DOC ID:
78

East and North Hertfordshire Teaching NHS Trust

Learning from Deaths Policy

About this document	
Document ID	78 **Version:** 04
Full review due before	01 June 2028
Document type	Policy
Version type	Full review of document – various amendments
Usage & applicability	For use Trust-wide by all roles at all sites

Summary

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

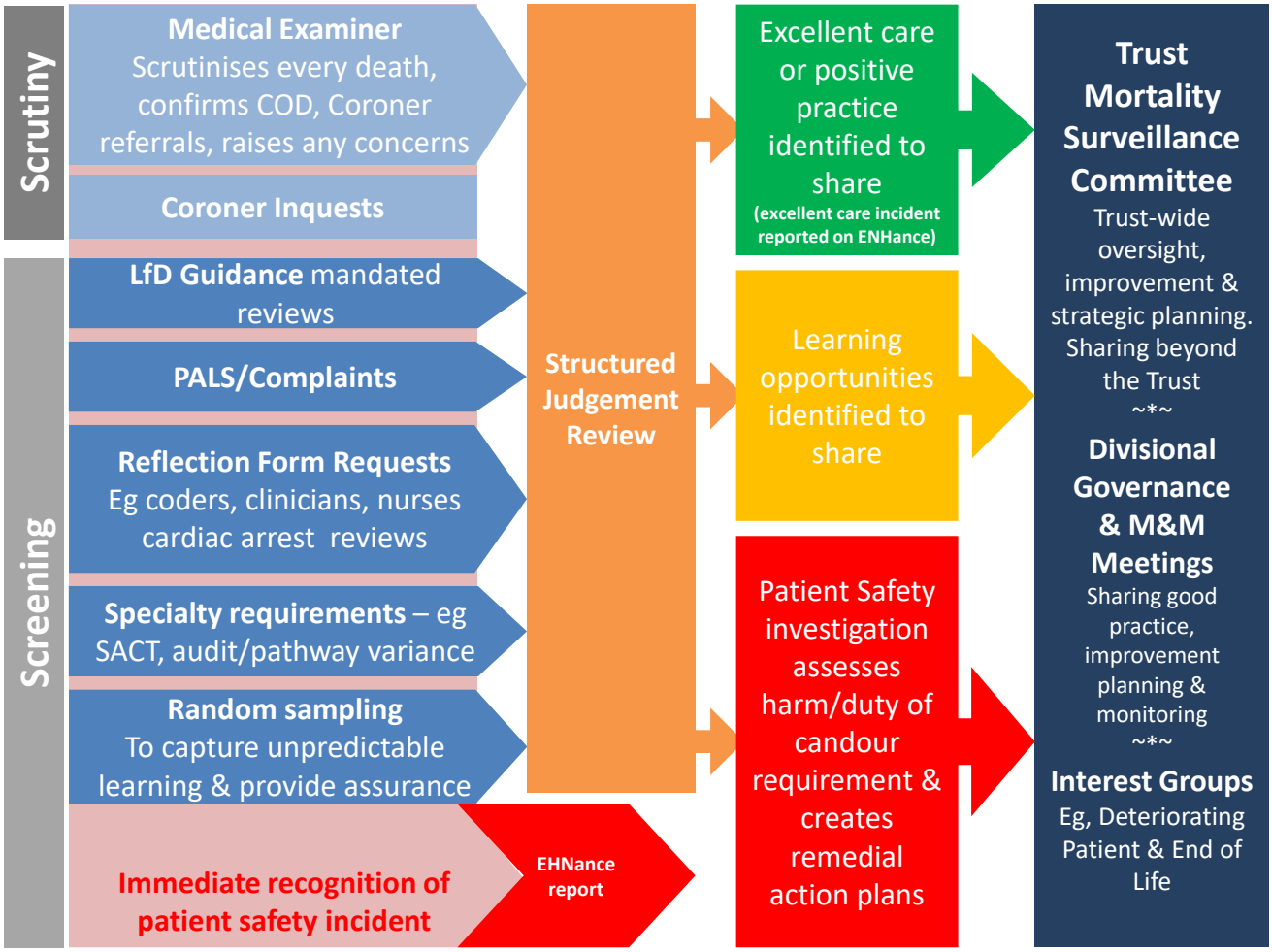
Key changes in this version:

- Introduction of the new Patient Safety Incident Response Framework (PSIRF)
- Statutory regulation of the Medical Examiner system from September 2024
- Introduction of SACT mortality review (30-day mortality after systemic anti-cancer therapy) process at Mount Vernon Cancer Centre.

