ACUTE HOSPITAL BEREAVEMENT SERVICES ASSESSMENT TOOL

Draft document for consultation

Issued by Bereavement Services Association

October 2014

Background – The need for bereavement services identified

In the Foreword to *When A Patient Dies* (2005)[1], Sir Liam Donaldson, the Chief Medical Officer at that time stated 'I firmly believe that providing sensitive, responsive information and support for bereaved families and others is not an optional extra.' Having reflected that services for bereaved people provided by acute hospital trusts had improved since 2001, he went on to assert 'it is essential that Trusts have in place systems, policies and practices that will ensure a coordinated response to bereavement is taken by all staff to meet individual needs regardless of religious or cultural needs.'

In 2014, it appears that still not every acute hospital has such a coordinated response in place in spite of the fact that it was in 2001, following widespread publicity and family distress around the retention of organs and tissues following post-mortem examinations, that Sir Liam first stated 'all NHS Trusts should provide support and advice to families at the time of bereavement.[2]

Surveys by the Department of Health[3] in 2001 and 2005 did show an improving picture of more trusts providing some level of service. The most recent work in this area by Green (2014)[4] is the first to try and establish the number of services and what they provide as well as the seniority of staff providing the service and level of relevant education they have received. What is revealed is considerable inconsistency in what services are provided and how.

When A Patient Dies (ibid) provided underlying principles for a service and described issues needing to be considered when establishing a service. It included a number of practical suggestions as to how some services might be provided with anecdotal accounts of relatives' experiences. The document did not however, set out to be a 'how to' manual. One member of the Bereavement Services Steering Group recalls seeing a published book purporting to be such a manual in the late 1980s, but some of the instructions given did not match the circumstances of a large teaching hospital at that time and the book proved not to be useful. Prior to 2005 there were Health Service Guidance (HSG) documents which gave specific guidance with regard to the provision of contact funerals by acute trusts only. These documents were superseded by When a Patient Dies (ibid). In 2011 the National End of Life Care programme published When a Person Dies[5] updating the 2005 document and extending its scope to recognise that people die in places where they may be residents rather than patients and also encompassing the need for information to guide commissioners of services. The document was marked as being due for review in 2013, but by that time the National End of Life Care Programme had come to end through reorganisation in the NHS.

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[1] *When A Patient Dies* Department of Health, London, 2005
http://webarchive.nationalarchives.gov.uk/20130107105354/http:/www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_412219

[2] *The removal, retention and use of human organs and tissue from post-mortem examination: advice from the Chief Medical Officer* Department of Health, London 2001
http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_406494

[3] *Survey of bereavement care and other support services* Department of Health, London, 2005
http://webarchive.nationalarchives.gov.uk/20080814090248/dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4115879

[4] Green, Mark *Unpublished Masters Research*

[5] BSA and PCC *When A Person Dies* National End of Life Care Programme, London, 2011
http://www.google.co.uk/url?sa=t&rct=j&q=&esrc=s&source=web&cd=2&ved=0CCUQFjAB&url=http%3A%2F%2Fwww.nhsiq.nhs.uk%2Fdownload.ashx%3Fmid%3D8259%26nid%3D8258&ei=wpTjU7KSIInK0QWCilHQBg&usg=AFQjCNHR98TeKgbXVKgrCL6-lUpGJOCI2Q&sig2=rltDeCICDl8ql7JlXj3YAw

What service should an acute hospital bereavement service provide?

While the need for bereavement support is acknowledged in many documents addressing end of life care provision, and the formal End of Life Care Pathway[6] describes Step 6 as care after the death including for the affected bereaved people, what this support comprises is mainly described in the NICE (2004) Improving Supportive and Palliative Care for Adults with Cancer[7].[i] This suggested that support for bereaved people could be provided with three components. The first recognises that most people will need information about the experience of grieving from professionals caring for the person nearing the end of their life but that most of their actual emotional/psychological support will come from family and friends. Some people will need more formal levels of support (Component Two) and a few will need highly specialist services able to support people through complicated grief (Component Three). Professionals need to be able to assess risk of complicated grief and ensure there is access to services appropriate to the needs of individuals, regardless of where the dying person was cared for. Information about the practical steps required after a death, e.g. how to register the death or about the involvement of the coroner is included in Component One.

