East and North Hertfordshire NHS
NHS Trust

Trust-wide Policy

for

Learning from Deaths

A document recommended for use

In: Trust-wide

By: All staff

For: All Patient Deaths

Key Words: Learning from deaths; mortality review, mortality case record review;

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4th October 2017

Trust ratification:

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Version	Date	Comment
1	October 2017	New Document

Equality Impact Assessment

This document has been reviewed in line with the Trust's Equality Impact Assessment guidance and no detriment was identified. This policy applies to all regardless of protected characteristic - age, sex, disability, gender-re-assignment, race, religion/belief, sexual orientation, marriage/civil partnership and pregnancy and maternity.

Dissemination and Access

This document can only be considered valid when viewed via the East & North Hertfordshire NHS Trust Knowledge Centre. If this document is printed in hard copy, or saved at another location, you must check that it matches the version on the Knowledge Centre.

Associated Documentation

Prefix	Title
CP231	Care of the Dying Person and those important to them in the last few days/hours of life
CP230	Personal Care After Death - Last Offices: What to do when a Patient Dies
	What to do When a Patient Dies Checklist
	Last Offices Checklist
CP253	Mortality Case Record Review Policy
	Following a Bereavement – A practical guide for family and friends (Bespoke suite of guides for ED, Child, Stillbirth, Neonatal, Early Pregnancy)
	Multi-agency Rapid Response Team for unexpected child deaths - Information for parents, families and carers
	LeDeR Guide for conduct of local reviews
CP 252	LeDeR Standard Operating Procedure
	LeDeR Programme leaflet for Families
	Child Death Review and Response Arrangements
7.3	Guidelines for Maternal Death
7.2	Guidelines for Pregnancy Loss (including late miscarriage, stillbirth and termination for foetal abnormality
CP180	Management of Serious Incidents Policy

Review

This document will be reviewed within three years of issue, or sooner in light of new evidence.

Key Messages

- How the Trust responds to and learns from deaths
- How the Trust responds to deaths of particular patients
- Links with the process for identifying serious incidents
- How the Trust engages with bereaved families and carers.

CONTENTS

1. INTRODUCTION

In December 2016 the CQC published its report 'Learning, Candour and Accountability: A review of the way NHS Trusts review and investigate the deaths of patients in England'. Commissioned by the Secretary of State for Health in response to the very low number of investigations and reviews of deaths at Southern Health NHS Foundation Trust, it concluded that opportunities to improve care for future patients were being missed due to insufficient consideration being paid to learning from deaths in the NHS.

The Secretary of State accepted the report's recommendations, asking the National Quality Board (NQB) to translate the recommendations into a framework for implementation across the NHS. In March 2017 the first step in this programme was published in the form of the National Guidance on Learning from Deaths.

This policy seeks to build on previous Trust policies relating to mortality review, investigation and bereavement while at the same time incorporating new requirements from the national guidance. Where appropriate it will reference associated Trust Policies including those covering deaths in specified areas which have special arrangements in place.

Further developments are anticipated in the short and medium-term future, not least with the proposed introduction of the Medical Examiner role, currently expected in April 2019. For this reason, this policy is likely to evolve over this time frame.

2. SCOPE

All patient deaths.

In future, in line with national recommendations, the feasibility of including deaths within 30 days of discharge will be considered.

3. PURPOSE

The purpose of this policy is to set out how the Trust responds to, and learns from, the deaths of patients who die under its care.

4. DEFINITIONS

(i)	Case record review:	The application of a case record/note review to determine whether there were any problems in the care provided to the patient who died in order to learn from what happened.
(ii)	Investigation:	The act or process of investigating; a systematic analysis of what happened, how it happened and why. This draws on evidence, including physical evidence, witness accounts, policies, procedures, guidance, good practice and observation - in order to identify the problems in care or service delivery that preceded an incident to understand how and why it occurred. The process aims to identify what may need to change in service provision in order to reduce the risk of future occurrence of similar events.
(iii)	Serious Incident:	A serious incident is defined as an incident resulting in death, serious/permanent harm or injury, or where there is serious risk to the objectives of the Trust and/or where the incident has the potential to produce significant legal/media interest.

(iv)	Death due to a problem in care:	A death that has been clinically assessed using a recognised methodology of case record/note review and determined more likely than not to have resulted from problems in healthcare and therefore to have been potentially avoidable.
(v)	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.

5. DUTIES

Board

While the Board bears overall responsibility for the quality of healthcare provided by our Trust, including all aspects of safety, it has a number of key responsibilities regarding the Trust's commitment to learning from deaths framework, namely, to:

- Provide visible and effective leadership in all aspects of quality improvement
- Ensure the Trust has robust systems for recognising, reporting and reviewing/investigating deaths
- Ensure that the case record review process is integral to the wider clinical governance processes
- Ensure the Trust learns from problems in care identified in the course of reviews/investigations by taking effective, sustainable action to address key issues
- Ensure due consideration is given to the needs and views of both patients and the public

Chief Executive

The Chief Executive is the accountable officer with overall responsibility for the quality of care in the organisation. As such they are responsible for ensuring that the systems and processes underpinning the Learning from Deaths Policy are in place and sufficiently robust to meet the requirements of both the policy and the underlying national guidance.

Non-Executive Directors

The Trust has appointed a named non-executive director to be responsible for oversight of the learning from deaths agenda. Their responsibility will include ensuring that the Trust has a systematic approach to identifying those deaths that will be reviewed.