Contents

Part 1 – Preliminary document information

A visual summary of this key function or process



1. Scope

The deaths of all patients who die in hospital: From July 2022 deaths of patients who die in ED have been 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 some 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

Term/acronym	Definition
Aqua	Advancing Quality Alliance. Supports health and care organisations to identify, refine and embed sustainable strategies for high-quality care and regulatory excellence.
Arden & GEM CSU's Azure Platform	Cloud-based platform hosting the SJR e-review tool, which allows for on-site or remote case note review.
Better Tomorrow	A collaborative workspace developed on the FutureNHS website providing a forum for those interested in learning from deaths and in how that learning can influence future patient care. In 2023 Better Tomorrow moved to the Advancing Quality Alliance (Aqua). This means support for improvements in learning from deaths remains available to organisations.
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.
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.
Learning response:	Any one of the system-based approaches for learning from patient safety incidents. Under PSIRF national tools have been developed that incorporate the well-established SEIPS framework (Systems Engineering Initiative for Patient Safety).
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 Apps:	Cloud-based platform previously hosting the SJR e-review tool, which allowed for on-site or remote case note review.
PSIRF	Patient Safety Incident Response Framework: sets 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. PSIRF replaces the Serious Incident Framework (SIF) (2015) and makes no distinction between 'patient safety incidents' and 'Serious Incidents'. As such it removes the 'Serious Incidents' classification and the threshold for it. Instead, the PSIRF promotes a proportionate approach to responding to patient safety incidents by ensuring thematic analysis and review of trends to allow an equal balance to manage associated risk, real-time learning and continuous improvement following incidents.
Patient safety incident:	Any healthcare related event that was unintended, unexpected and undesired and which could have or did cause harm to a patient.
Patient Safety Incident Investigation (PSII)	A PSII provides an in-depth review of a single patient safety incident or cluster of incidents to understand what happened and how.
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.
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*:	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, or exemplary 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 and patient safety incident learning responses by taking effective, sustainable action to address issues, ensuring cohesion with key Trust systems such as the patient safety incident response framework. This includes ensuring the NHSE mandatory requirement for a commissioned PSII to be undertaken in the event of an unexpected, unintended death
- 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-Executive 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.

Deputy Medical Director (Quality, Governance & Risk)
Responsible for providing focussed oversight of the key areas of quality, governance and risk on behalf of the Medical Director. This portfolio includes the learning from deaths remit.

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 strong lines of communication are maintained with the Mortality Support team thereby supporting a seamless integration of the Trust's Learning from Deaths work with the Trust's wider approach to learning and monitoring of key quality markers.

Mortality Surveillance Committee
The Mortality Surveillance Committee is a subcommittee of Quality and Safety Committee. It 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 which resulted in a patient safety incident escalation where: (i) PSII undertaken; (ii) the SJR reviewer considered the death to have been more than 50:50 likely to have been preventable; (iii) the SJR reviewer judged the care to have been very poor

- Approval of the quarterly Learning from Deaths report for submission to the Quality and Safety Committee and of the summary report to Board
- Consideration of quarterly 'Food for Thought' reviews which focus on themes identified from SJR outputs
- Commission and monitor the progress of improvement work undertaken by service areas where there have been recurrent mortality alerts or concerns
- 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 organisational development 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 noting 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 mortality reviewers drawn from across medical and surgical specialties. As a general principle, and wherever possible, Consultants should not review the deaths of patients who died under their care, although they may provide information to other reviewers regarding that patient. If they are allocated a death to review where they were involved in the patient care, they should immediately inform the Mortality Improvement Manager of the conflict of interest so the case can be reallocated. In exceptional circumstances where the specific expertise required only resides with those who were involved in the care of the deceased, or where there are unavoidable resource constraints, a second reviewer, not involved in the patient care, should be asked to have sight of the initial review in order to provide peer challenge.

Mortality reviewers are responsible for conducting structured judgement reviews of deaths in scope which have been identified for review based on national guidance criteria. They may also be required to provide a second review of cases requiring additional input relating to their particular area of expertise.

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) as the primary investigator. It is the responsibility of the DQM to complete an initial assessment and to liaise with the clinical team to ensure an appropriate harm review is undertaken.

