DOC ID:
CP 254

East and North Hertfordshire NHS Trust

Learning from Deaths

About this document	
Document ID	CP 254 **Version:** 003
Full review due before	01 February 2025
Document type	Policy
Usage & applicability	For use Trust wide by all staff at all sites

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 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.

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 and learning from patient safety incidents
- How the Trust engages with bereaved families and carers and external partners.

What you need to know about this version

VERSION TYPE: **Full review of document with amendments**

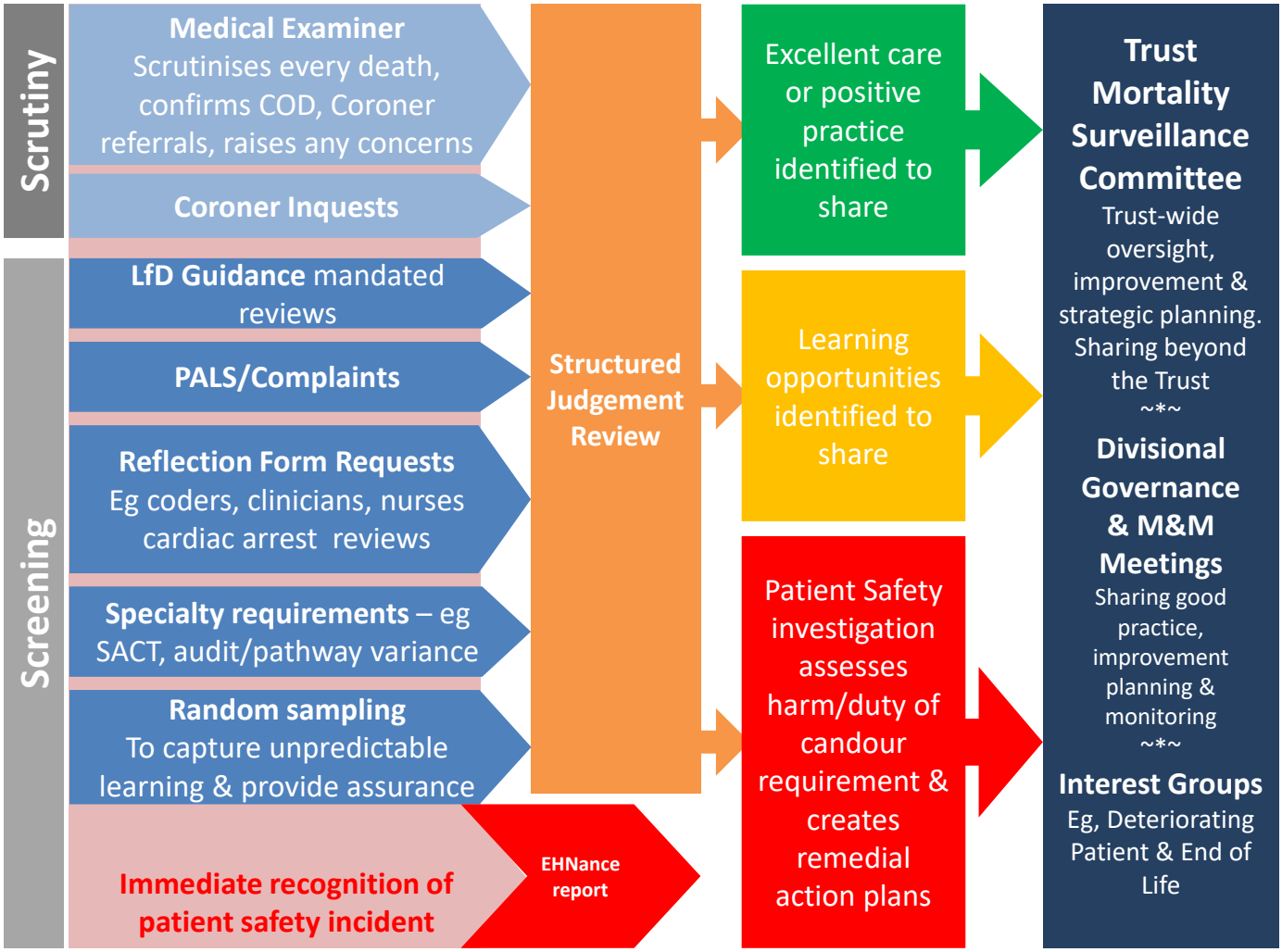
Key changes in this version:

- Adoption of new mortality review tool
- Changes to mortality review process
- Update to the associated document '*Additional information for families following a bereavement leaflet*'

Contents

Part 1 – Preliminary document information

Summary flowchart



1. Scope

The deaths of all patients who die in hospital: From July 2022 deaths of patients who die in ED are included in addition to in-patient deaths. These deaths had previously been subject to a separate review process.

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

2. 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.

3. Definitions

Better Tomorrow	A collaborative workspace on the FutureNHS website providing a forum for those interested in learning from deaths and in how that learning can influence future patient care.
Coroner	Coroners are independent judicial officers, appointed by the local authority, and are either doctors or lawyers responsible for investigating the cause of deaths.
Death due to a problem in care	A death that has been clinically assessed using a recognised methodology of structured judgement review and determined more likely than not to have resulted from problems in healthcare and therefore to have been potentially preventable.
Inquest	An inquest is an inquiry into the circumstances surrounding a death. The purpose of the inquest is to find out who the deceased person was and how, when and where they died and to provide the details needed for their death to be registered.
Investigation:	An investigation under the Serious Incident Framework
Learning Disability Mortality Review Programme (LeDeR):	LeDeR is a service improvement programme for people with a learning disability and autistic people. It works to improve care for people with a learning disability or autism, reduce health inequalities for these people and prevent them from suffering an early death.
Mortality screening and reflection:	A process whereby the care before death is reflected on, using a set of questions to identify any issues in the delivery of care. This should highlight where concerns exist, such as when the family or staff raise concerns about care. The process should also highlight excellent care practices. Where reflection identifies issues in the delivery of care, this triggers the conduct of a structured judgement review.
NHS England Applications:	The SJR e-review tool, which allows for on-site or remote case note review, is hosted on NHS England Applications.
Patient Safety	The Patient Safety Incident Response Framework (PSIRF) sets

Incident Response Framework (PSIRF)	out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety.
Patient safety incident:	Any healthcare related event that was unintended, unexpected and undesired and which could have or did cause harm to a patient.
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.
Serious Incident:	A nationally mandated classification. SIs are subject to rigorous scrutiny in terms of reporting, investigation and learning. Commissioners and the CQC are automatically notified of SIs.
Severe mental illness:	National guidance requires that all deaths of people with a severe mental illness should be subject to SJR. The Royal College of Psychiatrists guidance states that this would include patients with a diagnosis of psychosis or eating disorder during their last episode of care, those who had recently been admitted to a psychiatric ward, or where the patient was under the care of a crisis and home treatment team at the time of their death.
SJR*Plus* (SJR+):	Online mortality review form developed by the Better Tomorrow FutureNHS collaboration. It follows the principles of the Royal College of Physicians' (RCP) Structured Judgement Review (SJR), previously established within the National Mortality Case Record Review Programme (NMCRR).
Structured judgement review:	A clinical judgement-based review following a standardised format used to determine whether there were any problems in the care provided to the patient who died, in order to learn from what happened.
Unexpected death:	A death that was not expected to occur at or near the time of the event, or where the cause of death was not an expected cause. This can be where the person died as a result of a known condition but was not expected to die at this time or in the near future, or where there is another cause of death not related to their known condition.

4. 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 the 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
- Satisfy itself that the quarterly Learning from Deaths report demonstrates compliance with relevant national guidance
- Ensure that the structured judgement 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 issues, ensuring cohesion with key Trust systems such as the safety incident learning framework
- 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 Learning from Deaths Report to both the Quality and Safety Committee and the public Board meeting.

Associate Medical Director (Reducing Unwarranted Variation)

The Associate Medical Director provides clinical leadership regarding all day-to-day aspects of the learning from deaths programme and is Chair of the Trust's Mortality Surveillance Committee.

Mortality Improvement Lead

The Mortality Improvement Lead provides leadership to the organisation in all aspects of mortality monitoring and the national Learning from Deaths quality improvement framework, including the development and maintenance of appropriate policies and processes, to ensure that a culture of continuous quality improvement is maintained. Responsibilities include the provision of a quarterly thematic analysis of structured judgement review data, ensuring that learning is shared and discussed with the Mortality Surveillance Committee

and cascaded more widely across the Trust as agreed/directed by the Committee. A summary of key learning from deaths should also be included within the Trust's annual Quality Account.

Mortality Improvement Manager
The Mortality Improvement Manager will be responsible for the day-to-day management of the mortality review process including maintenance of the central mortality structured judgement review database and for the provision of regular reports relating to review outputs. They will also deputise for the Mortality Improvement Lead in all aspects of mortality monitoring and the national Learning from Deaths quality improvement framework.