All Non-Executives Directors are relied upon to champion quality improvement. In this regard it is imperative that they understand the mortality review process, ensure it can withstand external scrutiny and satisfy themselves that published information fairly and accurately reflects the Trust's approach, achievements and challenges regarding learning from deaths. Of critical importance is their willingness to provide robust challenge regarding the data provided, processes used and the effectiveness of quality improvement methods applied.

Medical Director

The Medical Director is the Board-level Director with overall responsibility for the learning from deaths agenda. They are responsible for the presentation of the Quarterly Mortality Report to both the Risk and Quality Committee and the public Board meeting.

Deputy Medical Director

The Deputy Medical Director has delegated responsibility from the Medical Director for the day to day management of the learning from deaths agenda.

Clinical Improvement Lead

The Clinical Improvement Lead will support the Medical Director/Deputy and provide a central point of contact for administration of the learning from deaths process. Key duties will include:

- Preparation of mortality board reports
- Day to day management of the mortality review and ACON (Areas of Concern) processes
- Administration of Mortality Surveillance Group
- Liaison with ENHCCG regarding administration of the Mortality Review Group.

Clinical Audit and Effective Manager

The Clinical Audit and Effectiveness Manager will be responsible for maintenance of the central mortality case record review database and for the provision of regular reports relating to review outputs, including a quarterly thematic analysis of review data.

Head of Quality and Patient Safety

The Head of Quality and Patient Safety is responsible for ensuring learning from mortality reviews, as discussed at the Clinical Governance Strategy Committee, is detailed within the RHD Learning Points. Also responsible for ensuring a summary of learning from deaths is included within the Trust's annual Quality Account.

Risk and Quality Committee

This Committee ensures that the Board has a sound assessment of risk and that the Trust has adequate plans, processes and systems for managing risk. It ensures that the Trust has an effective management and clinical governance framework which includes the assessment and monitoring of quality indicators which drive forward the development of quality of services and care, patient safety, patient experience and clinical outcomes and effectiveness.

A Mortality Report is presented to the Committee on a quarterly basis. This report monitors performance at Trust, Divisional and Diagnosis level, focussing on both areas of strategic importance and concern. From Q3 2017 it will also include the nationally mandated mortality statistics for the Trust. Consideration of this information provides the Committee with the opportunity for in-depth discussion and challenge thereby ensuring a robust clinical governance framework is in place for this key aspect of Trust performance.

Mortality Surveillance Group

Part I of the Clinical Governance Strategy Committee meeting which convenes monthly (except August) performs the duties of the Mortality Surveillance Group. Key duties include:

- Monitoring of key mortality matrices with appropriate coding/clinical review/investigation
- Final consideration of deaths where areas of concern were raised as a result of mortality review to ensure learning is captured and disseminated and the avoidability of death is agreed to inform required reporting
- Quarterly review of mortality review outputs with subsequent study of potential themes
- Identification of/action regarding quality improvement opportunities
- Escalation of significant concerns/risks to the Risk and Quality Committee.

Mortality Reviewers

The Trust has a substantial team of experienced medical reviewers drawn from Medicine, Surgery and Anaesthesia. As a general principle, and wherever possible, Consultants do not review the deaths of patients who died under their care, although they may provide information to other reviewers regarding that patient.

Mortality reviewers are responsible for conducting the Stage 1 review of deaths in scope. This includes the identification of concerns relating to care which triggers a Stage 2 review.

Clinical Specialties
A Responsible Consultant who has received notification that an area of concern has been raised in the course of a mortality case record review, relating to a patient who died under their care, must review the case notes and lead a discussion at their specialty's next RHD multi-professional meeting. They are responsible for ensuring that the outcome is documented in the minutes of the meeting and forwarded to the Clinical Audit team for onward reporting to the Mortality Surveillance Group.

Head of Clinical Coding
The Head of Clinical Coding will provide Coding expertise to both the Clinical Governance Strategy Committee and the Mortality Surveillance Group. They will also provide frontline coding reviews of cases underpinning alerts and contribute to more in-depth clinical reviews as required.

Bereavement Team
The Bereavement Team is responsible for frontline engagement with bereaved families and carers.

All Clinical Staff
All Clinical Staff are responsible for frontline engagement with bereaved families and carers as appropriate and for the maintenance of clear, contemporaneous, accurate record keeping in order to facilitate appropriate coding, so that mortality indices are an accurate reflection of Trust care.

6. HOW WE RESPOND TO AND LEARN FROM DEATHS

East and North Hertfordshire NHS Trust is committed to providing the highest possible standards of care for patients who die within the Trust and likewise to extend the best possible support to their family and carers.

While it is acknowledged that death is a natural and inevitable outcome for the majority of patients who die in acute trusts, it is also recognised that despite the best intentions and efforts of healthcare staff deficiencies in care do occur. The Trust translates its commitment into action by ensuring that:

- Policies and processes are in place that detail and enable best care for patients reaching the end of their life and for their family and carers following their death
- A robust mortality review process is followed to ensure that areas of concern regarding care are identified and investigated
- Governance processes are in place to ensure that learning is collated and shared with front line nursing/medical staff and those responsible for the development of the Trust's Quality Improvement Strategies and, where appropriate, partners in the wider healthcare community.

6.1 When a Patient Dies

The Trust recognises the critical importance of dealing sensitively and compassionately with patients who die in hospital and with their relatives and carers. It also recognises that it is equally important for all staff to feel assured that the care and service provided at this extremely difficult time is appropriate, respectful and of the highest standard. In addition, there are many formalities to be dealt with by both staff and the deceased families at this time. For this reason, the Trust has developed a variety of documents, some to support and direct staff when a patient dies and some to provide support and guidance to the bereaved.