Once the responsible consultant has reviewed the case notes they will attend their divisional incident review meeting/safety huddle, ensuring Duty of Candour and relevant learning is taken forward. If considered appropriate a learning response will be assigned. In cases where there is significant trust-wide learning or where it is felt that there is a greater than 50 percent chance that the death was preventable, the case will be escalated to PSERP to consider if it meets PSII criteria.

Clinical Governance Leads
Clinical Governance Leads are responsible for ensuring that SJRs are discussed at their M&M meetings, or appropriate governance forum, incorporating learning into Specialty specific quality improvement initiatives.

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 and improvement work 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. They review all medical certificates of cause of death completed by doctors with the aim of improving the quality/accuracy of cause of death certification. Additionally, they give bereaved families greater opportunity to raise concerns, ensuring referrals to Coroners are made appropriately and promoting learning/good practice by feeding into clinical governance processes – in particular by flagging cases for structured judgement review or for consideration by the patient safety team.

Medical Examiner Officers
The Medical Examiners are supported by Medical Examiner Officers who gather information from various sources and prepare cases for scrutiny. They also engage with bereaved families and carers to enable them to raise any concerns they may have regarding the care provided to the patient.

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 documents are related Trust policies and procedural documents, which are advised reading to supplement this document and/or process. These items are different to the titles listed in Part 1 References, which contains external resources referenced in the development of this document.

Document title	Doc ID	Originator
Mortality Structured Judgement Review	77	☒ENHT | ☐Affiliated network | ☐National/ regional
National Learning Disability Mortality Review SOP	CP 252	☒ENHT | ☐Affiliated network | ☐National/ regional
Child Death Standard Operating Procedure *[soon to be published]*	tbc	☒ENHT | ☐Affiliated network | ☐National/ regional
The Care of Adult Patients with Learning Disabilities	129	☒ENHT | ☐Affiliated network | ☐National/ regional
Care of the Dying Person	87	☒ENHT | ☐Affiliated network | ☐National/ regional
Personal Care After Death	92	☒ENHT | ☐Affiliated network | ☐National/ regional
PSIRF Policy *[soon to be published]*	tbc	☒ENHT | ☐Affiliated network | ☐National/ regional
PSIRF Standard Operating Procedure *[soon to be published]*	tbc	☒ENHT | ☐Affiliated network | ☐National/ regional
PSIRF Plan *[soon to be published]*	tbc	☒ENHT | ☐Affiliated network | ☐National/ regional
Maternal Death Guideline	656	☒ENHT | ☐Affiliated network | ☐National/ regional
The Perinatal Mortality Review Tool (PMRT) Process SOP	MAT 026	☒ENHT | ☐Affiliated network | ☐National/ regional
Pregnancy Loss After 12 Weeks of Gestation	641	☒ENHT | ☐Affiliated network | ☐National/ regional
Mortality Review Reflection Form	N/A	☒ENHT | ☐Affiliated network | ☐National/ regional
What to do When a Patient Dies Checklist	N/A	☒ENHT | ☐Affiliated network | ☐National/ regional
Last Offices Checklist	N/A	☒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)	N/A	☒ENHT | ☐Affiliated network | ☐National/ regional
Additional information for families following a bereavement: Leaflet in bereavement pack (signposts full text on Trust website)	N/A	☒ENHT | ☐Affiliated network | ☐National/ regional

6. Monitoring compliance

This document will be reviewed in **3 years** or earlier if any evidence or change in practice comes to light requiring an update to the document. Any further activity to monitor the use and compliance of the document at the Trust is documented below.

What will be monitored	How/Method/ Frequency	Lead	Reporting to	Deficiencies/ gaps Recommendations and actions
Compliance with the policy	Day to day oversight of the learning from deaths process	Mortality Improvement Lead supported by Mortality Improvement Manager	Associate Medical Director for Reducing Unwarranted Variation & Mortality Surveillance Committee	Any required adjustments will be drafted by the Mortality Improvement Lead for approval by the Mortality Surveillance Committee.
Adequacy and effectiveness of the policy	Day to day oversight of the learning from deaths process	Mortality Improvement Lead supported by Mortality Improvement Manager	Associate Medical Director for Reducing Unwarranted Variation & Mortality Surveillance Committee	Any required adjustments will be drafted by the Mortality Improvement Lead for approval by the Mortality Surveillance Committee.