Director of Quality
The Director of Quality will be responsible for ensuring that there is a seamless integration of the Mortality Improvement work into the Trust's wider Quality Improvement programme, thereby ensuring that the Trust's Learning from Deaths framework is firmly embedded in the organisation's Quality and Safety strategy.

Mortality Surveillance Committee
The Mortality Surveillance Committee provides assurance to the Trust Board regarding patient mortality. Such assurance is based on the review of care received by those who die and by reference to, and understanding of, mortality rates and statistics. The aim of the Committee is to work towards the elimination of all preventable in-hospital mortality. The committee meets monthly (with the exception of January and August). Key duties include:

- Monitoring of key mortality metrics with appropriate coding/clinical review/investigation
- Final consideration of deaths where concerns raised in a structured judgement review resulted in a patient safety incident escalation
- Approval of the quarterly Learning from Deaths report for submission to the Quality and Safety Committee
- Quarterly review of mortality review outputs with subsequent study of potential themes
- Identification of/action regarding quality improvement opportunities and appropriate capture and dissemination of learning
- Escalation of significant concerns/risks to the Quality and Safety Committee.

Quality and Safety Committee
The Quality and Safety Committee seeks assurance that appropriate arrangements are in place for measuring and monitoring quality and safety including clinical governance, clinical effectiveness and outcomes, research governance, information governance, health & safety, patient and public safety, organisational culture and OD and compliance with CQC regulation. The Committee is also responsible for assuring the Board that these arrangements are robust and effective and support the delivery of appropriate strategic objectives and quality transformation plans.

The Committee is responsible for discussion and approval of the quarterly Learning from Deaths Report. A summary of which is subsequently considered at the Trust's public Board meeting. This report monitors performance at Trust, Divisional and Diagnosis level, focussing on both areas of strategic importance and concern. Since Q3 2017 it also includes 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 Reviewers

The Trust has a multi-disciplinary team of experienced consultant reviewers drawn from the Planned and Unplanned Divisions. 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 structured judgement reviews of deaths in scope which have been identified for review based on national guidance criteria. This includes the identification of cases requiring further input from a different expert together with cases where concerns relating to care require investigation under the Trust's patient safety incident framework.

Divisional Quality Managers

Where a structured judgement review triggers a patient safety concern, the Mortality Support team raises a patient safety incident on ENHance, allocating the case to the relevant Divisional Quality Manager (DQM). It is the responsibility of the DQM to complete an initial assessment and reallocate the case to an appropriate handler. The degree of harm will be decided by the clinician following review and supplementary reporting.

Head of Clinical Coding

The Head of Clinical Coding will provide coding expertise to support the Medical Director, Mortality Improvement Lead and the Mortality Surveillance Committee. They will also provide frontline coding reviews of cases underpinning alerts and contribute to more in-depth clinical reviews as required.

Medical Examiners

The Medical Examiner function is a process which sits outside the normal governance structure of the Trust and is responsible to the Medical Director and the Regional Lead Medical Examiner. Medical Examiners are responsible for the scrutiny of all deaths which are not referred to the coroner.

Medical Examiner Officers

The Medical Examiners are supported by Medical Examiner Officers who gather information from various sources and prepare cases for scrutiny.

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.

5. Associated Documents

The following are related Trust policies and procedural documents, which are advised reading to supplement this document and/or process. The “References” section in part 2 contains external resources referenced in the development of this document.

Document title	Doc ID	Originator
Mortality Structured Judgement Review	CP 253	☒ENHT ☐Affiliated network ☐National/ regional
National Learning Disability Mortality Review SOP	CP 252	☒ENHT ☐Affiliated network ☐National/ regional
Care of the Dying Person and those important to them in the last few days/hours of life	CP231	☒ENHT ☐Affiliated network ☐National/ regional
Personal Care After Death - Last Offices: What to do when a Patient Dies	CP230	☒ENHT ☐Affiliated network ☐National/ regional
Management of incidents and serious incidents requiring investigation & learning	CSEC 049	☒ENHT ☐Affiliated network ☐National/ regional
Maternal Death	Key Guidelines 7.3	☒ENHT ☐Affiliated network ☐National/ regional
Pregnancy Loss	Key Guidelines 7.2	☒ENHT ☐Affiliated network ☐National/ regional
Mortality Review Reflection Form	Not applicable	☒ENHT ☐Affiliated network ☐National/ regional
What to do When a Patient Dies Checklist	Not applicable	☒ENHT ☐Affiliated network ☐National/ regional
Last Offices Checklist	Not applicable	☒ENHT ☐Affiliated network ☐National/ regional
Following a Bereavement – A practical guide for family and friends (Suite of guides for ED, Child, Stillbirth, Neonatal, Early Pregnancy, Loss of a baby under 24 weeks)	Not applicable	☒ENHT ☐Affiliated network ☐National/ regional
Learning from lives and deaths – People with a learning disability and autistic people (LeDeR) policy 2021	Not applicable	☐ENHT ☐Affiliated network ☒National/ regional
Child Death Review Statutory and Operational Guidance (England) 2018	Not applicable	☐ENHT ☐Affiliated network ☒National/ regional
Additional information for families following a bereavement: Leaflet in bereavement pack (signposts full text on Trust website)	Not applicable	☒ENHT ☐Affiliated network ☐National/ regional
Learning from deaths strategy 2022/24	Not	☒ENHT

	applicable	☐Affiliated network ☐National/ regional
Learning from deaths strategy 2022/24 positioning document	Not applicable	☒ENHT ☐Affiliated network

6. Monitoring compliance

It is the responsibility of the Mortality Improvement Lead to monitor compliance with this policy with the support of the Mortality Improvement Manager, via their day-to-day oversight of the learning from deaths programme.

In addition, the Mortality Surveillance Committee meets every month except January and August. It is a multi-disciplinary, multi-professional group, responsible for oversight of all aspects of mortality monitoring, mortality reduction initiatives and the national Learning from Deaths quality improvement framework. It is chaired by the Associate Medical Director with responsibility for reducing unwarranted variation, who together with the Medical Director, and the Mortality Improvement Lead, monitors the adequacy and effectiveness of the Trust's learning from deaths programme and instigates change and development as necessary.

6.1. Equality Analysis

The Trust supports the practice of evidencing due regard to equality considerations, ensuring the document and the function, outlined therein, 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.

This evidence is in the form of an equality analysis - a process which should be embedded within the early stages of planning or developments that relate to or impact on equality diversity and inclusion. This also applies to new proposals or changes to previous policy, procedure, strategy or processes that are coming up for review. More on this process and the location of a completed Equality Analysis can be found on the Equality, Diversity & Inclusion section of the intranet.

The document author has ensured the policy/guideline avoids affecting one group less or more favourably than another on the basis of:		**Impact Yes/No**	**Comments**
1	Age (younger people & children & older people)	NO	
2	Gender (men & women)	NO	
3	Race (include gypsies and travellers)	NO	
4	Disability (LD, hearing/visual impairment, physical disability, mental illness)	NO	
5	Religion/Belief	NO	

6	Sexual Orientation (Gay, Lesbian, Bisexual)	NO	
7	Gender Re-assignment	NO	
8	Marriage & Civil Partnership	NO	
9	Pregnancy & Maternity	NO	
10	Is there any evidence that some groups maybe affected differently?	NO	
11	Could this document have an impact on other groups not covered by a protected characteristic? (e.g.: low wage earners or carers)	NO	
If '**NO IMPACT'** is identified for any of the above protected characteristics then no further action is required.			
If '**YES IMPACT**' is identified a full impact assessment should be carried out in compliance with HR028 Equality & Human Rights Policy and linked to this document			
Any other comments: There is no evidence that this policy will negatively impact on any of the protected characteristics listed above, or other groups not covered by protected characteristics. To the contrary, the processes covered by the Policy, help the Trust to identify any inappropriate or unconscious bias, thereby promoting Equality, Diversity and Inclusion.			
Assessment completed by: Sarah El Sharnoubi, Mortality Improvement Lead **Date completed**: 2022-08-10			

7. 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*
- Implementing the medical examiner system: National Medical Examiner's good practice guidelines 2020
- Working Together to Safeguard Children: HM Government 2018
- Guidance for Trusts and Health Boards – Conducting Perinatal Mortality Reviews using the National Perinatal Mortality Review Tool (PMRT) 2018
- Child Death Review – Statutory and Operational Guidance (England) September 2018
- Multi-agency Rapid Response Team for unexpected child deaths - Information for parents, families and carers
- Learning from deaths – Guidance for NHS Trusts on working with bereaved families and carers July 2018
- Patient Safety Incident Response Framework and supporting guidance: https://www.england.nhs.uk/publication/patient-safety-incident-response-framework-and-supporting-guidance/

Part 2 – 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 extending 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 can 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
- The Medical Examiner function is fully embedded, providing independent scrutiny of deaths in line with national guidance
- A robust patient safety incident response plan is in place that is committed to ensuring learning and improvement are the constant priority of focus
- The Trust's mortality review process uses a clinical judgement-based, standardised format enabling the identification of both exemplary care and problems in care in order to learn and improve the quality of care provided
- Governance processes are in place to ensure that:
    - Appropriate monitoring is undertaken in order to assess and evidence improvement and where necessary instigate further action
    - 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.