Over time professionals have come to describe these as levels of bereavement care. These are not synonymous with the Levels that follow in this tool.

Many acute hospital staff who provide bereavement services are not trained in counselling and have a wide variety of occupational backgrounds. Within this community and others there is an informal consensus that as bereaved people are not ill and live within the community. Therefore support at levels two and three should be community based with certain exceptions, the main one of which is maternity services. This is in accordance with the NICE 2004 guidance (ibid) which states

12.31 Provider organisations should be equipped to offer the first component of bereavement support and have strategies in place to access the other components. Services should be accessible from all settings.

12.34 Providers should ensure that a leaflet is made available to families and carers around the time of the bereavement. Ideally, this should be developed locally, agreed by those involved in the provision of bereavement services, and include information on anticipated feelings and how to access local and national services.

So what are the essential components of a hospital bereavement service and how does one assess whether or not a service is good? This document is a first formal attempt to answer these questions. It is designed as a working tool and it is expected that it will evolve and change as other services around it also change e.g. the long expected and hoped for Medical Examiner (ME) Service. The Gloucestershire pilot site has shown the ME officer function can be very successfully provided from within an existing bereavement service, both within acute services and the community. This success has been replicated in the early adopter ME service in Birmingham.

The purpose of the Tool

Aims:

1. Describe the essential and desirable components of an acute trust bereavement service
2. Provide a tool for bereavement services to assess the current calibre of their service against what might be possible

[6] National End of Life Care Programme *The route to success – Transforming end of life care in acute hospitals* Crown Copyright, 2010 http://www.nhsiq.nhs.uk/8203.aspx

[7] http://www.nice.org.uk/guidance/csgsp/resources/supportive-and-palliative-care-the-manual-2

3. Provide a tool to ensure consistency for trusts wishing to benchmark their services against other trust
4. Assist bereavement services to map themselves against relevant standards
5. Enable trusts to provide an evidence base for the calibre of their service when tendering for medical examiner's officer services

Outside the scope of this document are:

1. Discussion of appropriate grading and remuneration for bereavement staff
2. Qualifications required to be able provide the type of bereavement services described herein. This is deliberately omitted as bereavement services are currently provided by staff with a wide variety of backgrounds including NHS clinical, scientific and administrative and others from outside the NHS. To the best of our knowledge no research has been undertaken which can demonstrate a qualitative difference between services provided by staff of different backgrounds.
3. Detailed policies or procedures

Bereavement Care Service Standards 2014[8]

The Bereavement Services Association (BSA) led the work stream of a joint project (funded by the Department of Health) with Cruse Bereavement Care to create standards that could be used by all types of service providing bereavement care in any context. The standards comprise six standards with three levels possible under each domain. However it is recognised within the document that not all the domains apply equally to all types of service and they will usually be used alongside frameworks that apply to particular professional groups and/or to locally determined standards appropriate to the individual context.

Where an entry in the tool would contribute to mapping a service against the Bereavement care service standards the relevant Standard number is noted.

Methodology

The lead author has managed the provision of bereavement services in two large multisite acute teaching trusts in different parts of the country. In both trusts detailed policies and procedures were facilities and written for trust wide use in cooperation with multidisciplinary teams when appropriate.

The initial idea for mapping a service to levels came from another member of the BSA steering committee who has also managed bereavement services in two different city trusts. This idea was a response to the Department of Health's team for death certification reform exploring the role of hospital bereavement services and their ability to host ME services. As the only organisation which exists specifically for members of staff working in bereavement services in the NHS, BSA

Key contributions were made by various members of the steering committee and this first draft is being distributed to acute trust bereavement services and others to test both the concept and invite comments concerning the details. An early draft was shared at a BSA annual conference (2012) and was generally welcomed although it was rightly noted that at that stage there was no referencing of other work.

Discussion with many colleagues over the years has revealed that most hospitals that have a centralised service have evolved to provide services in a similar way, although there appears to be

[8] BSA and Cruse *Bereavement care service standards,* on-line publication 2014 http://bsauk.org/uploads/593853480.pdf

considerable variation in the detail. This tool is based on both those elements that appear common to most services but also includes services that may only be currently provided in a few places as examples of what a service can aspire to deliver.