6.1. Equality Impact Assessment

The Trust supports the practice of evidencing due regard to equality considerations. This means those involved have ensured 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 impact assessment (only if initial screening form below prompts a full EIA) – 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 on previous policy, procedure, strategy or processes that are coming up for review. More on this process for completing Equality Impact Assessments can be found on the Equality, Diversity & Inclusion section of the intranet.

Initial EIA screening form

The document author has ensured this document avoids affecting one group less or more favourably than another on the basis of:		No impact	Yes, impact (Explain how)
1	Age (younger people & children & older people)	☒	☐
2	Gender (men & women)	☒	☐
3	Race (include travellers)	☒	☐
4	Disability (LD, hearing/visual impairment, physical disability, mental illness)	☒	☐
5	Religion/ Belief	☒	☐
6	Sexual Orientation (Gay, Lesbian, Bisexual)	☒	☐
7	Gender Re-assignment	☒	☐
8	Marriage & Civil Partnership	☒	☐
9	Pregnancy & Maternity	☒	☐
10	Is there any evidence that some groups maybe affected differently?	☒	☐
11	Could this document have an impact on other groups not covered by a protected characteristic? (e.g.: low wage earners or carers)	☒	☐
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. As per instructions, evidence of the EIA is to be recorded in Consultation & review section.			
Any other comments: There is no evidence that this policy will impact on any of the protected characteristics listed above, or other groups not covered by protected characteristics.			
EIA screening form completed by: Sarah El Sharnoubi, Mortality Improvement Lead **Date completed**: 20/03/2025			

6.2. Dissemination and Access

This document is considered valid when viewed via the staff intranet for East & North Hertfordshire NHS Trust. If this document is printed (in hard copy), or saved at another location, users of this document must ensure they are using the same version that is on the intranet.

7. References

1. Learning, Candour and Accountability, December 2016: *Care Quality Commission*
2. National Guidance on Learning from Deaths, March 2017: *National Quality Board*
3. Implementing the Learning from Deaths Framework: Key Requirements for Trust Board, July 2017: *NHS Improvement*
4. Implementing the medical examiner system: National Medical Examiner's good practice guidelines 2020

5. Working Together to Safeguard Children: HM Government 2023
6. Guidance for Trusts and Health Boards – Conducting Perinatal Mortality Reviews using the National Perinatal Mortality Review Tool (PMRT) 2018
7. Child Death Review – Statutory and Operational Guidance (England) September 2018
8. Sudden unexpected death in infancy and childhood: Multi-agency guidelines for care and investigation, RCPCH and RCPath– November 2016
9. Child Death Review and Response Arrangements – Joint Agency Response to Unexpected Child death's Protocol – May 2022
10. Learning from deaths – Guidance for NHS Trusts on working with bereaved families and carers, July 2018: *National Quality Board*
11. Learning from lives and deaths – People with a learning disability and autistic people (LeDeR) policy 2021: *NHS England and NHS Improvement*
12. Care of dying adults in the last days of life, December 2015: *NICE guideline NG31*
13. One chance to get it right: Improving people's experience of care in the last few days and hours of life, June 2014: *Leadership Alliance for the Care of Dying People*
14. Patient Safety Incident Response Framework and supporting guidance: https://www.england.nhs.uk/publication/patient-safety-incident-response-framework-and-supporting-guidance/
15. Sands Bereavement Support Book: https://www.sands.org.uk/sites/default/files/Sands%20Bereavement%20Book_Nov24.pdf
16. North Herts Sands: https://www.northhertssands.co.uk/

8. Acknowledgements

Not applicable.

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, we believe 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 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 use of this form is not restricted to the team who cared for the patient at the end of their life. It can be used by any team or individual whose role results in review of a death, such as the Coding team, the Resus team or a specialty team Mortality and Morbidity discussion.

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 in order to promote learning and robust governance.

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 has now taken place and the service became statutory from 9 September 2024.

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 the Coroner are made appropriately and promoting learning/good practice by feeding into clinical governance processes. In particular by flagging cases for structured judgement review or escalating a case on ENHance as a patient safety incident.

The process for the medical examiner system 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 came by their death and to provide the details needed for their death to be registered.

In addition to the detail required by law, the conclusion of an Inquest 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 in similar circumstances and they are not satisfied with the actions or learning taken to date, they are duty bound to 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 the 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.

