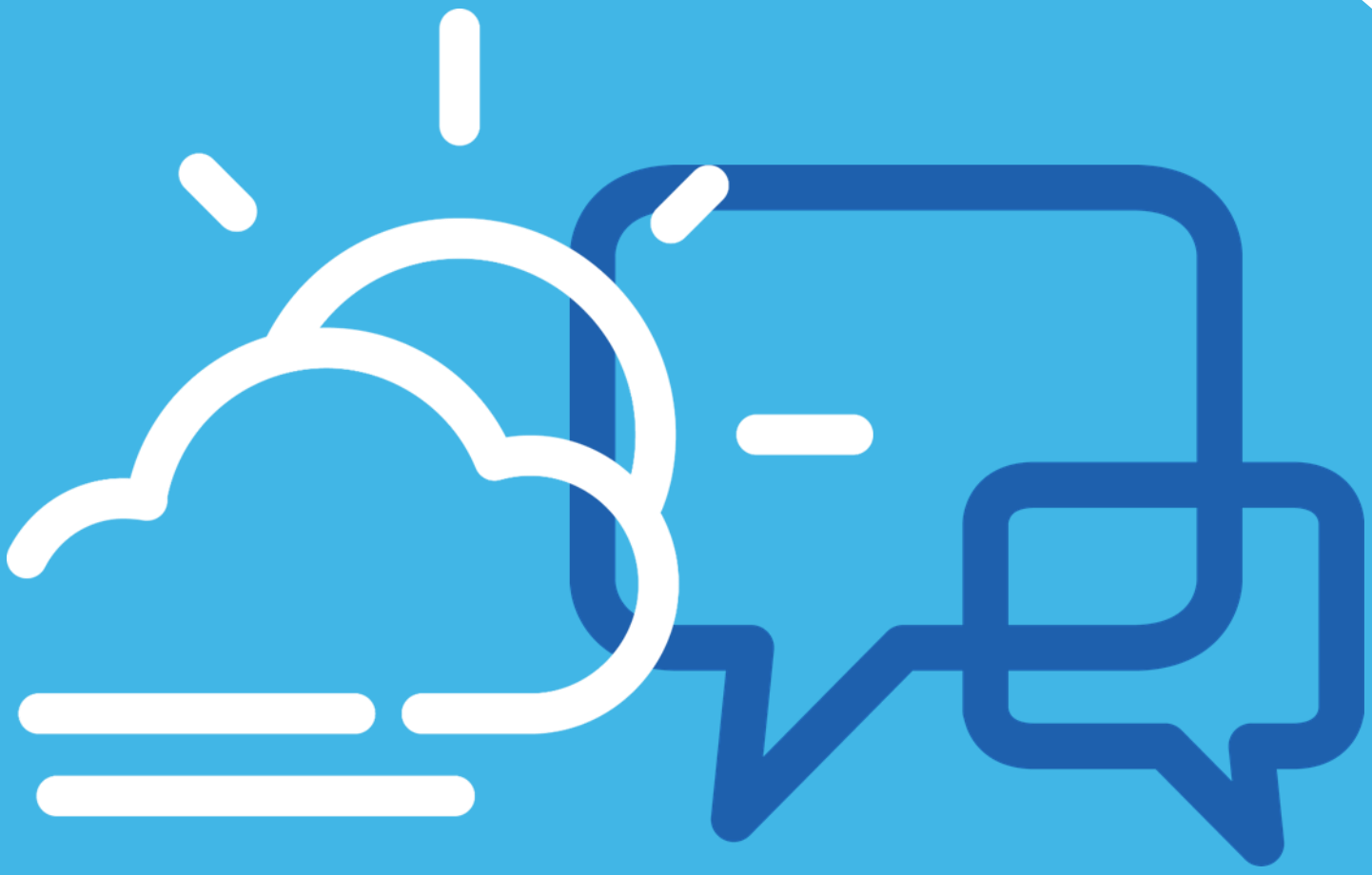
NHS
Greater Manchester Mental Health
NHS Foundation Trust

Learning from Deaths Policy

Greater Manchester Mental Health NHS Foundation Trust



Improving Lives

Document Name:	**Learning From Deaths Policy**
Executive Summary:	This policy will be used by all healthcare staff working in the Trust. GMMH will implement the requirements outlined in the Learning from Deaths framework as part of the organisation's existing procedures to learn from incidents and continually improve the quality of care provided to all patients.
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Contents

1. Introduction

In 2016 the CQC published its report – Learning, Candour & Accountability – a review of the way in which NHS Trusts review and investigate deaths of patients in England (2016)[1]. The report identified that there needed to be a much greater priority, emphasis and structure for NHS organisations to learn from the deaths of patients in their care.