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's family. 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.

The *Personal Care After Death Policy* 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. The Trust has also developed a suite of bespoke bereavement literature to support bereaved families and carers.

In July 2018 the National Quality Board published guidance on working with bereaved families and carers. This included a suggested template for a leaflet to support the bereaved following the death of a patient. This has been adapted for use by the Trust. Outline

information is included in the Trust's Bereavement literature, which signposts bereaved families to the full text which is available on the Trust website.

2. Reflection at the point of death

While the Mortality Support team identifies deaths for SJR review using national guidance criteria, the people best placed to flag cases for review are those who looked after the patient. For this reason, teams involved in the care of a patient at the point of death are encouraged to reflect on the care provided and complete a *Mortality Review Reflection Form* identifying cases where it is felt there would be value in the case being subject to a structured judgement review – whether this is because there are concerns, or where it is felt that excellent care should be highlighted. The reflection form is quick and easy to complete and is aimed at making the Trust's mortality review process readily accessible to all teams across all Divisions.

3. Medical Examiner

The Medical Examiner function is a process which sits outside the normal governance structure of the Trust and is responsible to the Medical Director and the Regional Lead Medical Examiner. The Medical Examiner service commenced as a pilot from 1 October 2020 and rolled out fully from the beginning of May 2021. Expansion of the service to incorporate scrutiny of deaths in the Community is scheduled to take place by the end of 2022/23.

Medical Examiners are responsible for the scrutiny of all deaths which are not referred to the coroner. They review all causes of death completed by doctors with the aim of improving the quality/accuracy of the cause of death certification.

Additionally, Medical Examiners give bereaved families greater opportunity to raise concerns, ensuring referrals to coroners are made appropriately and promote learning/good practice by feeding into clinical governance processes – in particular by flagging cases for priority mortality structured judgement review or for consideration by the Serious Incident Panel.

The process for medical examiner systems following a death is summarised in Appendix 1.

4. Inquests

An inquest is an external inquiry conducted by a Coroner, into the circumstances surrounding a death. Its purpose is to find out who the deceased person was and how, when and where they died and to provide the details needed for their death to be registered.

In addition to the detail required by law, their findings may also include narrative containing feedback to the Trust and/or those involved in the patient's care. Where the Coroner has concerns that there is the risk of a similar death occurring in the future, they issue a PFD report (Prevention of Future Deaths), also known as a Regulation 28 Report. The Trust must

respond to a PFD report in writing within 56 days setting out the actions taken/proposed to prevent a similar death in the future.

Important learning identified from the Coroner's narrative, and in particular from PFD reports is detailed in reports to the Quality and Safety Committee, and via Rolling Half Day or appropriate clinical governance forums.

5. Structured Judgement Review

A formal case record review process has been in place at the Trust since 2014. The process was originally 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.

From July 2022 the Trust has adopted the SJR*Plus* format for mortality review. This format has been developed by "Better Tomorrow"; a collaborative initiative hosted on the FutureNHS platform. SJR*Plus* is an e-review tool, in addition to which the Better Tomorrow collaborative provides a forum for discussion, learning and the promotion of best practice in the learning from deaths arena, its aim being *"To support effective learning from deaths in order to improve care for the living"*. Full details regarding the process are contained within the Trust's structured judgement review standard operating procedure, referenced under Associated Documents.

An overview of the Trust's process is provided in Appendix 2.

5.1 Inclusion criteria

Since Obstetric and Paediatric deaths are subject to specialist case review, they fall outside the scope of the Trust's structured judgement review process. With these exceptions, the Trust aims to review a minimum of 25% 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, but which do not appear to constitute a patient safety incident
- Deaths where the Medical Examiner has raised concerns, but which do not appear to constitute a patient safety incident
- Deaths of those with a learning disability (including autism) 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, and where individual structured judgement reviews are considered more effective than a thematic review
- Categories of death identified to inform the Trust's quality improvement initiatives.

5.2 Methodology

From July 2022 the Trust has adopted the SJR*Plus* format for mortality review. This format follows the principles of the Royal College of Physicians' (RCP) Structured Judgement Review (SJR), previously established within the National Mortality Case Record Review Programme (NMCRR). The RCP's NMCRR aimed to introduce a standardised methodology

for reviewing case records of adult patients who have died in acute general hospitals in England and Scotland. The primary goal of the methodology was to improve healthcare quality through qualitative analysis of mortality data using a standardised, validated approach linked to quality improvement activity.

The SJR*Plus* data collection tool further builds on the experience of the IHI Global Trigger Tool and PRISM 2. SJR*Plus* is hosted on NHS England Apps allowing for on site or remote case note review. It has been developed by "Better Tomorrow"; a collaborative initiative hosted on the FutureNHS platform.

5.3 Mortality reviewers

There is a multi-disciplinary team of experienced reviewers drawn from across Unplanned and Planned Divisions. All reviewers receive training on the use of the SJR*Plus* e-review tool provided by the Better Tomorrow team. In recognition of the importance of the role performed by the reviewers, time for the conduct of mortality review is incorporated into job plans.

6. Patient Safety Incidents

The Trust is committed to investigating and learning from all patient safety incidents and in particular those that involve the death of a patient. Within the Trust, management of the Patient Safety Incident Review Framework is overseen by the Patient Safety Forum, with key decision-making responsibilities held by the Medical Director and Chief Nurse, alongside the Director of Quality. Day to day management of the process sits with the Patient Safety Team managed by the Governance and Legal Lead.

The current Patient Safety Incident Framework includes a category of incidents called Serious Incidents (SIs). These are reported to the national Reporting and Learning System (RLS) and to the Strategic Executive Information System (StEIS) database which ensures oversight and monitoring by the Integrated Care Board's systems quality responsible officers, and also facilitates national learning. When a new SI is declared, the Rapid Incident Report is routinely shared with the ICB. There is regular liaison between the ICB and Patient Safety Team with concerns addressed at Quality Review Meetings. The CQC has access to NRLS and StEIS and contacts the Trust if it requires further specific information about an incident or a copy of any associated documentation.

The Trust's Management of Incidents and Serious Incidents requiring investigation and learning Policy (CSEC 049), referenced under Associated Documents, provides a comprehensive guide to the investigation of incidents. It is for all staff who are responsible for escalating cases which need a decision as to whether the case constitutes a Serious Incident or requires a different level/type of review. An overview of the current serious incident framework has been included at Appendix 5. It should be noted that by September 2023 this will be replaced by a new Trust Patient Safety Incident Response Framework Plan.

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 in the written learning points document that is shared across all Specialties and also to relevant Specialty Rolling Half Day clinical governance meetings for discussion. Inclusion of information in the Daily News is also used to promote Trust-wide sharing of important developments. The Patient Safety Forum is responsible for ensuring appropriate escalation of concerns to the Quality and Safety Committee and also for ensuring that key learning and themes inform the Trust's quality improvement initiatives.

7. Complaints

Following the closure of a formal complaint any actions are logged and monitored via the Trust wide risk reporting system Enhance. These actions are also disseminated via the Divisional Governance meetings, the Trust Wide Patient and Carer Committee and in the quarterly Patient Experience Report that is presented at the Trusts Quality and Safety Committee to provide Board level oversight. This range of activity ensures learning is shared at all levels across the Trust.

8. Claims

A summary of closed claims together with any learning identified through the Claims investigation process, is distributed to clinical teams through the Clinical Governance rolling half day programme and other divisional forums.

An annual report is also presented to the Quality and Safety Committee, providing Board level oversight. This report includes any identified themes, trends and notable developments. The report also includes benchmarking information so that trends in the organisation's performance can be compared with other similar Trusts.

9. Responding to deaths of particular patients

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

9.1 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 commenced in 2017 and was gradually rolled out across the country, with Hertfordshire joining in April 2017. Until June 2021 it was run by the University of Bristol.

LeDeR is a service improvement programme which aims to improve care, reduce health inequalities and prevent premature mortality of people with a learning disability and autistic people by reviewing information about the health and social care support people received.

Since June 2021 responsibility for the conduct of the LeDeR programme now falls to ICSs who are accountable to regional NHSEI teams and ultimately to the national NHSEI LeDeR team. Full details of the new process can be found in the associated document: *'Learning from lives and deaths – People with a learning disability and autistic people (LeDeR) policy 2021'.* An overview of the LeDeR review process taken from the 2021 policy is provided at Appendix 3.

As a consequence of the LeDeR programme, when a patient with learning disabilities or autism dies in one of our hospitals their death must be notified to the NHS LeDeR website. The LeDeR review process is subject to the National Data Opt-Out regulations meaning that the Data Opt-Out status of a patient with learning disabilities must be checked prior to notification. Guidance regarding notification, including how to check the patient's Data Opt-Out status, is contained within the associated document: *National Learning Disability Mortality Review SOP CP 252*.