In July 2022 the Trust adopted the SJR*Plus* format for mortality review. This format was developed by "Better Tomorrow"; a collaborative initiative originally hosted on the FutureNHS platform, which has now transferred to Aqua. SJR*Plus* is an e-review tool now provided by Aqua and hosted by AGEM. The Better Tomorrow collaborative also 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 review 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

The Trust aims to review a minimum of 25% of deaths which occur in the Trust (including ED and Mount Vernon Cancer Centre). As Obstetric and Paediatric deaths are subject to specialist nationally mandated review processes they fall outside the scope of the Trust's structured judgement review process. Detail of these processes can be found in the relevant documents detailed in Associated Documents (Part I, s.5). In line with the 2017 national guidance, the following categories of death will be prioritised for review:

- Deaths where the Medical Examiner has raised concerns following their scrutiny
- Deaths where the bereaved or staff raise significant concerns regarding care
- Deaths of those suffering from learning disabilities, 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

- Categories of death identified to inform the Trust's quality improvement initiatives.

A number of caveats should be noted with regard to the above:

1. If the Mortality Improvement Manager, when screening the above deaths identifies or suspects that harm may have been caused, they immediately raise a patient safety incident in place of an SJR. (An SJR may still be performed if there is agreement between the patient safety team and the mortality support team that an SJR would be the most appropriate learning response to the incident under PSIRF).
2. Where a mortality rate alert has been raised regarding a specialty/diagnosis/ treatment group, while the use of SJR may be considered, coding reviews and specific thematic clinical reviews are often chosen in place of individual SJRs
3. Categories of death identified to inform Trust quality improvement initiatives may also employ thematic reviews in preference to individual SJRs.

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 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 online allowing for on site or remote case note review. It was developed by "Better Tomorrow"; a collaborative initiative originally hosted on the FutureNHS platform, since moving to Aqua (Advanced Quality Alliance). An organisation committed to supporting health and care organisations to identify, refine and embed sustainable strategies for high quality care and regulatory excellence.

5.3. Mortality reviewers

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

Each year the Associate Medical Director and Mortality Improvement Lead meet with individual reviewers to provide an opportunity to exchange feedback regarding the workings of the mortality review process with the intention of continuing to refine the process and address issues as they arise.

These meetings are also used to provide reviewers with feedback regarding their reviews, to promote a culture of continuous learning and improvement of the quality of review outputs.

6. SJR/PSIRF Pathway

Where an SJR identifies issues which may have negatively impacted on the safety of the patient, the Mortality Support team raises an incident on ENHance. There are three main triggers in the SJR for such an escalation:

i. A problem in healthcare resulting in harm/probable harm
ii. Any evidence that the death may have been preventable
iii. An overall assessment of care as being poor or very poor.

Following escalation, the Trust's patient safety incident response process is followed to conclusion. Cases where the reviewer had judged the death to be more than 50:50 preventable or where the care was deemed to be very poor, together with all PSIIs, continue to be tracked by Mortality Support. On conclusion these cases are considered by the Mortality Surveillance Committee. This provides the Committee with final oversight of the escalated cases including the opportunity to consider whether it feels any further action or additional sharing of learning is required.

The Committee reconsiders the preventability of death and makes any adjustment to the initial reviewer score it considers appropriate, based on the totality of information available to it from the incident learning response. These revised scores inform the annual Quality Account assessment of deaths considered more likely than not to have been due to a problem in healthcare. An overview of the SJR/PSIRF pathway is provided at Appendix 3.

7. Patient Safety Incidents

The Trust is committed to learning from all patient safety incidents, including those that involve the death of a patient. Within the Trust, implementation of the Patient Safety Incident Response Framework (PSIRF) is overseen by the Quality and Safety Committee, supported by the Patient Safety Forum, with key decision-making responsibilities held by the Medical Director and Chief Nurse, alongside the Director of Quality.

PSIRF is a core element of the NHS Patient Safety Strategy approach for the development and maintenance of mechanisms (systems and processes) for responding to patient safety incidents (PSIs) to maximise learning and improvement.

Improving safety may require a combination of actions that affect clinical practice, organisational processes, information management, tools and equipment, communication methods, external factors, and individual person human factors. Therefore, how we respond and learn when an incident occurs requires a holistic approach to drive sustained improvement.