In 2017, the National Quality Board published National Guidance on Learning from Deaths *-A Framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care*. This set out a series of steps that NHS Trusts must take in order to demonstrate how learning from deaths is going to become an integral part of the Trust's approach. The development of this policy is part of that structured approach.

Greater Manchester Mental Health NHS Foundation Trust (GMMH) is committed to learning from deaths and understands how important this is to develop and change services in the line with learning. Learning from deaths fits with the Trust's ethos about putting patients, families and carers at the centre of everything it does. GMMH, in reviewing the care provided to people who have died, can help improve care for all patients by identifying problems associated with poor outcomes, and working to understand how and why these occur so that meaningful action can be taken.

GMMH is committed to ensuring that the Board has a clear line of sight to mortality data, themes, trends and learning from deaths. GMMH's Board has a clear role in providing visible and effective leadership to ensure the Trust addresses significant issues identified in reviews and investigations.

The Trust will ensure that our workforce, our patients, their carers' and our stakeholders are consulted on this policy. The Trust is committed to ensuring that where the Trust decides after completing an initial review of a death no further investigation is required the family will have an opportunity to challenge that decision. It will be the role of the Trust Mortality Review Group to review and amend this policy in the face of sustained critical challenge from families or carer groups, the Board or the workforce.

1.1. Purpose

This policy will be used by all healthcare staff working in the Trust. GMMH will implement the requirements outlined in the Learning from Deaths framework as part of the organisation's existing procedures to learn from incidents and continually improve the quality of care provided to all patients.

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This policy should be read in conjunction with the following Trust policies; 'In the event of death policy', Being Open and Duty of Candour policy, Incident Accident Near Miss policy and Customer Care policy. Together these policies set out the procedures for identifying, recording, reviewing and investigating the deaths of people in the care of GMMH and how staff and carers are then supported.

This policy will support relatives who have been bereaved by a service user's death, and how individuals should expect to be informed about and involved in any further action taken to review and/or investigate a death. It also describes how the Trust supports staff who may be affected by the death of someone in the Trust's care.

The policy sets out how the Trust will seek to learn from the care provided to patients who die, as part of its work to continually improve the quality of care it provides.

1.2. Scope

This policy applies to all staff whether they are employed by the Trust permanently, temporarily, through an agency or bank arrangement, are students on placement, are party to joint working arrangements or are contractors delivering services on the Trust's behalf.

2. Definitions

The *National Guidance on Learning from Deaths* includes a number of terms. These are defined below.

Death certification
The process of certifying, recording and registering death, the causes of death and any concerns about the care provided. This process includes identifying deaths for referral to the coroner.

Case record review
A structured desktop review of a case record/note, carried out by clinicians, to determine whether there were any problems in the care provided to a patient. Case record review is undertaken routinely to learn and improve in the absence of any particular concerns about care. This is because it can help find problems where there is no initial suggestion anything has gone wrong. It can also be done where concerns exist, such as when bereaved families or staff raise concerns about care.

Mortality review
A systematic exercise to review a series of individual case records using a structured or semi-structured methodology to identify any problems in care and to draw learning or conclusions to inform any further action that is needed to improve care within a setting or for a particular group of patients.

Serious Incident
Serious Incidents in healthcare are adverse events, where the consequences to patients, families and carers, staff or organisations are so significant, or the potential for learning is so great, that a heightened level of response is justified. Serious Incidents include: acts or omissions during care that result in unexpected or avoidable death, unexpected or avoidable injury resulting in serious harm – including those where the injury required treatment to prevent death or serious harm – abuse, Never Events, incidents that prevent (or threaten to prevent) an organisation's ability to continue to deliver an acceptable quality of healthcare services, and incidents that cause widespread public concern resulting in a loss of confidence in healthcare services.

