investigation.

The FLM can read through statements and reports with families and carers and clarify any terminology that is not understood, they can also feedback any further questions or comments to the investigation lead.

The FLM will also promote openness and transparency and can give process advice around cases that also come under the Duty of Candour.

It is important to note that the FLM will provide support and information, through what can be a difficult process for families, however they cannot assume the role of a counsellor. If the family requires professional support the FLM will signpost the family to relevant qualified services.

Circumstances may arise where the patient whose care is the subject of the investigation does not wish information to be shared with their family members and the FLM will liaise with the family to explain why the patients wish for confidentially must be respected.

The FLM can discuss any case with staff, will advise if your referral can be accepted and can clarify if they can provide support or signpost you to the appropriate process or person.

Sarah O'Neill

Family Liaison Manager

Appendix 3-Letter template

Dear **(Patient Representatives Name**)

My name is **[INSERT NAME]** and I am **[INSERT JOB TITLE]** for Solent NHS Trust.

I am writing to you, to offer my deepest condolences, following the death of, your **(Relationship to Deceased).** Please also accept my sincere apology that this incident happened, while (**Insert Deceased's Name)** was in our care.

In order to determine what happened and in line with the Duty of Candour regulations, I will now be conducting an investigation into the pathway of care for (**Insert Deceased's Name)**, The Duty of Candour applies where it has been identified that harm *may* have been caused to a person by omission of, or care provided and openly sharing any findings with you.

This investigation is standard procedure that is instigated when any serious event occurs and is undertaken in order to review the care given, to identify areas of good practice in the care provided, or lessons to be learned, in order to prevent any future incidents of a similar nature.

As part of the investigatory process we wish to involve the family/carers of our patient, for you to ask questions and to have the opportunity to obtain information and to express your feelings, which would form an important part of our investigation. We will then fully share our findings with you, in a supportive way that meets your needs and wishes.

I appreciate this may be a really difficult time to ask you to talk or think about these matters; however I felt it important to contact you and involve you with our investigation. If you would like to meet or speak with me or have any questions then please contact me as follows: **[INSERT NUMBER/EMAIL].**

The Trust also has a designated Family Liaison Manager (FLM), who is independent of the service and can support you at this time, should you wish to ask questions or make contact using the FLM, please let me know. The FLM can also guide you through the investigation process.

Once again I offer my sincerest apologies and condolences to you.

Yours Sincerely

Appendix 4

Equality Impact Assessment

Step 1 – Scoping; identify the policies aims	**Answer**		
1. What are the main aims and objectives of the document?	To implement a Trust wide Learning from Deaths process and policy in line with the recommendations of the National Guidance on Learning from Deaths March 17		
2. Who will be affected by it?	1. Families and carers of patients who have died 2. Staff working in Solent NHS		
3. What are the existing performance indicators/measures for this? What are the outcomes you want to achieve?	The standards are as per National LfD standards guidance 2017. Families and carers to be considered equal partners		
4. What information do you already have on the equality impact of this document?	None at this time		
5. Are there demographic changes or trends locally to be considered?	None at this time		
6. What other information do you need?	Awaiting further feedback		
Step 2 - Assessing the Impact; consider the data and research	**Yes**	**No**	**Answer** (Evidence)
1. Could the document unlawfully discriminate against any group?		X	
2. Can any group benefit or be excluded?		x	
3. Can any group be denied fair & equal access to or Treatment as a result of this document?		X	
4. Can this actively promote good relations with and Between different groups?	X		Increased engagement with families and carers
5. Have you carried out any consultation Internally/externally with relevant individual groups?	X		CD's, PL's, FLM and families
6. Have you used a variety of different methods of consultation/involvement		x	

Mental Capacity Act implications			
7. Will this document require a decision to be made by or about a service user? (Refer to the Mental Capacity Act document for further information)		X	This policy relates to patients who are deceased
External considerations			
8. What external factors have been considered in the Development of this policy?	X		National Guidance and developments. Feedback from families/carers
9. Are there any external implications in relation to this policy?	X		Quarterly reports are published on the website
10. Which external groups may be affected positively or Adversely as a consequence of this policy being implemented?			Patients, families, carers and staff – positive
If there is no negative impact – end the Impact Assessment here.			

Step 3 - Recommendations and Action Plans	Answer
1. Is the impact low, medium or high?	
2. What action/modification needs to be taken to minimise	
3. Are there likely to be different outcomes with any Modifications? Explain these?	
Step 4- Implementation, Monitoring and Review	Answer
1. What are the implementation and monitoring Arrangements, including timescales?	
2. Who within the Department/Team will be responsible for	

Step 5 - Publishing the Results	Answer
How will the results of this assessment be published and	