The Trust's PSIRF Plan and Policy, referenced under Associated Documents, set out how the Trust intends to respond to patient safety incidents.

Staff need to be familiar with this Plan and Policy to determine whether an improvement or a learning response is required following a safety incident.

Some events in healthcare require a specific type of response as set out in policies or regulations (see table below). These responses may include mandatory Patient Safety Incident Investigation (PSII), review by, or referral to, another body or team, depending on the nature of the event.

Nationally mandated learning responses (ENHT Patient safety Incident Response Plan 2023/24)

Patient safety incident type	Required response	Anticipated improvement route
Death thought more likely than not due to problems in care (incident meeting the learning from deaths criteria for patient safety incident investigations (PSIIs)	PSII	Create local organisational actions and feed these into the safety improvement plan
Deaths of patients detained under the Mental Health Act (1983) or where the Mental Capacity Act (2005) applies, where there is reason to think that the death may be linked to problems in care (incidents meeting the learning from deaths criteria)	PSII	Create local organisational actions and feed these into the safety improvement plan
Child deaths	Refer for Child Death Overview Panel review Locally-led PSII (or other response) may be required alongside the panel review – organisations should liaise with the panel	Respond to recommendations as required and feed actions into the safety improvement plan
Deaths of persons with learning disabilities/autism	Refer for Learning Disability Mortality Review (LeDeR) Locally-led PSII (or other response) may be required alongside the LeDeR – organisations should liaise with this	Respond to recommendations as required and feed actions into the safety improvement plan

The new Patient Safety Event Response Panel (PSERP) is responsible for agreeing the commissioning of PSIIs and overseeing organisational themes and trends of reported patient safety incidents.

This Learning from Deaths Policy sets out how the Trust complies with key requirements of the 2017 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 learning response 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 patient safety incident response and be given the opportunity to inform the terms of reference.

After completion of the learning response, learning, safety improvements and actions are shared within the division, Patient Safety Forum, Quality & Safety Committee (the ICB is in attendance) and all PSIIs are presented to the Board.

Learning and feedback are also 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 monitoring progress against safety actions, for ensuring appropriate escalation of concerns to the Quality and Safety Committee and for ensuring that key learning and themes inform the Trust's quality improvement initiatives.

8. 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 Group, and in the quarterly Patient and Carer 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.

9. 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 each month 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.

10. Employee support

It is recognised that some cases involving the death of a patient, whether they result in an SJR, a patient safety incident, complaint or claim, can cause significant distress to the members of staff involved. All staff are reminded that there is a variety of support available and are encouraged to access this support whenever they need it. Information regarding what support is available can be accessed on the intranet via the enquire button on the bottom right of the screen or via the People team/HR page under the Health at work services tab.

11. 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 patients (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.

11.1. 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.

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 ICBs 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 referenced 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 5.

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. Guidance regarding notification is contained within the associated document: *National Learning Disability Mortality Review SOP CP 252*. The LeDeR review process has now been granted an exemption from the National Data Opt-Out by the Health Research Authority Confidentiality Advisory Group to the Secretary of State. This means it is no longer necessary to check the Data Opt-Out status of an LD patient prior to notification of their death to the LeDeR programme.

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 made available 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 Patient Administration System and a weekly report provided to the Mortality Support team.

To further safeguard these vulnerable patients and maximise learning from their deaths, all cases where care is judged to have been below 'good' are notified to the LD Lead and escalated as patient safety incidents, ensuring further consideration and review at specialty level.

Finally, from April 2025, all LD deaths will be discussed at Mortality Surveillance Committee once SJRs and patient safety reviews have been concluded.

11.2. Patients with severe mental illness

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. This group of patients includes those receiving active treatment for severe mental illnesses, requiring registered mental health nurse (RMN) monitoring, and being held under the Mental Health Act.

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, 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 which focus on patients likely to have severe mental illnesses, like bipolar disorder or anorexia, are:

- all patients where family, carers, or staff have raised concerns about the care provided
- 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.

While discussions have taken place regarding the scope for creating a system flag for severe mental illness, concerns remain as to whether this is appropriate. Additionally, the Medical Examiner now scrutinises all deaths and is required to flag patients with severe mental illness for structured judgement review. While this should ensure all relevant deaths are reviewed, a weekly Business Intelligence report based on relevant ICD-10 codes is also used to identify appropriate deaths for review. Although the national guidance requires the review of patients with *severe* mental illness, our approach is to review deaths where there is

any clear evidence of mental health issues in an attempt to safeguard these vulnerable patients.