Investigation
A systematic analysis of what happened, how it happened and why, usually following an adverse event when significant concerns exist about the care provided. Investigations draw on evidence, including physical evidence, witness accounts, organisational policies, procedures, guidance, good practice and observation, to identify problems in care or service delivery that preceded an incident and to understand how and why those problems occurred. The process aims to identify what may need to change in service provision or care delivery to reduce the risk of similar events in the future. Investigation can be triggered by, and follow, case record review, or may be initiated without a case record review happening first.

Death due to a problem in care
A death that has been clinically assessed using a recognised method of case record review, where the reviewers feel that the death is more likely than not to have resulted from problems in care delivery/service provision. (Note, this is not a legal term and is not the same as cause of death').

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.

3. Duties

GMMH is committed to working with all our Clinical Commissioning Groups to continually improve learn from deaths and will work with other stakeholder groups across the footprint to be receptive to concerns made regarding service delivery. GMMH also works closely with our HM Coroners to ensure learning identified from inquests is shared both internal to the Trust but also externally with other providers with the aim of preventing future deaths.

3.1. Chief Executive

Overall responsibility for implementing the policy.

3.2. Freedom to Speak up Guardian

Will ensure that any whistle-blowing case that involves evidence of poor care and treatment that could have meant that a preventable or avoidable death of a patient has occurred is immediately escalated to the Chief Executive.

3.3. Non-Executive Directors (including the role of a lead non-executive director in taking oversight of progress in implementing the Learning from Deaths agenda)

- responsibilities relating to the framework include:
- understanding the review process: ensuring the processes for reviewing and learning from deaths are robust and can withstand external scrutiny
- championing quality improvement that leads to actions that improve patient safety within GM.

Assuring published information: accurately reflects GMMH's approach, achievements and challenges.

3.4. Medical Director

- Is the designated executive officer for Patient Safety and the implementation of the policy
- Assure the Board that the mortality review process is functioning correctly
- Ensure that arrangements are in place so that all clinical staff as appropriate are aware of their responsibilities to contribute to the process.
- Chair of the Mortality Review Group and provide a summary of the report to Quality Governance Committee and the Board.
- Work with other regional medical directors to support and promote the sharing of provider-led learning within the Greater Manchester Partnership.
- Chair of the Trust's Post Incident Review Group and communicate where appropriate to the Board

3.5. Director of Nursing and Governance

- Will have overarching responsibility for ensuring that GMMH works with partner agencies and Safeguarding Boards to ensure that participation and learning from Serious Case Reviews and Safeguarding Adult Review deaths is communicated throughout the organisation's workforce.
- Deputy Chair of responsibilities for the post Incident Review Group
- Ensure implementation of this policy across all clinical areas

3.6. Associate Directors/Heads of Operations

- Ensure their service has a representation at the Trust Mortality Review Group
- Ensure findings and learning from the Trust Mortality review are reported and discussed as part of the their local governance process
- Ensure their staff are aware of their roles and responsibilities in line with this policy and the importance of reporting and reviewing all service user deaths in line with the Trust and National frameworks

3.7. Head of Patient Safety and Governance

Has responsibility and oversight of all deaths reported to the Trust

- responsibility and oversight of the processes for decision-making of all deaths reported to the Trust
- Responsibility and oversight of serious incident reporting of deaths to the NHS Strategic Executive Information System (STEIS).
- Responsibility to support Trust-wide learning from deaths to improve services for our patients and carers.

Will work in partnership with other providers within the Greater Manchester Partnership to ensure lessons learned cross NHS Trust boundaries for the benefit of the wider Greater Manchester population.

3.8. All Staff

- To be aware of this policy and how to implement all the elements of this policy to their practice
- Ensure they report all deaths and contribute to any Trust or external investigation following a service users death
- Ensure they report all concerns raised by Carers and families following a death

3.9. Non-Executive Board Members

- All Trust directors, executive and non-executive, have a responsibility to constructively challenge the decisions of the board
- Non-executive directors, in particular, have a duty to ensure that such challenge is made.
- Scrutinise the performance of the provider's management in meeting agreed goals and objectives and monitor the reporting of performance.
- Non-executive directors should satisfy themselves as to the integrity of financial, clinical and other information, and that clinical quality controls and systems of risk management, for example, are robust and defensible.

- Ensure the processes their organisation have in place are robust, focus on learning and can withstand external scrutiny, by providing challenge and support;

- quality improvement becomes and remains the purpose of the exercise, by championing and supporting learning, leading to meaningful and effective actions that improve patient safety and experience, and supporting cultural change;

- Information the provider publishes is a fair and accurate reflection of its achievements and challenges.