Of particular importance among these documents is the Personal Care After Death Policy. This provides guidance for staff, not only reminding them of the most important principles underpinning the care of the patient and their family/carers before and after the patient's death, but also guiding them through key elements of both patient care and required procedures following death. It also outlines the role of the Trust's Bereavement Service.

In certain circumstances there are special mandated requirements covering the response to the death of particular cohorts of patients. These will be dealt with separately under point 7 below.

6.2 Mortality Case Record Review

A formal case record review process has been in place at the Trust since 2014. The process was established as a continuous audit to promote learning and to inform the Trust's commitment to achieving continual improvement in the standard of care provided to patients and to the quality of clinical coding within the Trust. Full details regarding the process are contained within the Trust's Mortality Case Record Review Policy, referenced under Associated Documents.

6.2.1 Inclusion Criteria

Since Obstetric and Paediatric deaths are subject to specialist case review they fall outside the scope of the Trust's standard case record review process. With these exceptions, the Trust aims to review a minimum of 50% of remaining inpatient deaths. In line with the 2017 national guidance, the following categories of death will be prioritised for review:

- Deaths where the bereaved or staff raise significant concerns regarding care
- Deaths of those suffering from learning disabilities or severe mental illness
- Deaths of patients who were not expected to die, eg elective procedures
- Deaths in a specialty/diagnosis/treatment group where an "alarm" has been raised
- Categories of death identified to inform the Trust's quality improvement initiatives.

Currently, deaths of fractured neck of femur patients and those who have died at Mount Vernon Cancer Centre are reviewed separately in their specialist areas. This is in part due to established processes being in place and partly due to each requiring bespoke elements to their reviews. To comply with the requirements of the 2017 national guidance the outputs of these reviews will be added to the central data for reporting purposes. Subject to completion of a feasibility study regarding appropriate development of the existing IT infrastructure, it has been agreed in principal that these will be subsumed into the central database.

6.2.2 Methodology

At present the Trust uses its own bespoke case record review methodology. This was developed by a multi-professional team drawn from Medicine, Surgery and Anaesthesia. It is a structured, evidence based review format comprised of a core section of questions relating to care that are relevant to all specialties, with additional Medicine/Surgery specific sections.

With the anticipated availability of the Royal College of Physician's methodology, a review is currently underway of this and other available methodologies, such as PRISM, to decide which approach the Trust believes will best serve its commitment to learning and constantly improving patient care in the future. Changes to the Trust's current methodology are anticipated and the Learning from Deaths Policy will be updated to reflect these as appropriate.

6.2.3 Mortality Reviewers

There is a substantial team of experienced reviewers drawn from across Medical, Surgical and Anaesthetic specialties. New reviewers receive training and assistance from existing experienced reviewers. In recognition of the importance of the role performed by the reviewers, time for the conduct of mortality review is incorporated into job plans.

7. RESPONDING TO DEATHS OF PARTICULAR PATIENTS

The 2017 National Quality Board (NQB) guidance requires that trusts indicate how they examine the care provided to the specific types of patient (detailed below). The national guidance, while recognising that special processes may be appropriate for these types of death, has stipulated that detail regarding deaths in these cohorts should be included in the quarterly reports to Board from Q3 2017.

7.1 Patients with learning disabilities

The national Learning Disabilities Mortality Review (LeDeR) Programme was commissioned by the Healthcare Quality Improvement Partnership (HQIP) on behalf of NHS England following recommendations made in the Confidential Inquiry into premature deaths of people with learning disabilities (CIPOLD). The programme is based at the University of Bristol. Commencing in 2017, it is gradually being rolled out across the country, with Hertfordshire joining in April 2017.

A local Steering Group is now in place, whose membership includes the ENHT Deputy Director of Nursing. This Group is responsible for the implementation of the LeDeR Programme in the area and for ensuring that any learning, recommendations and actions are reviewed and taken forward using locally agreed governance structures.

As a consequence of the new programme, when a patient with learning disabilities dies in one of our hospitals their death will be notified to the National LD mortality review programme at Bristol University (LeDeR). This results in the conduct of an initial review by a local reviewer. Where concerns are raised regarding the quality of care received or where the patient fits the criteria for an annually nominated themed priority review, a further in-depth multi-agency review follows.

The central LeDeR programme team will provide each Steering Group with an annual report summarising the data that has been collated and analysed from the review processes pertaining to their area. The ENHT Deputy Director of Nursing will be responsible for providing this report (together with any interim direct feedback gained) to the Mortality Surveillance Group of the Clinical Governance Strategy Committee for consideration and to enable any relevant learning to be incorporated into the Trust's quality improvement work.

Provided at Appendix 1 and 2 are details of the LeDeR programme structure and review process/timeline.

In addition to the national process the Trust will conduct its own internal case record review of all patients with learning disabilities who die within its care. Once completed, the internal review will be uploaded to the national programme to support the formal LeDeR review process. The Trust has put in place a number of measures to ensure the capture of LD deaths including the introduction of a Standard Operating Procedure detailing notification requirements, incorporation of an LD flag on the new Lorenzo Patient Administration System and a weekly report provided to the Audit department. It is acknowledged that as the LeDeR programme is embedded further internal process and policy development may be required.

7.2 Patients with severe mental health needs

Following concerns raised in the CQC's Learning, Candour and Accountability Report published in December 2016, the 2017 Learning from Deaths national guidance stipulated that Trusts must have systems in place to flag patients with severe mental health needs so that if they die in an Acute Trust setting their care can be reviewed.