The tool therefore describes all the possible elements that would ideally be provided in an acute trust bereavement service. Not all trusts currently provide all of these elements. Therefore core elements that would be essential for provision of medical examiner support have been identified and at least 80% of these should have been achieved at Level 3 to demonstrate the capability to provide such a service. The aim should be to provide 100% of the core elements within 12 months of the assessment with a clear plan as to how this can be achieved.

Some aspects of a service provided, e.g. a memorial service, may be good in themselves, but should not necessarily impact on the level achieved by a bereavement service.

In some cases, part of a service, e.g. the preparation of cremation medical forms, may be overseen by mortuary staff. This can be notified on the form to indicate that a service exists elsewhere in the trust. However this will impact of the Level achieved as preparing cremation medical forms in this way is usually less efficient because it depends on the request for the form being submitted by a funeral director rather than a pro-active approach by bereavement staff in conversation with the bereaved family.

This is a draft document being issued to BSA members and other interested parties for consultation.

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TECHNICAL NOTES

Each of the pages following describes elements of the service which might be provided by an acute hospital trust bereavement service. These are divided under the headings of Facilities, Governance, Services, Appointment Content and Relationships.

Each aspect of the service is described under different Levels, to enable staff or commissioners to assess the calibre of the service provided in terms of what the service comprises. The empty boxes beneath the individual descriptions are to allow a certain level to be checked. If the tool is used in a pdf version, it can be 'saved as' allowing the boxes to be expanded and further notes added. It should be noted that the quality of how a service is provided cannot be wholly assessed using this tool as this depends on the use of key performance indicators and user feedback - both professional users of the service and bereaved clients.

The Tool was partly designed to help commissioners of Medical Examiner (ME)services to determine whether an existing hospital bereavement serve has the capability to provide a Medical Eaminer's Officer function. It is expected that to be able to provide such support to an ME, a service should have attained Level 3 in atleast 80% of the entries described as core services with realistic prospect of 100% of core services provided within 12 months of the assessment. The key is provided on each page to facilitate completion of the document.

As described in the Introduction, where entries in the Levels can be used as part of mapping a service against the National Bereavement Care Standards, the relevant Standard is noted in the grid.

FACILITIES PROVIDED

KEY	Partial implementation with action plan to achieve by a target date	In place with evidence	Enhancements	May be present but does not affect level
	Core level - must be achieved to provide ME Officer function	Core level - must be achieved to provide ME Officer function		

	Level 1	Level 2	Level 3 Required Level for ME Officer function	Level 4	Level 4*	Options not affecting service level
Service base	MCCDs/property issued from ward or non-specialist office	Centralised bereavement function with dedicated staff	Centralised bereavement function with dedicated staff	Centralised bereavement function with dedicated staff		
example space for service use - will appear under every entry in final tool						
Facilities (Wheelchair and step free access assumed across all levels) **STANDARD 6**	Clear signage Waiting area Toilets near	Clear signage Waiting area Toilets near	as before AND private meeting area	as before AND private waiting and meeting areas	Appointments may be arranged elsewhere within trust premises to suit needs of bereaved person	Integrated bereavement suite with proximity to mortuary
Hours of service	Weekdays 10-4	Weekdays 9-5	Weekdays 9-5 with out of hours procedures	Weekdays 8-5 with out of hours procedures	Bereavement staff on-call for advice to out of hours staff	

Appointment system STANDARD 2	Appointments made by ward staff without reference to bereavement service	Appointments made pro-actively by contacting bereavement service to account for the nature of the case. Flexibility to accommodate walk-in & emergency enquiries	Appointments made pro-actively by contacting bereavement service to account for the nature of the case. Flexibility to accommodate walk-in & emergency enquiries	As before and appointments made by bereavement staff contacting the nominated next of person after assessment of the case		
Pre-appointment/ contact information available to families explaining bereavement service STANDARD 2		Ward staff routinely give information about service to bereaved families in writing or by phone	Ward staff routinely give information about service to bereaved families in writing or by phone	Ward staff routinely give information about service to bereaved families in writing or by phone		
Access to interpreting services (phone and face to face) STANDARD 6						
Staff familiar with use of Typetalk STANDARD 6						
Materials available for use of sight impaired people STANDARD 6						
Materials available for use by learning disabled people STANDARD 6						