3.10. Mortality Review Group

- The purpose of the Group is to provide oversight of patient deaths, and to manage and monitor the Trust's response in relation to Investigations and provide assurance for those deaths not investigated:

- The purpose of the Group is to provide oversight of patient deaths, and to manage and monitor the Trust's response in relation to Investigations and provide assurance for those deaths not investigated:

- To review/ scrutinise mortality data across the Trust

- To source and benchmark deaths that occur whilst in Trust care against other published data available (National Confidential Inquiry, National Reporting and Learning System, Mazars report)

- To identify and support strategies to reduce unexpected deaths including patient suicides and homicides.

- To ensure investigation of patient deaths are conducted in line with the National SI Framework.

- To provide assurance to the Trust Board that themes are identified and action plans developed against key areas.

- To provide Executive overview and assurance that deaths are monitored and themes identified.

- Provide reports and statistical evidence to NHS England, DoH, CQC, and CCG where requested.

3.11. Serious Review Group/Post Incident Review Group

- provide executive oversight of serious incidents subject to StEIS reporting and comprehensive investigation,

- manage and monitor the Trust's response in relation to the investigation and action planning,
- Monitor action plans developed as a result of external investigation and scrutiny.
- Review feedback templates following Positive Learning Events.

4. Processes and Procedures

4.1. Procedure

GMMH will continue to work with partner agencies in establishing procedures to continue to learn from deaths (e.g. NHS England and Independent Homicide Reviews; Home Office and Domestic Homicide Reviews; local safeguarding boards for child or vulnerable adult deaths. It will also begin to establish protocols for working with individual CCG learning disability mortality review groups when these are established in line with the national Learning Disability programme.

4.2. The Process for recording Deaths in Care

All patient deaths must be reported through the Trust incident reporting and risk management process (please refer to the Incident Accident Near miss policy for further guidance). Incident reporting requires staff to provide information on the incident occurring including:

- What happened and when
- Where the incident happened
- People involved in the incident
- What actions have been completed
- If there has been Being Open communication
- The Incident grade and actual impact
- Police involvement

Local managers are responsible for ensuring that all patient safety incidents are reported in a timely manner. In order to meet national reporting requirements the recording of the incident must be completed within 24 hours of the incident being identified.

The notification rules set up in our datix incident reporting system means that the appropriate local managers known as (Dif 2 managers) are alerted to the incident. The Datix Dif 2 manager is required to quality check the incident record within the incident reporting system and 'approve the incident within 48 hours. This includes checking:

- Checking the detail of the information in the incident report.
- Confirming the correct incident category/code has been selected.
- Confirming the incident has been correctly graded.
- Ensuring that there has been appropriate communication with the patient and/or relatives.
- Ensuring that appropriate support is identified for service user/s and staff.

- Ensuring that action required maintaining the safety of service users, staff and others have been identified and completed.
- That appropriate immediate actions to reduce the opportunity for a similar incident to occur have been taken.

All Staff and identified Dif 2 managers receive face-to-face training by the Trust Incident team on how to report and manage incidents during their Trust and local induction and as requested.

Death of a person with a learning disability– the service reporting the death of a patient who is has a learning disability will be sent the leDeR-reporting template by the Trust incident team to complete. The incident Team will then upload the completed leDeR template onto the on-line Bristol leDeR programme who will then share this information with the designated regional (LeDeR) coordinator who dependent on the circumstances of the death will liaise with the Trust to agree where further investigation may be required. The Trust is committed to supporting the improvement of services through learning from any death of a learning-disabled person and will ensure cooperation with our Local Authorities and CCGs leDeR processes in line with the National Guidance for learning from deaths 2017.

Death of a person who is subject to the Mental Health Act (1983 – as amended by the Mental Health Act 2007)) – GM. has systems and processes in place within the Mental Health Law administration network to report these deaths to the Care Quality Commission.