While the Trust is committed to ensuring the highest standards of care to vulnerable patients with special mental health needs, it also recognises that the area of Mental Health is both complex and sensitive. The Rapid Assessment, Interface and Discharge mental health service (RAID) is delivered by specialist staff from Hertfordshire Partnership University NHS Foundation Trust who work alongside our hospital staff. This service enables faster identification of mental health needs among hospital inpatients of all ages, as well as people arriving at the Emergency Department. The team is involved in the care of those suffering from an acute mental health episode during an admission and also usually with patients who have a key worker assigned to them and who have been admitted for elective surgery. However, they may not be involved with all patients with a mental health disorder, particularly those who are managed and stable. Furthermore, when consulted regarding the possibility of a severe mental illness flag being created on the Trust's Patient Administration System they felt that this ran counter to moves to change attitudes towards mental health with the removal of such labelling.

The alternative method to identify and flag severe mental illness patients is via reference to relevant coding. However, there are a multitude of potential conditions/corresponding codes and the national guidance provided no clear definition as to what conditions should be considered to be under the severe mental illness banner. Clarification is being sought from the Learning from Death programme leaders in this regard.

In the interim, internal discussions are taking place to agree a working ‘basket of conditions’ that can be used to identify relevant deaths for review using the Trust’s standard case record review. Further changes are expected as a result of the current work being co-ordinated by NHS England relating to the development of a mental health review method. When published, the Trust will reassess its processes and policies in the light of guidance and requirements.

7.3 Infant or child (under 18) deaths

The procedural requirements following the death of a child or young person are understandably rigorous and extend beyond the bounds of Trust. There are two processes, both of which are managed locally via the Hertfordshire Safeguarding Children Board (HSCB).

7.3.1 Child Death Overview Panel (CDOP)

There is a Statutory requirement for all local safeguarding boards to have a CDOP panel to review all child deaths 0-18 years old ('Working Together to Safeguard Children' by HM Government - Every Child Matters). The purpose is to ensure a systematic review of the factors contributing to the death, to identify cases where a Serious Case Review is required and to collate and share learning in an attempt to prevent future child deaths. Individual learning points may be communicated back to the relevant department by the CDOP. For wider and general issues that impact on the public, direct interventions are taken by the HSCB, possibly by way of the provision of public information literature. Additionally, an annual report is published providing statistics regarding the deaths; lessons learned and recommendations made.

7.3.2 Rapid Response Framework

The procedures and responsibilities for this framework are provided in the Rapid Response Protocol published by the HSCB. An overview of the process is included in Appendix 3 and the comprehensive guidance “Child Death Review and Response Arrangements – Rapid Response Protocol” is cited as an Associated Document. The framework details the HSCB multi-agency response to the sudden or unexpected death of a child. Professionals from a number of different agencies and disciplines will be involved following such a death not only to try to establish the cause, but also to provide vital support to the family at such a devastating time.

Within the Trust both doctors and nurses are familiar with the process and liaise closely with the multi-agency team undertaking the investigation. All relevant policy documentation is available within the acute paediatrics section of the Trust’s intranet site. Learning is agreed and disseminated by the local Steering Group (attended by representatives from the Trust’s Safeguarding team) with information being cascaded to the relevant Trust teams.

7.4 Maternal deaths

The Trust follows the national recommendation that all maternal deaths should be reported to MBRRACE-UK. This is a collaboration appointed by the Healthcare Quality Improvement Partnership (HQIP) to continue the national programme of work investigating maternal deaths, stillbirths and infant deaths, including the Confidential Enquiry into Maternal Deaths (CEMD). The programme of work is now called the Maternal, New-born and Infant Outcome Review Programme (MNI-CORP). Additionally, all maternal deaths, which are extremely rare, are subject internally to a Serious Incident investigation.

The Trust’s document “Guideline for Maternal Death” (cited as an Associated Document) provides detailed information regarding the definition and categories of maternal deaths together with clear instructions on the process to be followed and allocation of responsibility. Maternal deaths are particularly traumatic and central to the policy is the provision of support for both family and members of staff and the involvement of the Trust's Bereavement service.

Annual MBRRACE-UK reports provide general learning which informs internal quality improvement initiatives. Specific, detailed actions and learning are provided by the internal Serious Incident investigation – which are shared via the Trust's clinical governance processes with the Directorate and wider clinical arena as appropriate. Inclusion in Serious Incident Reports to the Risk and Quality Committee also ensure Board awareness of issues raised. Appropriate learning is used to develop quality improvement work.

7.5 Perinatal deaths

Within the Obstetrics and Gynaecology Directorate detailed guidance is provided regarding Pregnancy Loss, which includes miscarriage, stillbirth and termination due to foetal abnormality. This guidance (referenced under Associated Documents) acknowledges that pregnancy loss at any gestation can be a sad and potentially devastating event for the woman and her family and an extremely sad and stressful experience for all the personnel involved in their care and that no matter what the circumstances it results in a particularly difficult kind of grief. For this reason, the vital importance of endeavouring to aid the grieving process by being open, supportive, sensitive and caring towards the woman and her family is emphasised. Additionally, support is provided by the Bereavement Office and bespoke literature provided to guide them.