GOVERNANCE

KEY	Partial implementation with action plan to achieve by a target date	In place with evidence	Enhancements	May be present but does not affect level
	Core level - must be achieved to provide ME Officer function	Core level - must be achieved to provide ME Officer function		

	Level 1	Level 2	Level 3 Required Level for ME Officer function	Level 4	Level 4*	Options not affecting service level
Executive support			Nominated executive level lead	Nominated executive level lead		
Managerial support	Generalist	Generalist	Appropriate specialist e.g. Bereavement, pathology, chaplaincy or nursing	Dedicated bereavement specialist manager with management of service as their primary role		
Service provided matched to numbers and complexity of deaths STANDARDS 1 & 2		Staffing levels and facilities adequate to speak to families within 1 working day and see them within 2 working days	Staffing levels and facilities adequate to speak to families within 1 working day and see them within 2 working days	Staffing levels and facilities adequate to speak to families within 1 working day and see them within 2 working days		
Policies/ Procedures	Ward/office procedures	Ward/office procedures	Trust wide integrated policies for end of life care/ bereavement with local procedures	Trust wide integrated policies for end of life care/ bereavement with local procedures		
Return of patients' property & valuables	General trust policy	Specific policy for return of deceased patients' property & valuables	Specific policy for return of deceased patients' property & valuables with return coordinated by bereavement service	Specific policy for return of deceased patients' property & valuables with return coordinated by bereavement service	As before with aesthetic means of return of property	

Diversity STANDARD 2	Able to evidence awareness of needs of different groups after a death and respond	Able to evidence awareness of needs of different groups after a death and respond	Active liaison with local faith/ethnic/ community groups and able to facilitate equitable procedures including out of hours	Active liaison with local faith/ethnic/ community groups and able to facilitate equitable procedures including out of hours		
Record-keeping	Basic record keeping of deaths/MCCD or coroner/NOK/ other transactions	Detailed record keeping for each death	Database	Database with functionality integrated with trust systems Bereavement staff write in clinical records if appropriate	Regular reports produced for management and clinical governance purposes	
Audit/KPIs STANDARD 7			KPIs being developed	KPIs in place for key activities Benchmarking against other services has taken place or is planned	External review of service activity has taken place or planned Performance data published within/outside the trust	
Client feedback STANDARD 7			Client questionnaire used to monitor their experiences	Client questionnaire used to monitor their experiences	Client focus groups used when planning new services	
Standards STANDARD 2			Awareness of national standards applicable to service	Services mapped against applicable national standards	Services mapped against applicable national standards	
Access to training STANDARD 5	Statutory training only	Staff encouraged to undergo role specific training as part of CPD	Staff encouraged to undergo role specific training as part of CPD	As before & Staff encouraged to train as trainers	As before & Staff trained as trainers	
Staff support STANDARD 4		Staff have easy access to management for operational & personalised support as required	Regular appraisals & CPD in place for all staff in service	Regular appraisals & CPD in place for all staff in service	Access to formal supervision	

SERVICES PROVIDED

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	Core level - must be achieved to provide ME Officer function	Core level - must be achieved to provide ME Officer function		

	Level 1	Level 2	Level 3 Required Level for ME Officer function	Level 4	Level 4*	Options not affecting service level
Support for medical documentation	Simple advice re completion of medical documentation & referral to the coroner	Simple advice re completion of medical documentation & referral to the coroner	Demonstrable understanding and ability to explain principles of completion of MCCD, referral to the coroner and other documentation such as cremation medical forms	Demonstrable understanding and ability to explain principles of completion of MCCD, referral to the coroner and other documentation		
Involvement in post-mortem consent procedures		Staff aware of procedures and able to make documents available to medical staff	Staff trained to be able to facilitate complete of post-mortem consent documentation & answer questions from family	Staff trained to be able to facilitate complete of post-mortem consent documentation & answer questions from family		
Support for families during viewings	Viewing appointments arranged	Viewing appointments arranged and families escorted	Staff able to discuss merits or otherwise of viewing at different stages e.g. Pre-PM, after PM, at funeral director and provide support during viewings	Staff able to discuss merits or otherwise of viewing at different stages e.g. Pre-PM, after PM, at funeral director and provide support during viewings	Staff entrusted to provide support for viewing for coroners deaths if requested	
Bereavement appointment content not referenced elsewhere	see separate chart					