4.3. Selecting Deaths for Case Record Review

GMMH considers that any patient under our care at the time of their death will have their death reported onto our electronic risk management system Datix. The Trust accepts that not all deaths will require comprehensive investigation and will take a proportionate approach using an initial fact finding three day review process to assess whether or not further information or investigation is required. Three-day reviews are requested for all incidents graded 4 or 5 in our risk management system Datix. All three-day reviews following a death are reviewed by the weekly executive Serious Incident Review (SUI) panel who will decide where further review is required, type of investigation and seniority and specialism of the investigation team required to lead a review

Following the death of a service user, the weekly SUI Panel will also consider:

- deaths where bereaved families, carers, or staff, have raised a significant concern about the quality of care provision
- all deaths where an ‘alarm’ has been raised with the provider through whatever means (for example, concerns raised by the Care Quality Commission or another regulator)
- all deaths relating to a suspected suicide where the patient was under the care of the Trust or died within six months of discharged.
- Where concerns have been raised by another organisation and a request has been made to review the care provided to an individual service user who may not have been under GMMH’s direct care at time of death but where GMMH

may have been involved at some point with the provision of the individuals care. It will be the responsibility of the Clinical Governance Team to coordinate this response.

- all deaths of detained patients and those subject to DOLS

GMMH will work in partnership with other providers to carry out reviews and investigations when a person has received care from several health or social care providers. As a Trust, we are committed to a partnership approach with all stakeholders to learn lessons for our services when we have been involved in a patient's care.

Communicating with families and carers of the deceased is an essential part of the process for the Trust to understand families'/carer's viewpoint. Involvement of a carers/family begins with a genuine apology and condolences for the loss of their loved one and for the death of our service user. All staff working for the Trust will ensure that the principles of Being Open and Duty of candour are reflected into their values and behaviours.

Following the death of a GMMH service user, the local clinical team will nominate a senior healthcare professional to contact the deceased's carer
Family member to arrange a face-to-face meeting as per the Trust Being Open policy. For investigations into a service user's death the Trust will ensure that carers and relatives are involved and have the opportunity to contribute from the start of the investigation Terms of reference and processes. Families will also be provided with a supportive face-to-face reading and copy of the final investigation report.

The Trust recognises that certain Trust forums or committees have a responsibility for supporting the mortality surveillance work e.g. Medicines Management group, End of Life group, Ligature group and Suicide Prevention Group and will escalate emerging themes or concerns to the Trust Mortality Review Group.

4.4. Review Methods

For full details into the type of reviews completed by GMMH following a service user's death please read the Incident accident and Near miss policy.

Three day Review: completed for all level 4 and 5 serious Incidents. It is an initial fact finding review to be completed within 3 days from an incident being reported. The review will be completed by a local manager and will be an initial case note review and time line of events to identify any areas of concern during a service user's care. The weekly executive Serious Incident review panel who will decide where further review is required reviews all Three-day reviews

Concise Review (RCA 1): This form of review is a concise review using root cause analysis methodology. This review may be indicated for incidents where no harm or low harm has occurred and where harm is not deemed to be permanent or where a cluster of similar incidents has occurred and more detailed analysis of the incident is required than that provided in the 3-day review. This type of review will be confirmed after consideration by the weekly Trust Serious Incident review panel.

The Concise review will be completed by a nominated Manager within the service and will involve the further gathering of information regarding the events leading up to the incident, including a review of care delivery and all relevant documents e.g. Care plan, risk management plan, handover records observation records etc.

A Concise review is the opportunity for the local Multi-Disciplinary team (MDT) to explore the events leading up to the incident and identifies any potential lessons to be learned within the team or for the service. The manager completing the review must make every attempt to gather facts from as many key professionals involved in an individual's care. The service will then be able to demonstrate lessons that have been learned.

Example of types of incident that is likely to result in concise review as per the National SUI framework

- Some expected deaths where areas of learning for a team have been identified relating to practice or local processes but where these did not contribute to the death in any way

Comprehensive Review (RCA 2) this form of review takes a comprehensive Root Cause Analysis approach and will be conducted for specific serious untoward incidents (SUIs) that are categorised as level (4 - 5) within Datix at the discretion of the SUI Panel in keeping with local policy and/or commissioning bodies. Comprehensive Reviews will usually consist of a nominated review lead who is deemed to be of sufficient seniority and have the relevant skills and experience.
Depending on the circumstances of the serious Incident e.g. sudden unexpected in-patient death or unexpected community patient (where the death is not deemed to be due to natural causes) it will be agreed at the weekly executive SUI panel the specialism and expertise required by the investigator and if the review will be completed by an investigator internally to the Trust or independent to the Trust.
Any Comprehensive review must be completed and submitted to the Clinical Governance Team within 40 working days in order for the Trust to achieve the national timeframes to be submitted to our clinical commissioning group

Examples of incident types that may result in a Comprehensive review:

- Unexpected death of **any** service user where GMMH was main care provider and *where cause of death was not due to natural cause's e.g*. Suspected suicide (to include those unexpected deaths where an inpatient is on leave or has gone AWOL or missing.
- Unexpected Death of a service user with a learning disability
- Medication incidents leading to moderate- severe harm or death of a GMMH services user.
- Poor discharge planning by a GMMH service causing moderate, severe harm or death to a service user.