In addition to the national process the Trust conducts its own internal structured judgement review of all patients with learning disabilities or autism who die within its care. Once completed, the internal review is provided to the local LeDeR programme to support the formal LeDeR review process. The Trust has a number of measures in place to ensure the capture of learning disability deaths, including incorporation of a Learning Disability flag on the Lorenzo Patient Administration System and a weekly report provided to the Mortality Support team.

9.2 Patients with severe mental health issues

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 could 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 assessment and signposting service is delivered by the Mental Health Liaison Team. This team is made up of 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 (under 18s are seen by the Children Crisis Assessment and Treatment Team also known as CCATT), 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.

Following discussion, our mental health specialist colleagues at Hertfordshire Partnership University NHS Foundation Trust, have recommended that we base our criteria for mortality review on the 'red flags' detailed in the national learning from deaths guidance for NHS mental health trusts, drawn up by the Royal College of Psychiatrists (RCPsych) in November 2018. These flags focus on patients likely to have severe mental illnesses, like bipolar disorder or anorexia, are:

- where the patient has experienced psychosis or an eating disorder during their last episode of care
- where the patient was recently admitted to a psychiatric ward
- where the patient was under the care of a crisis and home treatment team at the time of their death.

Discussions have continued regarding the scope for creating a system flag for severe mental illness. Concerns remain as to whether this is appropriate. Consequently, a weekly Business Intelligence report based on relevant ICD-10 codes is used to identify appropriate deaths for review.

9.3 Infant or child (under 18 years) deaths

The procedural requirements following the death of a child or young person are understandably rigorous and extend beyond the bounds of Trust. These processes are laid out in the 'Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children' and adapted by Hertfordshire Safeguarding Children Partnership (HSCP), in their 'Child Death Review and Response Arrangements – Joint Agency Response to Unexpected Child Death's Protocol'.

9.3.1 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 HSCP, 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.

9.3.2 Joint Agency Response

The HSCP Joint Agency Response Arrangements detail the Hertfordshire Safeguarding Children Partnership (HSCP) multi-agency response to the sudden or unexpected death of a child. They should be followed by all professionals in conjunction with any relevant policies, procedures and protocols of their own agency. Professionals from a number of different

agencies and disciplines will become involved following an unexpected death in infancy or childhood to try to establish the cause of the death and support the family. This Joint Agency Response protocol is intended to provide guidance to the professionals confronted with these tragic events. It is acknowledged that each death has unique circumstances, and each professional has their own experience and expertise to draw on in their handling of individual cases. There are however common aspects to the management of unexpected deaths in infancy or childhood and it is important to achieve good practice and a consistent approach. An overview of the process is provided at Appendix 4.

Child Death Review Meetings: A multi-agency Child Death Review Meeting (CDRM) should be convened by the Joint Agency Response Nurse as soon as possible after the final post-mortem result is available (the timing will vary according to circumstances but should be no more than 8 – 12 weeks after the death).

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. All acute and community child deaths are reported as a patient safety incident and presented at the Serious Incident Review Panel (SIRP) to identify any learning. 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.

9.4 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 to external investigation by the Healthcare Safety Investigation Branch (HSIB).

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 regarding the process to be followed and allocation of responsibilities. 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 and are shared via the Trust's clinical governance processes with the Directorate and wider clinical arena as appropriate. Inclusion of Serious Incident Reports to the Quality and Safety Committee also ensures Board awareness of issues raised. Appropriate learning is used to develop quality improvement work.

9.5 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 is an extremely sad and stressful experience for all the staff involved in their care. It recognises 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. The Chief Nurse is immediately notified of any cases where the reviewer identifies significant deficiencies in care such that a Serious Incident may have taken place.

The Trust's Perinatal Mortality Review Group meets monthly to review all perinatal deaths from 22+0 gestation to 28 days after birth, to complete the Perinatal Mortality Review Tool (PMRT). The aim of the PMRT is to support standardised perinatal mortality review across NHS maternity and neonatal units in England, Scotland and Wales. The tool supports systematic, multidisciplinary, high quality reviews of the circumstances and care leading up to and surrounding each late foetal loss (the baby is between 22+0 and 23+6 weeks), stillbirth, neonatal deaths up to 28 days and the deaths of babies who die in the post-neonatal period having received neonatal care.

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 Trust Quality and Safety Committee, and if necessary, the Risk Register. The Trust also contributes to the "Each Baby Counts" RCOG database for all babies who die intrapartum.

At a Divisional level, an annual audit is conducted and presented at the Rolling half day. The information provided focuses on broad spectrum learning from the review process including demographics, risk factors, underlying causes of suboptimal care, antenatal care, suggested preventative improvements, together with any learning gained from women who have had a stillbirth.

The national PMRT tool enables the production of national reports detailing themes and trends associated with perinatal deaths to facilitate national sharing of learning and benchmarking with Peer trusts.

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.

9.6 Mount Vernon Cancer Centre

Mount Vernon Cancer Centre (MVCC) is one of the four hospitals which make up the East and North Hertfordshire NHS Trust. It is a well renowned, highly specialised cancer centre based in Northwood in Middlesex. While providing highly specialised services, it still operates under the Trust's central quality and governance umbrella.

While many treatments are conducted in an out-patient/day case environment, there are also inpatient facilities.

Although there are only a few in-patient deaths at MVCC, and the vast majority of these are expected, in line with our Trust-wide drive to learn from deaths to improve our care for the living, MVCC follows the Trust's learning from deaths policy.

MVCC prides itself on being a centre of excellence with staff united in their goal to provide the highest standards of care and timely treatment for its patients. For this reason, despite the fact that most deaths are expected, the service has chosen to conduct structured judgement reviews of all in-patient deaths.

Outputs of these reviews are used locally to inform quality improvement initiatives at MVCC, as well as feeding into the Trust's central learning from deaths work.

10. Engagement with bereaved families

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 ensuring 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. One of the principal drivers behind the introduction of the Medical Examiner system was to provide bereaved families with greater transparency and opportunities to raise concerns.

Bereaved families are contacted by the Medical Examiner Office prior to the MCCD being issued to establish if they have any concerns or questions about the death, and to act on them appropriately.

Where concerns are raised, if the Medical Examiner has reason to believe that harm may have been caused warranting investigation under the Serious Incident framework, the death is referred to the patient safety team.

Where it is not considered that the concerns fulfil the relevant criteria for such an investigation, the death will be subject to formal mortality structured judgement review. If this review indicates that harm may have been caused resulting in any possibility that the death may have been preventable, or where it was considered that the level of care provided was poor, the case will be raised as a patient safety incident, ensuring it is discussed at Divisional/Specialty level with appropriate remedial actions taken. Once concluded all such escalated cases are considered by the Mortality Surveillance Committee.

In July 2018 the National Quality Board published '*Learning from deaths – Guidance for NHS Trusts on working with bereaved families and carers*'. The recommended template included in the guidance has been adapted for local use. This leaflet provides bereaved families with a clear outline of the Trust's approach to reviewing, investigating and learning from the deaths of those who die in our care. It tells bereaved families what they should do if they have concerns. Outline information is included in a leaflet that forms part of the support pack provided to bereaved families by the bereavement team following the death of a patient. This leaflet signposts bereaved families to the full text which is available on the Trust website.

11. Governance and reporting

The Trust is committed not only to the elimination of preventable deaths of patients within its care, but also to constant improvement in the quality of care received by patients facing the end of their life while in hospital. To enable this, the Trust ensures its governance arrangements are robust and gives due focus to the review, investigation and reporting of deaths.

11.1 Mortality Surveillance Committee

The Mortality Surveillance Committee meets monthly with the exception of January and August. This multi-disciplinary, multi-professional group is responsible for oversight of all aspects of mortality monitoring, mortality reduction initiatives and the national Learning from Deaths quality improvement framework. It reports into the Quality and Safety Committee by way of the quarterly Learning from Deaths report. Its core remit covers the monitoring/consideration of:

- Monitoring of key mortality metrics with appropriate coding/clinical review/investigation
- Final consideration of deaths where concerns raised in a structured judgement review resulted in a Datix escalation

- Approval of the quarterly Learning from Deaths report for submission to the Quality and Safety Committee
- Quarterly review of mortality review outputs with subsequent study of themes
- Identification of/action regarding quality improvement opportunities and appropriate capture and dissemination of learning
- Escalation of significant concerns/risks to the Quality and Safety Committee.

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 metrics is firmly embedded within the Trust's culture at Specialty, Divisional, Sub-Committee and Board level. Key headline and diagnosis level data is provided to Mortality Surveillance Committee, and both the Quality and Safety Committee and Board (via the quarterly Learning from Deaths Report).

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, structured judgement review, coding review, and in some cases care in the community in the formulation of its quality improvement work.

11.2 Trust Board via Quality and Safety Committee

In line with national guidance and in recognition of the vital importance of Executive oversight of the Trust's approach to learning from deaths, once approved by the Mortality Surveillance Committee, the quarterly Learning from Deaths report is presented to the Quality and Safety Committee, with a summary report subsequently presented to the public Board meeting by the Medical Director.

11.2.1 Quarterly Learning from Deaths Report

Key elements of the report include updates on:

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

From October 2017 the information mandated by the new national guidance has also been included, 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.