Provision of literature	National literature available	National and local literature available	National and local literature actively offered together with appropriate specialist signposting	National and local literature actively offered together with appropriate specialist signposting		
Assessment of bereavement support needs **STANDARD 3**		Aware of and able to signpost local and national bereavement support	Able to describe known risk factors for difficulties in bereavement and advise/signpost appropriately	Able to describe known risk factors for difficulties in bereavement and advise/signpost appropriately	Established referral pathways for on-going psychological support	
Follow-up service offered for families **STANDARD 3**		Able to advise bereaved people how to take forward concerns & signpost for other support needs	Follow-up offered in defined cases e.g. Post-mortem examination and general offer made to all bereaved people	Structured follow-up service in place with defined criteria for when appropriate with supporting literature	Follow-up offered for all deaths provided consent received	Condolence cards
Annual memorial events						One or more memorial events
Active involvement in local resolution of concerns		Staff authorised to make immediate contact with medical/other staff if immediate discussion/ response will resolve outstanding concerns	Staff authorised to make immediate contact with medical/other staff if immediate discussion/ response will resolve outstanding concerns	Bereavement staff facilitate meetings between bereaved people and staff to promote local resolution, including acting as an advocate for families if required	Bereavement staff facilitate meetings between bereaved people and staff to promote local resolution, including acting as an advocate for families if required	

Provision of literature	National literature available	National and local literature available	National and local literature actively offered together with appropriate specialist signposting	National and local literature actively offered together with appropriate specialist signposting		
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Involvement in training		Introduction to service included in trust induction programmes	Introduction to service included in trust induction programmes Ad hoc training provided to staff groups	Relevant aspects of service introduced in key staff induction programmes i.e. Medical, nursing, mortuary, portering & reception Regular involvement in training for trust staff	Involved in training design/delivery to a wider audience that the trust	
Support for bereaved patients			Bereaved patients supported by ward visits (if necessary) and support to complete formalities/arrange funeral etc if needed		If no other agencies available support visits to bereaved patients available	
Baby deaths		Clear signposting if not responsible for baby deaths/funerals	Clear definition of roles and responsibilities across maternity/paediatric, chaplaincy & bereavement services for responding to baby (inc fetuses) deaths and arranging funerals			
Community deaths for which bereaved make contact with hospital service		Basic bereavement information can be sent. Clear signposting on appropriate procedures.	Basic bereavement information can be sent. Clear signposting on appropriate procedures.	As before and follow-up facilitated e.g. meeting with medical staff	As before and follow-up facilitated e.g. meeting with medical staff	Community viewings supported if coroners officers off-site/unavailable
Services for deceased patients with no-one responsible for or able to afford arrangements	There is currently so much variation in who provides these services, e.g. Bereavement service, finance, admin and how they are provided that it has been decided to exclude this from the first edition of the tool.					Out-source tracing & funeral arrangements to local authority
Notification of GP of death within 1 working day of death		GP notified of event of death & location	GP notified of event of death & location	GP notified with cause of death or referral to coroner & clinician contact details	GP notified with cause of death or referral to coroner & clinician contact details	
Patient Admin systems	Able to view & request appropriate staff to modify	Able to view & modify if death not entered	Able to view & modify if death not entered	As before and able to cancel open appts	As before and able to cancel open appts	
Pre-death appts available **STANDARD 2**						

APPOINTMENT CONTENT
(may be face to face and/or telephone spread over more than one contact)

KEY	Partial implementation with action plan to achieve by a target date	In place with evidence
	Core level - must be achieved to provide ME Officer function	Core level - must be achieved to provide ME Officer function

STANDARDS 2 & 3	Level 1	Level 2	Level 3 Required Level for ME Officer function	Level 4
Time allowed for appointment	less than 20 mins	less than 30 mins	30 mins	30 mins or more
Ascertain existing knowledge /experience of post-death procedures				
Content of MCCD				
Explain rationale of MCCD content				
Explain cause of death				
Explain need to register or referral to coroner				