Case Record Review is a method used to determine whether there were any problems in the care provided to a patient within a particular service. It is

undertaken routinely to learn and improve care but where there may not be any significant care failings identified or raised. This is because it can help identify problems where there is no initial suggestion anything has gone wrong. A case note review may be commissioned following the SUI panel having sight of the three day review following a death where the panel feel further interrogation of a services users record of care is required for further panel assurances or where concerns have been raised such as when bereaved families/carers or staff raise concerns about an element of care provision.

Development of the national mental health Structured Judgement Review (SJR tool).

The SJR tool is another method providers can apply to the reviewing of a service users records in identifying problems during service delivery. The SJR tool specific to mental health is currently being developed by NHS Improvement and the Royal College of Psychiatrists and is therefore not available for implementation. GMMH and other GM Mental Health Providers are working with the Humber Mental Health Foundation Trust SJR pilot sites to support development and roll out of the SJR tool specific for mental health, which should be ready for implementation early 2018.

Although GMMH is not a learning Disability Trust it will adhere to the reporting of all learning disability deaths to the LeDeR programme in consultation with our CCGs who are currently establishing local Learning Disability Mortality Review Groups.

GMMH is currently developing an alert system within our Risk management system to help us identify the death of a service user with a learning disability so that timely reporting and reviewing of all LD deaths takes place.

Level Three NHS England Independent Investigations

These reviews will be commissioned and led by an external independent investigation team appointed by NHS England for the following SUIs

Homicide where the perpetrator was a GMMH service user with a mental illness or other mental disorder and who has been in contact with specialist mental health services within the last 6 months.

Following any Homicide where the perpetrator was a GMMH service user who has been in contact with GMMH services within the last 6 month GMMH would complete its own internal SIR review as mentioned previously. This report will then be shared with and reviewed by our CCG who in consultation with NHS England will then agree to commission a further independent Homicide review in line with the process laid out in the National Serious Incident Framework (2015)

All Trust staff are required to actively engage in any independent investigation process as requested and will be supported by the Trust to do so.

4.5. Selecting Cases requiring further investigation

Where the Trust identifies a patient safety incident that requires further investigation, this will be managed in line with the Trust's Incident Accident and Near Miss policy.

The weekly Executive Serious incident Review Panel, will review the detail and circumstances of all grade 4 and 5 incidents to determine if the incident meets the national serious Incident reporting criteria –STEIS. Reporting to STEIS and NHSE will be in line with the National Serious Incident Reporting framework 2015. Our CCGs will be informed (via STEIS and/or verbally if required) of a Serious Incident within 2 working days of it being discovered. This will be completed via the Trust Incident Team.

4.6. Reviewing outputs from review and investigation to inform quality improvement

Cascading Learning internally to GMMH

GMMH has a track record for being a learning organisation. A number of methods are used to share learning following any Trust investigation or review process.
The purpose of carrying out reviews of incidents is for the Trust to learn lessons in a positive manner and ensure that actions that did or could have led to patient or staff harm are not repeated.

Some examples of how the Trust shares the learning following serious incidents:

- Positive Multidisciplinary Lessons Learned events coordinated by a senior service lead following the findings from any Trust investigation. It is an opportunity for the clinical team to meet in a safe environment and reflect on the investigation findings and review how practices can be improved.
- Monthly computer splash screens used to distribute learning themes from incidents/.complaints /inquests.
- Risk Management Group discussions where directorates share information about adverse events and near misses.
- Via review of Trust Mortality data by the Trust Mortality Review group with learning then shared by service leads
- Local and Trust Medicines Management Group information sharing around medicine management themes.
- Sharing learning at all levels of the trust including the Board, Quality Governance Committee, and Operational Leadership Committee, Senior Leadership Team meetings to local operational, team meetings, and specialist groups that report to the Quality Governance Committee.
- Annual Thematic Reviews of incident/Serious Incident Review themes and Trend analysis reports.