The Trust is committed to learning from all perinatal deaths. As a result, all intra-uterine deaths are reviewed by the MDT at the time of the loss and subsequently by the Bereavement Group, which uses the national SCOR system to grade the loss. Cases are discussed at the Clinical Governance Rolling Half Day (RHD) meeting. Lessons learned are shared with the appropriate multi-disciplinary team. If themes are identified, action plans are formulated and monitored at subsequent RHD meetings. Unresolved actions are escalated to the Clinical Governance Strategy Committee, and if necessary the Risk Register. The Trust also contributes to the "Each Baby Counts" RCOG database for all babies who die intrapartum.

Additionally, feedback from bereaved parents from Local Support Groups and via National Guidance from organisations such as the Miscarriage Association and the Stillbirth and Neonatal Death charity (SANDS) enables the Bereavement Support Midwife to continually assess the standard of care given and where appropriate to support changes in practice. Specific changes in bereavement care, resulting from the above sources, may be presented annually by the Bereavement Support Midwife at the Specialty RHD meeting.

8. SERIOUS INCIDENTS

The Trust is committed to investigating and learning from all Serious Incidents (SIs) and in particular those that involve the death of a patient. Within the Trust, management of the Serious Incident framework is overseen by the Patient Safety Committee, with key decision-making responsibilities held by the Medical Director and Director of Nursing and day to day management of the process sitting with the Patient Safety Manager.

All SIs are reported to the national Reporting and Learning System (RLS) with onward reporting to the CQC. Additionally, details of all SIs are uploaded to the Strategic Executive Information System (StEIS) database which ensures oversight and monitoring by the Trust's Commissioners and also facilitates national learning. There is regular liaison between the CCG and Patient Safety Team with concerns addressed at Quality Review Meetings.

The Trust's Management of Serious Incidents Policy, referenced under Associated Documents, provides a comprehensive guide to the investigation of SIs for all staff responsible for the escalation of where a decision needs to be made as to whether the incident is a Serious Incident or

Incident Requiring Investigation (IRI). An overview of the framework has been included at Appendix 4.

The above policy covers how the Trust complies with key requirements of the 2017 Learning from Deaths national guidance. Central to this is the way in which the Trust engages with bereaved families and carers, including how they are supported and involved in the investigation process and how the Trust complies with its Duty of Candour. It recognises that families/carers can provide valuable insight into events surrounding the incident and should be made aware as soon as possible, in person and in writing, of the process, rationale and purpose of the investigation and be given the opportunity to inform the terms of reference.

Following conclusion of investigations learning and feedback is provided to relevant Specialty Rolling Half Day clinical governance meetings for discussion. Inclusion of information in the Patient Safety Matters newsletter is also used to promote Trust-wide sharing of important developments. The Patient Safety Committee is responsible for ensuring appropriate escalation of concerns to the Risk and Quality Committee and also for ensuring that key learning and themes inform the Trust's quality improvement initiatives.

9. ENGAGEMENT WITH BEREAVED FAMILIES AND CARERS

The Trust recognises that bereaved people depend on bereavement services and on those who provide them at a particularly distressing and difficult time. It is appreciated that the memories of the death and of the person who has died can be affected by the quality of these services and that the experience not only leading up to but also following the death can influence the grieving process and longer-term health of the bereaved. The Trust is committed to treating the family with care, sensitivity and respect.

It is recognised that every death is unique and the age of the patient and circumstances leading up to their death result in diverse challenges for their loved ones. For this reason, the Trust has developed a suite of bereavement literature to support families, tailored to meet these varied needs. In addition to a general bereavement leaflet there are leaflets for Emergency Department Deaths, Stillbirths, Child, Neonatal and Early pregnancy (up to 24 weeks).

The Trust is committed to treating bereaved families and carers as equal partners following a bereavement. This includes engaging with them in a clear, honest and compassionate manner at all times and to ensure that if the family has concerns regarding the quality of care received by their loved one, they are provided with the opportunity to raise these. Such cases will be brought to the attention of the Medical Director. Where appropriate they will be investigated under the Serious Incident framework. Where it is not considered that they fulfil the relevant criteria for such an investigation, they will be subject to formal mortality case record review, raised as an Area of Concern and considered by the Clinical Governance Committee, with a final report provided to the family.

10. GOVERNANCE AND REPORTING

The Trust is committed to the reduction of mortality rates for patients within its care. To enable this, the Trust ensures its governance arrangements are robust and gives due focus to the review, investigation and reporting of deaths.

10.1 Board via Risk and Quality Committee

There is an established quarterly Mortality report presented to the Risk and Quality Committee and subsequent Board meeting by the Medical Director. Key elements have included updates on:

- Headline mortality data including the number of deaths, reviews, ACONs (including outcomes/learning)
- Key mortality matrices/CUSUM alerts
- Areas of focussed work to improve mortality
- Strategically important pathways/initiatives.

From October 2017 this will be developed to include the information mandated by the new national guidance, namely:

- Total number of deaths
- Number of deaths subject to case record review
- Number of deaths investigated under the Serious Incident framework
- Details of Infant/Child, perinatal/maternal deaths and those relating to patients with Learning Disabilities or severe mental illness
- Number of deaths that were reviewed/investigated and as a result considered to be more likely than not to be due to problems in care
- Themes and issues identified from review and investigation
- Actions taken in response, actions planned and where possible an assessment of the impact of actions taken.

In addition, a separate detailed Serious Incident Report is presented to the Risk and Quality Committee, also on a quarterly basis.