Ascertain burial/ cremation/ overseas and explain documentation				
Ascertain need & signpost if concerns about funding for funeral				
Information available on local funeral directors in an objective format				
Information available on choices available for arranging a funeral				
Offer information on loss and bereavement as appropriate to the death and people affected				
Information available on estate administration and probate				
Give information on other bereavement issues as need is established				

RELATIONSHIPS

KEY	Partial implementation with action plan to achieve by a target date	In place with evidence	Enhancements	May be present but does not affect level
	Core level - must be achieved to provide ME Officer function	Core level - must be achieved to provide ME Officer function		

STANDARD 2	Level 1	Level 2	Level 3 Required Level for ME Officer function	Level 4	Level 4*	Options not affecting service level
Liaison with mortuary staff		Active liaison when required e.g. PMs, coroner referral, cremation forms, release	Active liaison with mortuary staff on policy/ procedural issues as well as day to day processes	Active liaison with mortuary staff on policy/ procedural issues as well as day to day processes	Integrated service	
Liaison with facilities staff (reception/ portering)			Active liaison with management on bereavement issues including staff training	Active liaison with management on bereavement issues including staff training		
Liaison with organ/tissue and body donation services	Aware of organ/tissue donation and can signpost when appropriate	Aware of organ/tissue donation and can signpost when appropriate	Knowledgeable about organ/tissue donation/body & can facilitate contact when appropriate. Offer post-mortem examination with donation if other donation not possible.	Knowledgeable about organ/tissue donation/body & can facilitate contact when appropriate. Offer post-mortem examination with donation if other donation not possible.		

Liaison with registration & coronial services	Accurate signposting	Able to give explanation of role of coroner/officers and registrar to the bereaved and professional colleagues. Case related liaison as required.	Regular management level liaison Staff knowledgeable about roles, responsibilities and challenges of other services	Regular management level liaison Staff knowledgeable about roles, responsibilities and challenges of other services	On-site registration service	TUO service available
Relationship with complaints/ governance functions		Signposting to PALS/complaints department as appropriate	Complaints dept notified if staff aware that there is an existing complaint/ incident related to the deceased or one is anticipated from the relatives if local resolution appears not to be an option	IT systems allow bereavement staff to check if a complaint/ incident investigation is in progress OR adding a deceased record creates an alert for complaints/ governance staff	Regular contact & review of complaints for bereavement related themes & inclusion of bereavement staff in investigation processes or for contact with families if appropriate	
Wider involvement		Involvement in local networks	Membership of professional/ local & network organisations	Membership of professional/ local & national network organisations	Engaged in local and national service development projects	

CONSULTATION QUESTIONS

Questions for acute trust bereavement services

Please continue on additional sheets of paper if needed.
Post to Anne Wadey, Bereavement Advice Centre, Heron House, Stratford upon Avon CV37 9BX
Or email your response to anne.wadey@bereavementadvice.org by 31st December 2014

Optional: Name & contact details:
1a For acute trust bereavement services: Do you feel you could use the tool to assess the service you provide? If no, please explain why not.
2 How difficult would it be for you to gather the evidence to support your assessment?
3 Could you comply with 80% of level 3 now and 100% in 12 months time? If no, please explain what is preventing this.
4 If you answered no to Q3, Could you comply with 80% of level 3 in 12 months time? If no, please explain what is preventing this.
5 Do you think the tool is useful? If no, why not?
6 If you answered yes to Q5, will you use the tool? If no, why not?
7a From what you know of the Medical Examiner function, do you think level 3 is the correct level for a service to be competent to provide medical examiner's officer functions? If no, why not?
8a Is there anything missing which you think should be added? If yes, please explain**.**
9a Any other comments you want to add.

Questions for other services are overleaf. Thank you for your help

Questions for other services

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Or email your response to anne.wadey@bereavementadvice.org by 31st December 2014

Optional: Name & contact details:
What type of service do you provide:
1b Do you feel you could use the tool to assess an acute trust bereavement service if you wanted to commission or partner with it in some way? If no, please explain why not?
5b Do you think the tool is useful? If no, why not?
7b From what you know of the Medical Examiner function, do you think level 3 is the correct level for a service to be competent to provide medical examiner's officer functions? If no, why not?
8b Is there anything missing which you think should be added? If yes, please explain.
9b Any other comments you want to add.
10 Do you think this tool could be adapted for any other context?

Thank you for your help