The Trust monitors that lessons have been learned following incidents via a variety of processes such as:

- Improved working practices and culture through evidence of Trust wide increased reporting figures around incidents and Near Misses with the overall aim of reducing the same type and severity of incidents occurring.
- Evidence will also be provided through staff and service user/carer surveys, families and friends test
- Positive MDT Learning Events feedback Templates

- Trust wide clinical audits completed by services and Trust audit team. All of which will be presented through the annual clinical audit report to the relevant committees of the Trust Board.
- Trend analysis report

Regional learning

In order to share the learning from serious incidents external to GMMH the Trust will:

- Share and receive information relating to serious incident alerts between other providers and other agencies e.g. NHS Improvement
- Work closely with our CCG in raising awareness around emerging themes/trends from our incident data
- Participate in Benchmarking events with key partners to inform regional learning with partner Trusts and agencies to improve patient safety within mental health services.

Evaluation of learning is achieved via:

- Positive MDT Learning Events progress report monitored at the Monthly Post Incident Review Panel.
- Annual Positive learning Events report prepared for our Quality Governance Committee.

Quality Improvement

The Annual Quality Account is the process used to share organisational learning and successful quality improvement initiatives and projects by services and local teams. Annual quality account reports are stored on the public facing website for any member of the public to access.

4.7. Presenting relevant Trust information relating to mortality data in board reports

In line with the *National Guidance on Learning from Deaths* GMMH will share its GMMH mortality data quarterly via its public board meetings highlighting action taken by the Board to lead the organisation in further improving quality of care under the Learning from Deaths framework.

4.8. Supporting and involving Carers and Families

The *National Guidance on Learning from Deaths*[2] specifies that Trusts should engage meaningfully and compassionately with bereaved families and carers at all stages of responding to a death, and details the key principles that Trusts should follow.

Communicating effectively with service users and/or their carers is a vital part of the process of dealing with errors or incidents. The needs of those affected should be a

primary concern for those involved in the response to and the investigation of serious incidents.

It is important that affected patients, staff, victims, perpetrators, patients / victims' families and carers are involved and supported throughout the investigation.

Involvement begins with a genuine apology, or in instances when an act or omission has not been identified, an expression of sympathy for the outcome of the incident e.g. condolences for the patient's death.

For further guidance on supporting, those affected or bereaved by a death and the stages of Duty of Candour responsibilities staff should access the following policies:

- Incident Accident and near Miss policy
- Being Open
- Customer care compliments and concerns.
- In the event of death policy
- GMMH are currently developing a Bereavement nurse Liaison role with the aim of supporting carers and relatives affected or bereaved following a services user's death. This role will also deliver training to staff around Bereavement awareness and how services can support carers and relatives when a service user dies
- Guidance that will be given to families and carers on obtaining legal advice (should they require it) or other support.

4.9. Supporting and involving staff

It is important to recognise that serious incidents can have a significant impact on staff who were involved or who may have witnessed a serious incident. Like victims and families they will want to know what happened and why and what can be done to prevent the incident happening again.

GMMH has a responsibility to support all staff who are affected by the death of a patient and where appropriate will involve them in the investigation processes. The Clinical Governance Department will also use its systems and processes to support all staff who are required to be involved in the Coronial process.

The need to arrange Post Incident Debriefing using the Trust Post Incident Debrief service (PIDS) for a clinical team affected by a serious incident should be considered in a timely manner by Associate Directors and Heads of Operations. Staff involved in any internal or external investigation should be supported by their immediate line manager and have the opportunity where relevant to access professional advice from their relevant professional body, union, staff counselling services and occupational health services. They should also be provided with information about the stages of the investigation and how they will be expected to contribute to the process. (Please refer to the Incident Accident and near Miss policy to access the PIDS)

For any staff who are in training including trainee doctors/ student nurses and other health care professionals, appropriate educational contacts should be notified as appropriate. Following any serious incident, senior managers should ensure their staff

are informed of outcomes of investigations via Positive MDT Learning Events and or via individual supervision processes. Where an incident investigation report has been completed, the service manager should feed the investigation findings and recommendations back to staff as soon as possible.