10.2 Mortality Surveillance Group (subset of Clinical Governance Strategy Committee)

The Mortality Surveillance Group meets monthly as a subset of the Clinical Governance Strategy Committee. This multi-disciplinary, multi-professional group is responsible for oversight of day to day mortality reduction initiatives. Its core remit covers the monitoring/consideration of:

- Key mortality matrices/CUSUM alerts
- Trust Mortality Improvement Dashboard
- Coding accuracy
- Quarterly Thematic Report (based on mortality review outputs)
- Final consideration of ACONs (including using a systematic approach to decide on the avoidability of the deaths).

The Trust recognises the importance of considering key mortality data, in particular Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital-level Mortality Indicator (SHMI). Regular monitoring of such matrices is firmly embedded within Trust's culture at Specialty, Divisional, Sub-Committee and Board level. The Trust's Mortality Improvement Dashboard includes key headline data and is provided to both the Risk and Quality Committee (via the quarterly Mortality Report) and to the Mortality Surveillance Group.

It is acknowledged that the relationship between mortality rates and the quality of patient care is a complex one. For this reason, the Trust seeks to ensure the triangulation of available information from many sources including mortality data, case record review, coding review, and in some cases care in the community in the formulation of its quality improvement work.

10.3 Rolling Half Day Clinical Governance Meetings

These half day sessions, which are held ten times per year, provide the opportunity for protected clinical governance time. All non-emergency clinics and lists are cancelled. Attendance is for as many staff as possible, from all appropriate disciplines and professions, including general managers, assistant general managers, nurses and therapists. Central to the topics covered are cases raised as Areas of Concern (ACONs) as a consequence of mortality case record reviews, the outcomes of Serious Incident investigations together with Complaints and Claims. These meetings provide a forum for discussion, learning and the creation of appropriate Specialty specific actions plans. For this reason, they represent a vital element of the Trust's Learning from Deaths framework.

10.4 Mortality Review Group (In collaboration with Commissioners)

This group is a collaborative initiative between East & North Hertfordshire Clinical Commissioning Group and the Trust and meets 3 times a year. Chaired by the ENCCG Clinical Lead, the group works to address cross boundary mortality issues, monitor mortality rates, agree and review action plans in order to promote the highest standards of clinical care and a reduction in mortality rates.

11. LEARNING

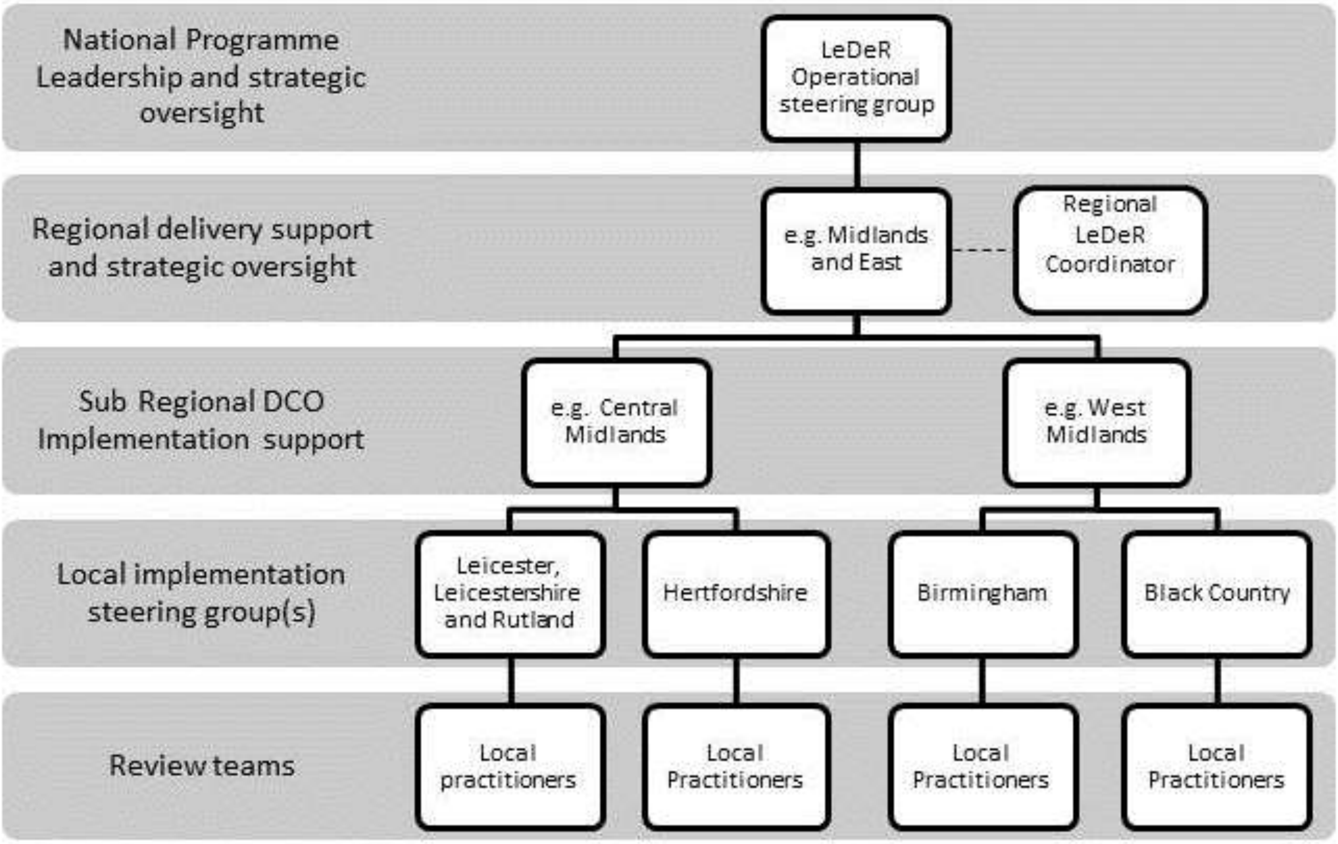
The potential for learning provided by the outputs of Mortality Case Record Review, Serious Incidents, Inquests and Complaints is immense. While the Trust already has embedded processes in place for capitalising on this learning, it is currently seeking to further enrich the quality of its Learning from Deaths work via greater collaborative analysis across internal Trust processes. Work is on-going to better coordinate the outputs of the various processes. This will both inform the quarterly Learning from Deaths reporting to Board and the Trust's Quality Improvement planning.