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

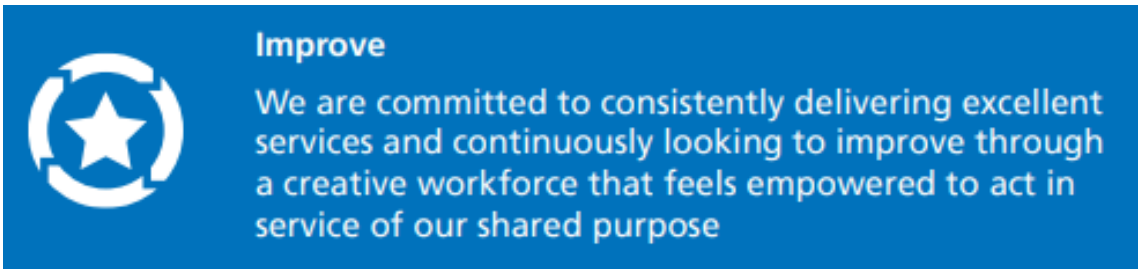
11.3 Rolling Half Day clinical governance meetings

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 operational managers, doctors, nurses and therapists. Central to the topics covered are incidents raised as a consequence of mortality structured judgement 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, not least because learning points from cases discussed at Mortality Surveillance Committee are shared at these sessions.

11.4 Commissioner engagement

The Trust is keen to work closely with our Commissioners on matters related to learning from deaths. To foster a relationship of collaboration and transparency, once the quarterly learning from deaths report has been presented to the Quality and Safety Committee, it is shared with the ICB and followed up with a conversation allowing discussion of any points of concern or interest they may have.

12. Continuous Improvement



This commitment is one of the three central strands of the Trust's values refreshed in 2022. It emphasises how we strive to ensure that continuous improvement underpins all our quality improvement and governance processes.

This commitment is further developed in our Quality Strategy, Patient Safety Incident Response Framework Plan and similarly lies at the heart of our learning from deaths strategy.

12.1 Learning from Deaths Strategy

In recognition of the fundamental importance of the Trust's Learning from Deaths work, for the first time a standalone Learning from Deaths strategy has been created for 2022/24. It is closely aligned with the Trust's strategic aims and values together with those embodied in the Quality Strategy. Notice has also been taken of NHS England's overarching priorities for 2022/23. Central to the strategy is a set of objectives, including key performance indicators, with corresponding outcome measures. The primary aim of the learning from deaths strategy is to achieve a progressive reduction in the number of preventable deaths by creating a framework and focus for our learning from deaths work.

13. Sharing what we learn

The potential for learning provided by Medical Examiner scrutiny together with the outputs from Mortality Structured Judgement Reviews, Patient Safety Incidents, Inquests, Complaints and other review/survey results is significant. 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 and quality improvement work via greater collaborative analysis across internal Trust processes.

13.1 Forums for sharing and learning

Principal forums for sharing learning are those referenced under section 8 above. This list includes Trust Committees together with Divisional and Speciality clinical governance forums such as Rolling Half Days. Learning is also shared with relevant focus working groups such as Deteriorating Patient and End of Life.

Additionally, new ways of sharing learning are constantly being investigated. Current developments are outlined below.

13.2 Better Tomorrow

"Better Tomorrow" is an exciting new collaborative initiative hosted on the FutureNHS platform, whose aim is *"To support effective learning from deaths in order to improve care for the living"*. It provides a national forum for discussion, learning and the promotion of best practice in the learning from deaths arena. Of particular value is a monthly Mortality Leads Forum, where ideas, challenges and potential solutions can be discussed and shared among mortality leads from different Trusts.

13.3 Systems support

12.3.1 SJR*Plus*/NHS England Apps

A key aspect of the Better Tomorrow initiative has been the development of a mortality e-review form, based on the RCP Structured Judgement Review format, which has been named SJR*Plus*. Developed on an NHSE hosted platform called ORIS, in December 2022 it was migrated to NHS England Apps, with the potential that it may become a national dataset.

From 1 July 2022 SJR*Plus* replaced the Trust's historic in-house mortality audit tool. Key benefits of adopting the SJR+/BT proposition include the fact that it comes with a ready-

made, highly interactive SJR*Plus* report tool, together with a best practice dashboard tool, both developed by the Making Data Count team at NHSE.

13.3.2 InPhase: Incident Oversight (ENHance)
Also of particular relevance is the adoption in 2022 of the InPhase Incident Oversight software (ENHance) which is intended to play a vital role in providing enhanced management and reporting capability to inform both reporting to Board and the Trust's quality improvement and strategic planning initiatives.

The aim of ENHance is to provide triangulated visibility. Through integration across all elements of the system, and health systems from other suppliers, including Patient Safety Incident Reporting, Perfect Ward, EPR, data warehouses and many others, it empowers staff to see problems, trends and exceptions and predict future events and create actions to prevent further issues.

A phased introduction began in June 2022. Although the software does not specifically include a mortality module, discussions are planned to assess the potential either for the creation of such a module, or the integration of SJR outputs from NHS England Apps onto ENHance.

13.3.3 Qlik Sense deaths report
Initially created to assist the mortality support team and mortality reviewers by bringing together key deaths data, the Qlik Sense mortality area is being further developed to provide easily accessible data to other interested parties across the Trust.

13.4 Mortality Support intranet page

To enhance the visibility and accessibility of supporting material and learning there is now a Mortality Support intranet page. This not only provides support information for our mortality reviewers but, moving forward, will also be used as a sharing point for important documents and learning outputs, including case studies with links to useful internal and external resources.

13.5 Beyond the Trust

We continue to look for ways to foster greater communication and sharing of learning with other system partners across our wider healthcare community.

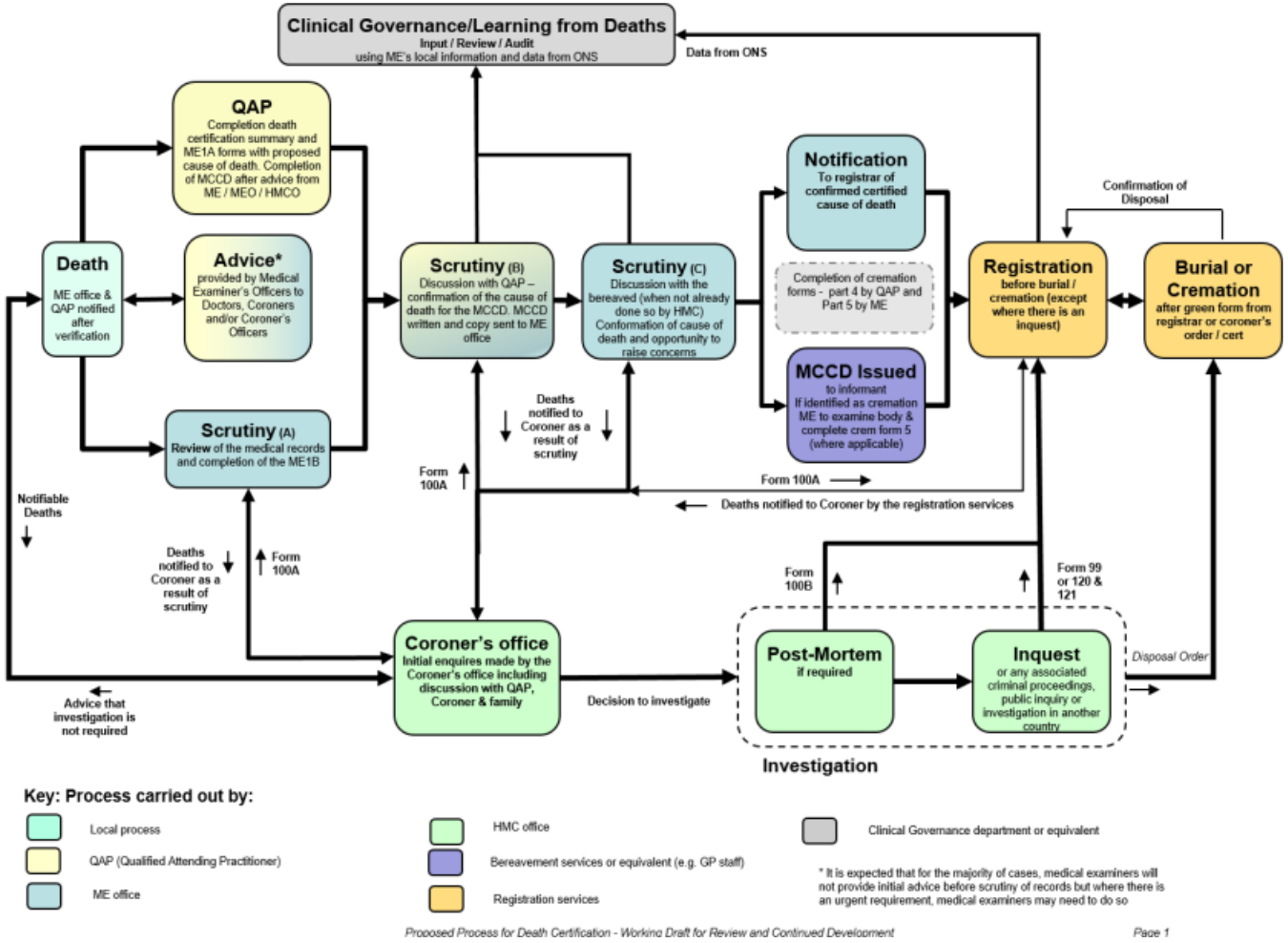
As the Medical Examiner function is expanded to incorporate scrutiny of all community deaths there will be both opportunities and challenges regarding learning from deaths, sharing learning and using it effectively.