In the case of training doctors, this will be via the use of a nominated individual selected by the Medical Education Lead. The nominated individual will be the lead support for that Training Doctor ensuring continuity if they have moved to another organisation. This nominated individual will then contact the Training Doctor once an internal investigation is completed to arrange a face-to-face meeting to discuss the finding and any learning from the incident including reflective practice. This will be the responsibility of the nominated person.

In the case of non-medical students this will be via the mentor or clinical educator with the support of the practice education facilitator (PEF) and the relevant college or higher education institution where required. When a non-medical student's placement within the Trust has ended, the PEF will liaise with the student's college or university link lecturer to ensure feedback is given. The college/university can also request that a PEF attend.

5. Training Requirements

GMMH will ensure that trained staff carry out investigations. The Trust's Learning and development team manage training Records for staff.

The clinical governance team will support investigators in completing any investigation or review on behalf of the Trust. Training in Root Cause Analyse and the principle of investigations is provided on a quarterly basis via the Trust learning and development Hub. Training on 'Being open' is delivered via the use of the external training team 'Patient Safety Science' commissioned annually. Staff are also able to access further guidance and resources on incident investigation via NHS England:

http://www.nrls.npsa.nhs.uk/resources/collections/root-cause-analysis/

Other supporting resources available for staff relating to NHS investigation is available to staff to access via

http://www.nrls.npsa.nhs.uk/resources/rca-conditions/

Communication / Training Plan	
Payments to Service Users and Carers	
Goal / purpose of the communication / training plan	To ensure that policy is implemented successfully.
Target group for communication	All health care staff.
Target Numbers	As above
How will the communication / training be carried out?	The document will be available on the Intranet.
Who will carry out the communication / training?	Head of Patient Safety and Governance and Mortality review group leads
Funding	Some funding may be required for training staff around using the Structure judgment review process. This is currently being arranged with the Humber NHS Trust who have agreed to deliver training across the GM Mortality review Group
Measurement of Success	Internal audit of processes
Issue date policy	October 2017
Start and completion date of communication / training plan	October 2017
Support from Training Services	Coordination of staff attendance at RCA and investigation skills training

6. Monitoring

Monitoring Criteria	Yes / No
Are all members of staff trained accordingly to carry out the requirements of the policy?	**Nominated Senior staff are training in investigation skills**
Are all members of staff aware of the existence and details of the policy?	**Yes**
Are all new starters made aware of this policy during local induction processes?	**Yes**
Have all old versions of this policy stored locally (either electronically or as a hard copy) been removed?	**Yes**
Are the processes contained in the policy followed correctly?	**Yes**

7. Resource/Implementation Issues

Not applicable.

8. Risk Issues

None identified.

9. Requirements, Supporting Documents and References

9.1. Requirements

Under the *National Guidance on Learning from Deaths*, published by the National Quality Board in March 2017, all NHS Trusts are expected to:

Publish an updated policy by September 2017 on how their organisation responds to and learns from deaths of patients, who die under their management and care, including:

- how their processes respond to the death of an individual with a learning disability, severe mental illness, an infant or child death, a stillbirth or a maternal death
- their evidence-based approach to undertaking case record reviews
- the categories and selection of deaths in scope for case record review (and how the organisation will determine whether a full investigation is needed)
- how the Trust engages with bereaved families and carers, including how the Trust supports them and involves them in investigations
- how staff affected by the deaths of patients will be supported by the Trust.

How Trusts Collect and share information on deaths

From December 2017 All Trust are required to collect and publish their Mortality data via their public board meetings.

Relating to:

- the total number of inpatient deaths in an organisation's care
- the number of deaths the Trust has subjected to case record review (desktop review of case notes using a structured method)
- the number of deaths investigated under the Serious Incident framework (and declared as Serious Incidents)
- of those deaths subject to case record review or investigated, estimates of how many deaths were more likely than not to be due to problems in care
- the themes and issues identified from review and investigation, including examples of good practice
- how the findings from reviews and investigations have been used to inform and support quality improvement activity and any other actions taken, and progress in implementation.

This policy sets out GMMH's approach to meeting these requirements.

9.2. Supporting Documents

Not applicable.

9.3. References

National Guidance on Learning from Deaths, published by the National Quality Board in March 2017

10. Subject Expert and Feedback

If you require any information about this policy please contact Julie.bodnarec@gmmh.nhs.uk

11. Review

This policy will be reviewed in four years' time.