12. REFERENCES

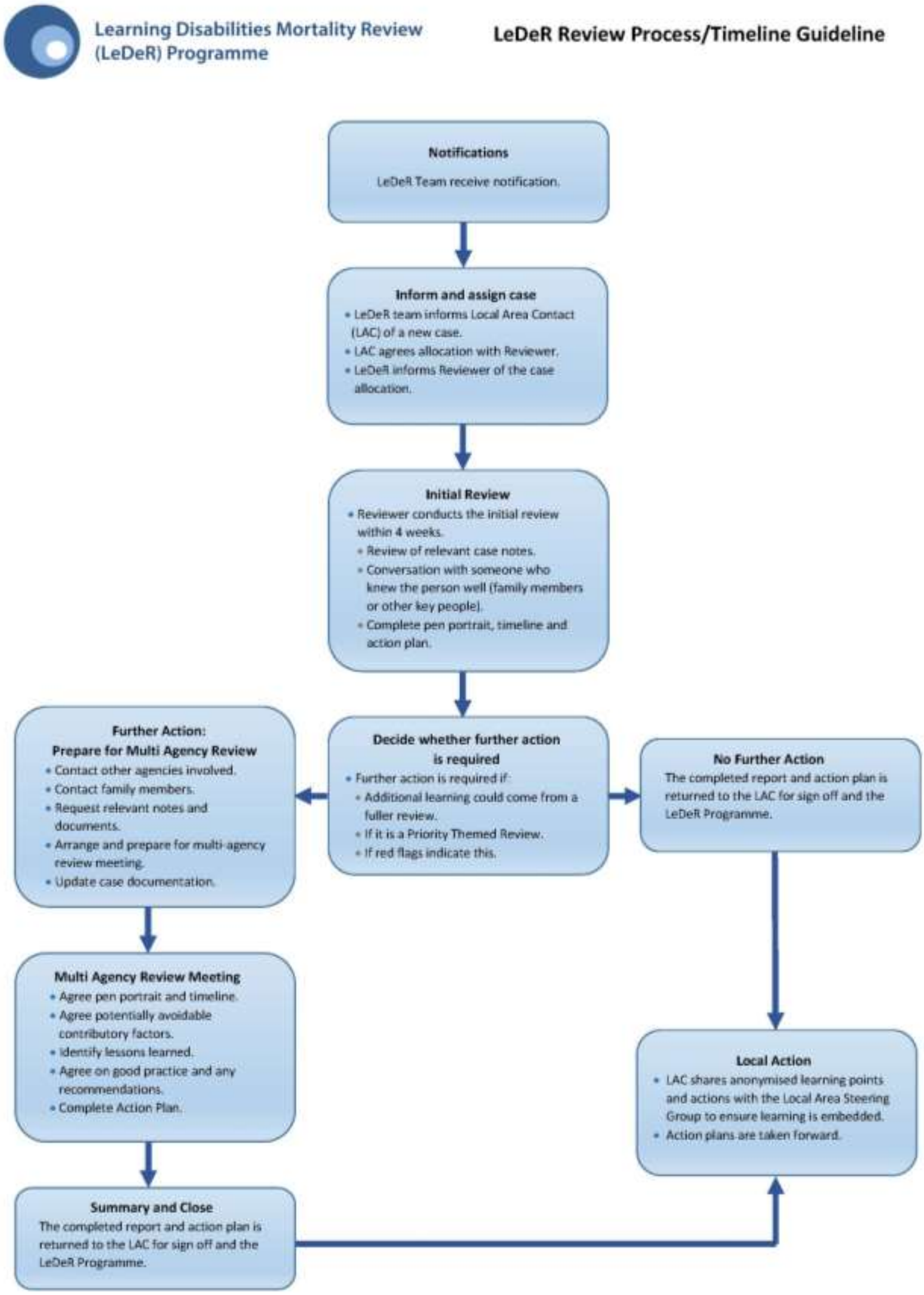
- Learning, Candour and Accountability, December 2016: *Care Quality Commission*
- National Guidance on Learning from Deaths, March 2017: *National Quality Board*
- Implementing the Learning from Deaths Framework: Key Requirements for Trust Board, July 2017: *NHS Improvement*
- Guidance on the Conduct of Local Reviews of the Deaths of People with Learning Disabilities, September 2016: *NHS England*
- National Learning Disability Mortality Review – Midlands & East Regional Implementation Support Plan, October 2016: *Louisa Whait*
- 'Working Together to Safeguard Children' by HM Government - Every child matters

13. APPENDICES

Appendix 1: LeDeR Programme Structure



Appendix 2: LeDeR Review Process/Timeline Guideline



Learning Disabilities Mortality Review (LeDeR) Programme

LeDeR Review Process/Timeline Guideline

Notifications

LeDeR Team receive notification.