We are committed to finding ways to collaborate with colleagues beyond the Trust, whether in Primary or Secondary care, including community, mental health and other acute providers.

One example of this has been the formation of the Hertfordshire and West Essex Mortality network in January 2023, comprising mortality leads from key acute, mental health and community trusts. The group convenes quarterly to discuss learning from deaths topics of mutual interest and to look for ways that we can work together to drive learning and improvement.

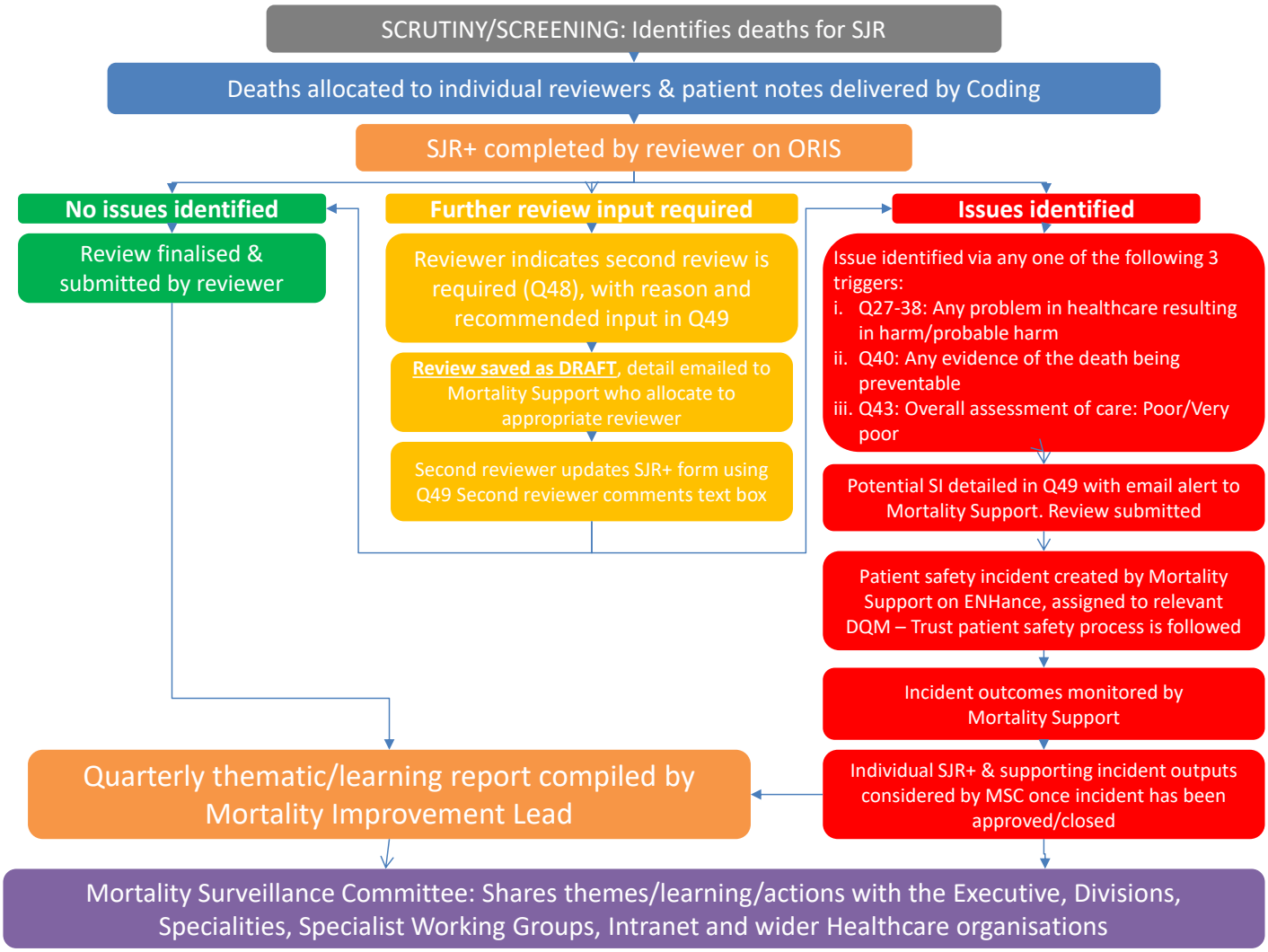
Part 3 – Appendices

Appendix 1: Death Certification Process

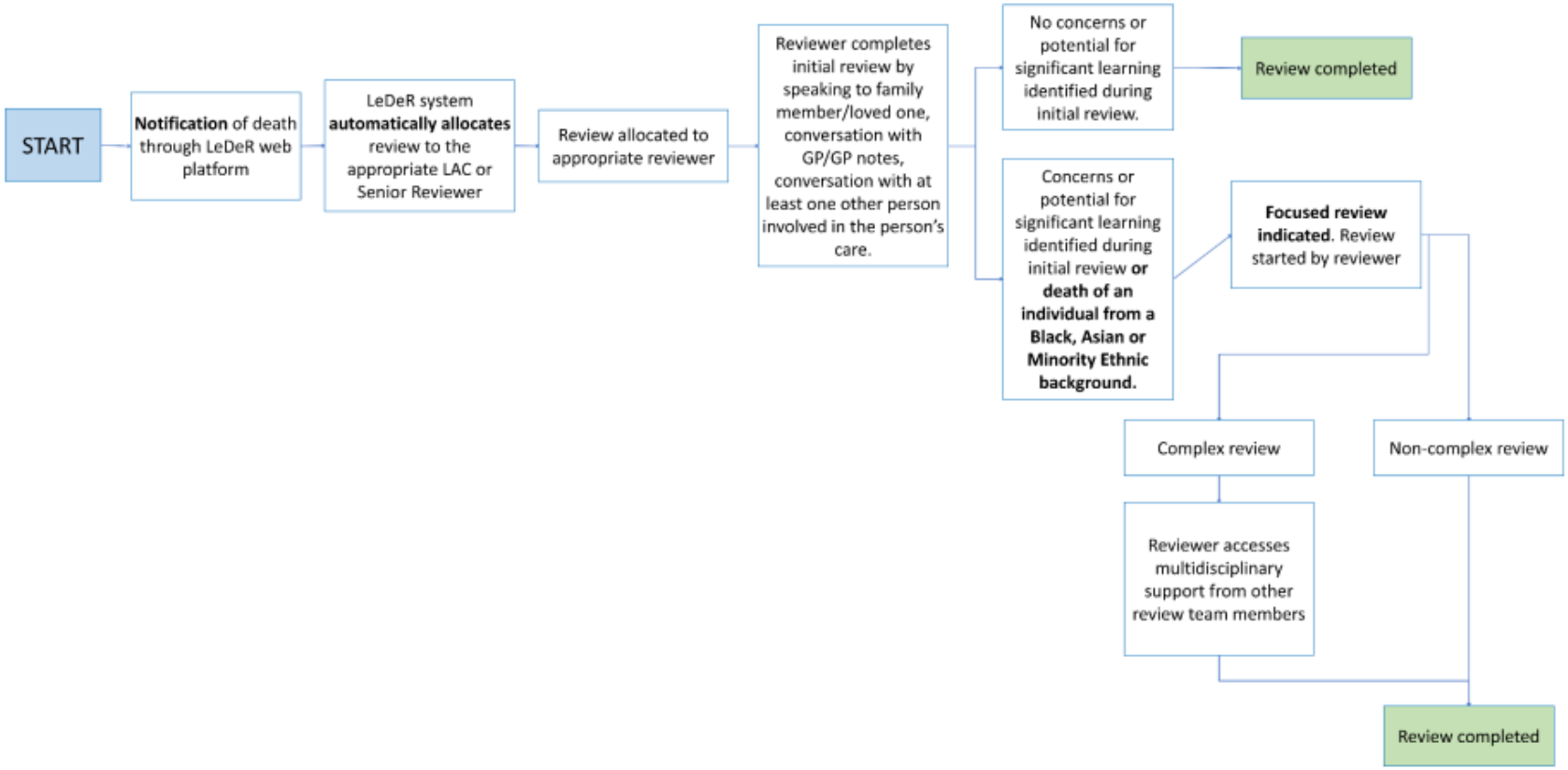


Source: Implementing the medical examiner system: National Medical Examiner's good practice guidelines, January 2020