Inform and assign case

- LeDeR team informs Local Area Contact (LAC) of a new case.
- LAC agrees allocation with Reviewer.
- LeDeR informs Reviewer of the case allocation.

Initial Review

- Reviewer conducts the initial review within 4 weeks.
  - Review of relevant case notes.
  - Conversation with someone who knew the person well (family members or other key people).
  - Complete pen portrait, timeline and action plan.

Decide whether further action is required

- Further action is required if:
  - Additional learning could come from a fuller review.
  - If it is a Priority Themed Review.
  - If red flags indicate this.

Further Action: Prepare for Multi Agency Review

- Contact other agencies involved.
- Contact family members.
- Request relevant notes and documents.
- Arrange and prepare for multi-agency review meeting.
- Update case documentation.

No Further Action

The completed report and action plan is returned to the LAC for sign off and the LeDeR Programme.

Multi Agency Review Meeting

- Agree pen portrait and timeline.
- Agree potentially avoidable contributory factors.
- Identify lessons learned.
- Agree on good practice and any recommendations.
- Complete Action Plan.

Local Action

- LAC shares anonymised learning points and actions with the Local Area Steering Group to ensure learning is embedded.
- Action plans are taken forward.

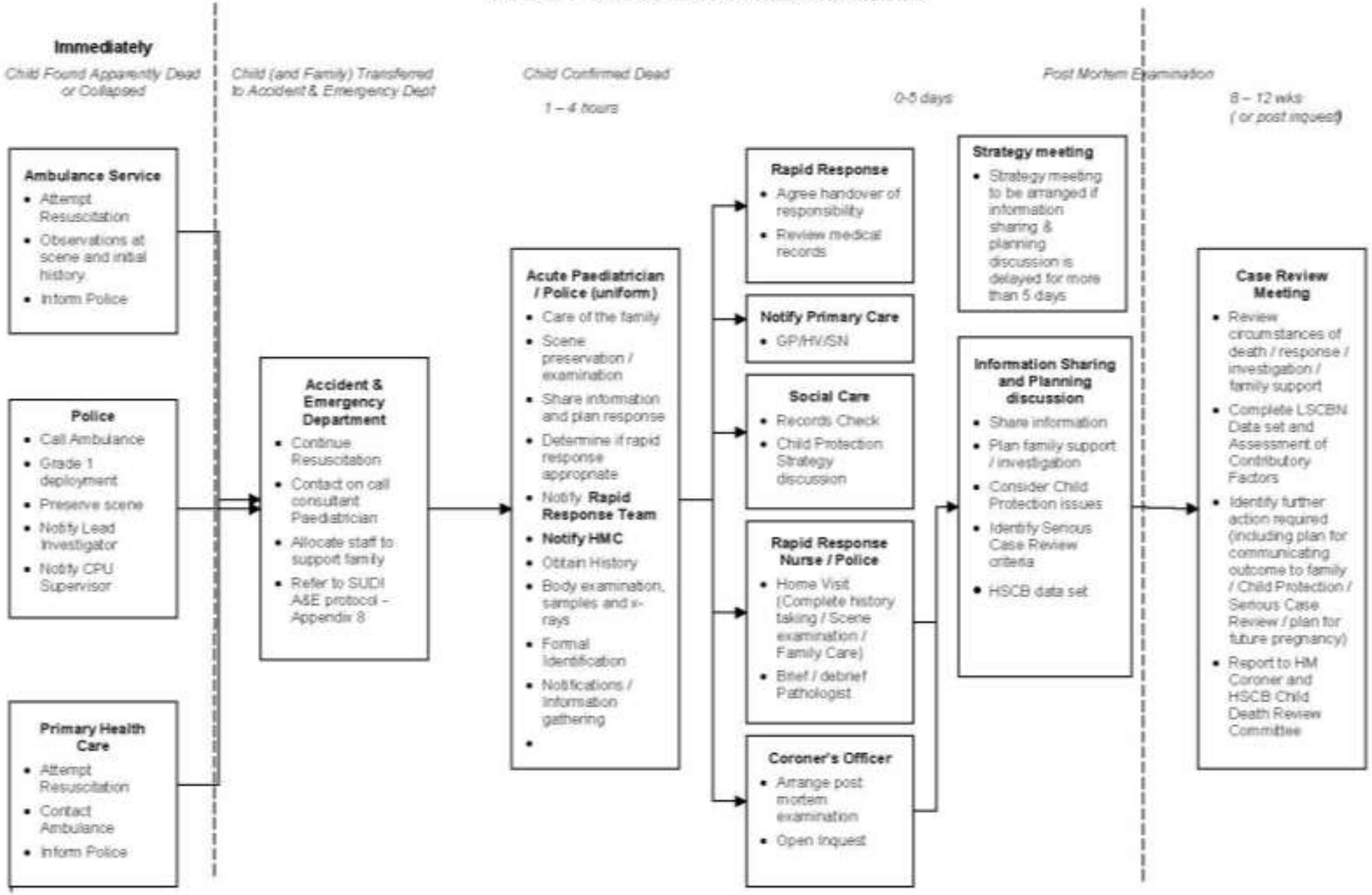
Summary and Close

The completed report and action plan is returned to the LAC for sign off and the LeDeR Programme.

Appendix 3: Child Death Rapid Response Responsibilities

HERTFORDSHIRE safeguardingchildren BOARD

FIGURE 1 – FLOWCHART OF RESPONSIBILITIES



Appendix 4: Serious Incident Framework