Appendix 2: Structured judgement review process

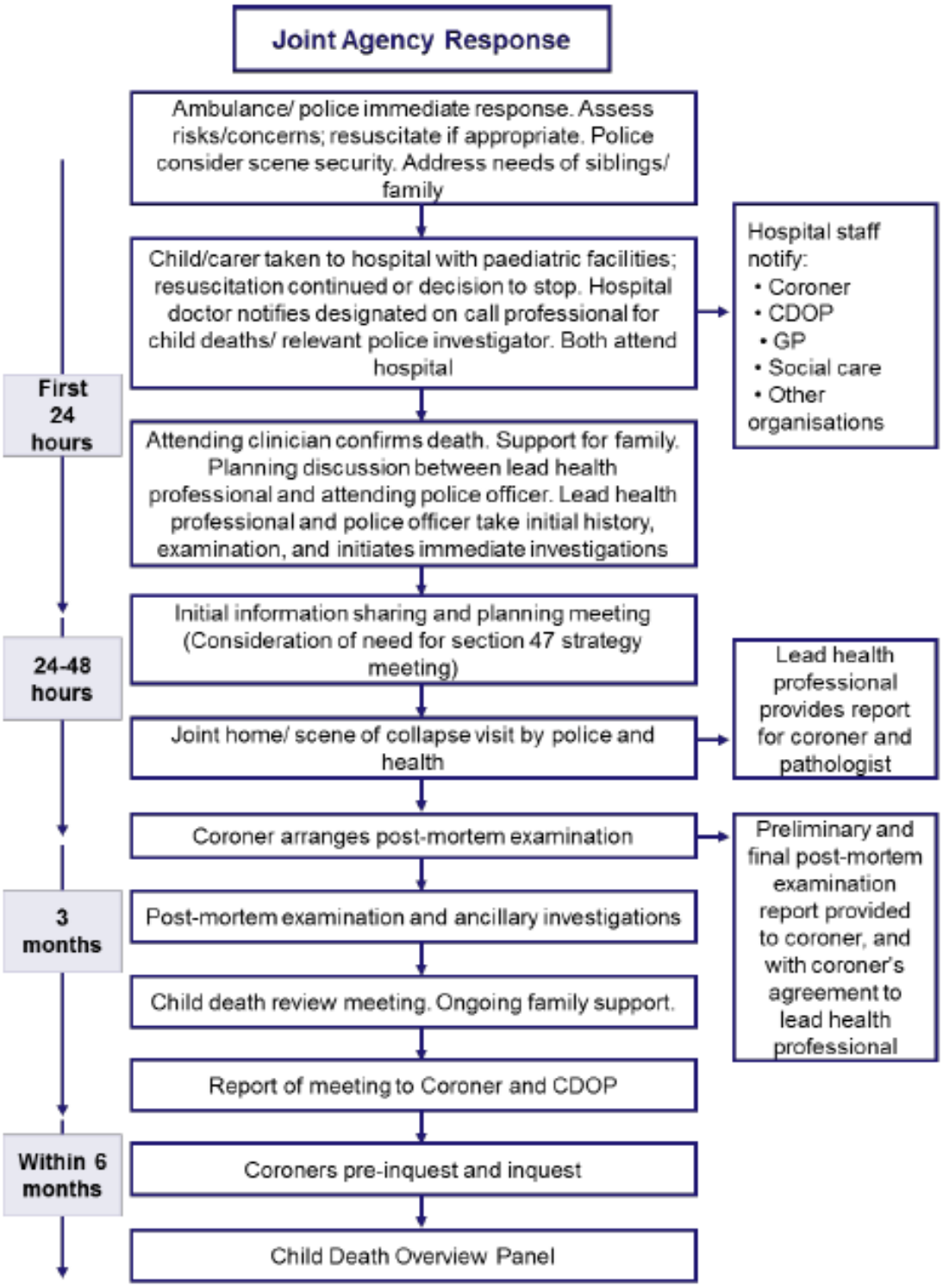


Appendix 3: LeDeR review process overview



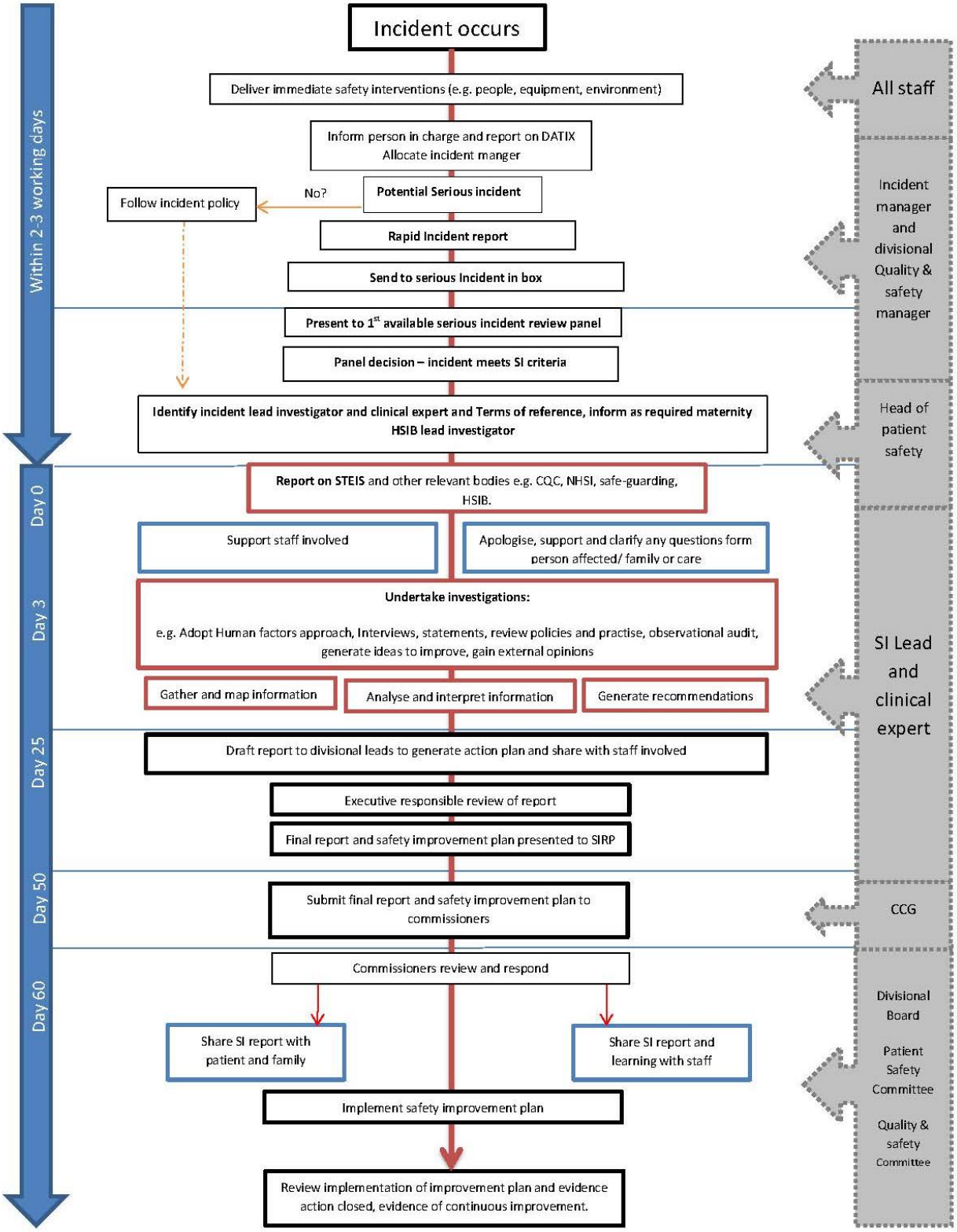
Learning from lives and deaths – People with a learning disability and autistic people (LeDeR) policy 2021

Appendix 4: Joint Agency Response Responsibilities



Source: Child Death Review Statutory and Operational Guidance (England) October 2018

Appendix 5: Serious Incident Framework



Version 1.0
3/12/18

Part 4 – Document management information

Document info	CP 254 , V – 003 Learning from Deaths
Document type	SELECT ONE ☐ Competency ☐ Guideline ☐ Pathway ☒ Policy ☐ Procedure ☐ Protocol ☐ Standard Operating Procedure Selected- Policy
Document applicability across the organisation	SELECT ONE ☒ For use Trust wide ☐ For use clinically cross specialty ☐ For use in multiple areas (non-clinical) ☐ For use locally only Selected- For use Trust wide by all staff at all sites
Review cycle	☒ Every 3 years (standard) ☐Annual review ☐ Other: **2025-02-01**
Version type	SELECT ONE ☐New document – full consultation and endorsements ☒Full review of document - various amendments/ complete re-write ☐Full review of document - minor amendments ☐Full review of document - no changes to content, still fit for use ☐Interim update - document not fully reviewed, amendments only Selected-Full review of document with amendments
Keywords	Learning from deaths, mortality review,
Version author	Sarah El Sharnoubi, Mortality Improvement Lead Medical Directors Office ☐Cancer ☐Planned ☐Unplanned ☒Corporate/Directorate
Document owner	Sarah El Sharnoubi, Mortality Improvement Lead Medical Directors Office ☐Cancer ☐Planned ☐Unplanned ☒Corporate/Directorate
Document classifications	Please select all that apply to this document ☐ **Sensitive information**: This document contains sensitive information that should not be shared outside the organisation ☐ **Public website**: this document has been selected for publication on the Trust website, maintained by the Communications Dept. ☐ **Patient Consent**: This document contains content about patient consent ☐ **Forms** - This document contains forms in use at the Trust ☒ None of the above

Consultation

The document author has considered the following **resource implications** and **impact to Trust-wide functions/services**, which also require **oversight** of local processes. Any of these listed stakeholders may also be an endorser of the final version of this document in the Record of agreement section.

If a new document, or newly amended content to this version contains processes that will have an impact on Trust functions and their users, the following actions are required.

Input from Trust function	Action required by author
1. **Equality, Diversity & inclusion**	Trust documents require an Equality Analysis screening as evidence that the protected characteristics under Equality Act 2010 have been considered, as per Part 1, section 6.1 in this document ☒As the document author, I understand I need to complete the Equality analysis screening to determine if a full assessment is required. See Equality, Diversity & Inclusion section of the intranet for details
2. Clinical Ethics Committee	This document may contain content that is contentious or raises moral debate. ☒No – proceed to next item ☐Yes – please see following actions **Step 1**: Seek advice from Clinical Ethics committee: ethics.enh-tr@nhs.net **Step 2**: Please provide the following info: Date of recommendations received- Were recommendations implemented and/or incorporated into document? ☐yes ☐no What was recommendation-
3. Medicines Management (Pharmacy)	This document contains processes about the use of medicines at the Trust. ☒No – proceed to next item ☐Yes – please follow these steps **Step 1**: Contact local pharmacy lead to coordinate presentation to Therapeutics Policy Committee for their **endorsement.** **Step 2**: Record endorsement in Endorser 1 or 2 in the Record of agreement.
4. Nursing	This document contains processes that will have an impact on nursing staff and nursing care or that would affect routines. ☐No – proceed to next item ☒Yes – please see following steps **Step 1: Contact Nursing & Midwifery Excellence team** to discuss who would need to be involved in reviewing and agreeing the document is fit for use at the Trust.

Input from Trust function	Action required by author
	☐Clinical skills group and/or ☐Nursing and Midwifery Executive Committee and/or ☒Other: Review/Endorsement by the Chief Nurse **Step 2**: Record agreed participants in consultation in item 10 "Other areas/stakeholders" or on Record of agreement as either Endorser 1 or Endorser 2.
5. People (Human resources)	This document contains processes or information about the recruitment or management of staff. ☒No – proceed to next item ☐Yes **Step 1**: contact Trust Partnership (committee -including staff side) should be included in initial discussions. **Step 2**: Record endorsement in Endorser 1 or 2 in the Record of agreement.
6. Finance	This document contains processes or information that affects the acquisition of resources (recurring or one-off) or payments of salaries or anything that has financial implications either Trust wide or locally within the Trust. ☒No – proceed to next item ☐Yes – please follow steps **Step 1**: Involve/request input from: ☐payroll, ☐local budget holders, ☐anti-fraud team Name of contact: **Step 2**: In the Record of agreement, list review participants as Endorser 1 or Endorser 2.
7. Estates & Facilities	This document contains processes or information about the use of Trust property or affects facilities and security on Trust premises. ☒No – proceed to next item ☐Yes **Step 1**: Involve/request input from ☐Estates ☐Facilities **Step 2**: Record endorsement in Endorser 1 or 2 in the Record of agreement.
8. Digital (IT)	This document contains processes or information about the use of Trust computer hardware, software or systems. ☒No – proceed to next item ☐Yes **Step 1**: Involve/request input from the appropriate team in Digital services

Input from Trust function	Action required by author
	Step 2: Record endorsement in Endorser 1 or 2 in the Record of agreement.

9. Other areas or stakeholders

Please record evidence (ie date of meetings or email) of activity with any other departments, groups, stakeholders involved in the update/development of this document.

Team, department, stakeholder	Activity type	Date (meeting or email)
Nick James, Lead Medical Examiner	☒Content contribution ☐Usability testing ☐Other:	18.10.2022 email
Enda Gallagher, Adult Safeguarding Lead Nurse	☒Content contribution ☐Usability testing ☐Other:	27.09.2022 email
Ivy Erhahon, Mental Health Matron/Lead Nurse	☒Content contribution ☐Usability testing ☐Other:	02.11.2022 email
Jay Vaid, Divisional Quality Manager, Children's Services Dr Gunjan Jain, Consultant, Paediatrics	☒Content contribution ☐Usability testing ☐Other:	17.11.2022 email
Maria Williams, Maternity Clinical Governance Coordinator	☒Content contribution ☐Usability testing ☐Other:	18.10.2022 email
Jacqui Hylton, Bereavement Support Midwife Maria Williams, Maternity Clinical Governance Coordinator	☒Content contribution ☐Usability testing ☐Other:	28.09.2022 emails
Lucinda Berry, Legal and Governance Lead	☒Content contribution ☐Usability testing ☐Other:	17.10.2022 & 21.10.2022 emails
Kelly Wallace-Bates, Lead Nurse for End of Life and Palliative Care Sharon Dudley, Mortuary and Bereavement Matron	☒Content contribution ☐Usability testing ☐Other:	17.10.2022 email
Sophie Williams, Complaints PALS and Patient and Carer Experience Lead	☐Content contribution ☒Usability testing ☐Other:	19.10.2022 email
Mount Vernon Cancer Centre: Sarah James, Hospital Director, MVCC	☐Content contribution	12.02.2023 email

Input from Trust function	Action required by author	
	☒Usability testing ☐Other:	
Theresa Murphy, Chief Nurse	☐Content contribution ☐Usability testing ☐Other:	18.11.2022 email
Mark Hearn, Associate Medical Director for reducing unwarranted variation, Chair of Mortality Surveillance Committee	☐Content contribution ☒Usability testing ☐Other:	16.11.2022 email
Margaret Mary Devaney, Director of Quality	☒Content contribution ☐Usability testing ☐Other:	29.01.2023 email
Bridget Sanders, Medical Programme Director	☐Content contribution ☒Usability testing ☐Other:	29.11.2022 email
Lyn Thomas, Divisional Quality Manager, Unplanned Care	☐Content contribution ☒Usability testing ☐Other:	29.11.2022 email
Sarah Waterman, Divisional Quality Manager, Planned Care	☐Content contribution ☒Usability testing ☐Other:	24.11.2022 email

☒At least one of the above is a formal endorser in the Record of agreement
☒I understand an endorser and/or approver may request evidence of consultation before their sign off is granted.

Implementation

The author and department owner of this document are responsible for providing the current version for circulation and informing local staff and other key stakeholders (internal and, if applicable, external) of the existence of this document and any relevant updates.

Below is an outline of the standard activity following the approval of a document. The author may add actions in the formal implementation plan.

Action	Lead	Schedule of activity
Email final approved version to policies@enh-tr@nhs.net.	Version author/ document owner	Upon approval
Document uploaded to the intranet so users can search for the document or browse via intranet folders.	Policies team	Upon completion of governance and standards checks
This version will be included in a summary of updated documents that is cascaded via internal communications channels, such as: • Monthly report on Intranet • Every Rolling half day • Shared at various meetings for divisions, committees or groups	Documents manager	Upon document upload
Promote the updated document	Author/document owner	Team meetings

Record of agreement

Full details of the **endorsement and approval process** can be found in policy **CP 116 - Trust policies and procedural documents**.

Document info	DOC ID: **CP 254**, Version: **003** Title: **Learning from Deaths** Type **Policy** Applicability **For use Trust wide by all staff at all sites** Version type **Full review of document with amendments** Date of next full review **2025-02-01** Division and dept of document owner:	Sign-off type: ☒TYPE A: All endorsers + approver required ☐TYPE B: Endorser 1 + approver required ☐TYPE C: Endorser 3 + approver required
Endorser 1	**Mortality Surveillance Committee** Formal agreement by endorser confirming this version is fit for use at the Trust was recorded at this group meeting: 2023-02-08 Item 5f.	
Endorser 2	**Dr Mark Hearn, Associate Medical Director** Record of formal agreement by endorser this version is fit for use at the Trust in meeting minutes: 2023-02-08 meeting Item no: 5f	
Endorser 3	**Theresa Murphy, Chief Nurse** Record of formal agreement by endorser this version is fit for use at the Trust in email dated 2022-11-18	
Endorser 4	Record of agreement by **Policy Compliance Group** on 2023-03-24, under action log item 053	
Approval	**Dr Michael Chilvers, Medical Director** Approver agrees with the endorsements above confirming this document is fit for use at the Trust Approval recorded via email dated: 09.02.2023	
Governance checks	Marie Orara, Documents Manager, 2023-03-23	