11.3. 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'.

11.3.1. Joint Agency Response

The HSCP Joint Agency Response Arrangements detail the 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 6.

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 Trust's Patient Safety Event Response Panel (PSERP) 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.

11.3.2. 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.

11.4. 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, Newborn and Infant Outcome Review Programme* (MNI-CORP). Additionally, all maternal deaths, which are extremely rare, are subject to external investigation by the Maternity and Newborn Safety Investigation Branch (MNSI).

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 safety actions and learning are provided by the internal Patient Safety Incident Investigation (PSII) and Claims, Incidents and Complaints Triangulation quarterly reports, and are shared via the Trust's clinical governance processes with the Directorate and wider clinical arena as appropriate. Inclusion of MNSI reports to the Quality and Safety Committee (QSC) also ensures Board awareness of issues raised. Appropriate learning is used to develop patient safety alerts and quality improvement work.

11.5. Perinatal deaths

Within the Women's and Children's Directorate detailed guidance is provided regarding Pregnancy Loss, which includes miscarriage, stillbirth and termination of pregnancy due to foetal abnormality. This guidance (referenced under Associated Documents) acknowledges that pregnancy loss at any gestation can be a potentially traumatic and devastating event for a woman and her family and is also an extremely sad and stressful experience for all of 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, responsive, supportive, sensitive and caring towards the woman and her family is emphasised. A specialist obstetric and midwifery bereavement team lead on patient engagement and support for bereaved families. Additional support may be provided by the Bereavement Office and bespoke literature provided to guide them.

The Trust is committed to learning from all perinatal deaths by way of multi-disciplinary review at the time of the loss. The Chief Nurse is immediately notified of any cases where the review panel identifies significant deficiencies in care such that a PSII is required.

All neonatal deaths (babies born alive at 20 weeks gestation or greater who die up to 28 days after birth) will be reported as a statutory requirement to MBRRACE-UK and the Child Death Overview Panels (CDOPs) via the Cascade notification system. The notification must take place within two working days of the death (excluding weekends and bank holidays) by the maternity bereavement or governance team. The MNSI programme investigates all term babies (at least 37 completed weeks of gestation) following labour with an outcome of intrapartum stillbirth, early neonatal death or severe brain injury. Cases of babies who have Magnetic Resonance Imaging (MRI) confirming Hypoxic Ischaemic Encephalopathy (HIE) and who die after 6 days of birth require referral to the NHS Resolution Early Notification Scheme (ENS) as part of the Clinical Negligence Scheme for Trusts (CNST). A multi-agency Joint Agency Response (JAR) meeting may be held to provide support to families when an infants' death is sudden, unexpected or unexplained, to better understand the cause of death and identify factors that may have contributed to the death in order to develop recommendations to prevent similar future deaths.

The Trust's Perinatal Mortality Review Group meets monthly to review all perinatal deaths from 20+0 weeks 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 pregnancy loss (the foetus is between 22+0 and 23+6 weeks gestation), stillbirth, neonatal death (where the baby is born alive after 20+0 weeks gestation and up to 28 days after birth), and the deaths of babies who die up to one year after birth having received neonatal treatment or care. 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 against peer trusts.

Cases are discussed at the monthly Perinatal Morbidity and Mortality (PMM) meeting. Lessons learned are shared with the appropriate multi-disciplinary team. If themes are identified, action plans are formulated and monitored at subsequent PMRT and PMM meetings. Unresolved actions are escalated to the Trust Quality and Safety Committee (QSC), and if necessary, the Risk Register. The Trust also contributes to the Royal College of Obstetricians and Gynaecologists (RCOG) "Each Baby Counts" database for all babies who die in the intrapartum period.

At a Divisional level, an annual audit is conducted and presented at the Clinical Governance Rolling Half Day (RHD), The Women's and Neonatal Safety and Quality Committee (TWNSQC) and Maternity and Neonatal Safety Champions (MNSC) forum. The information provided focuses on broad-spectrum learning from the review process including demographics, particularly ethnicity, learning disability, socio-economic deprivation and safeguarding, obstetric and neonatal risk factors, underlying causes of sub-optimal care, antenatal, intrapartum and postnatal care, including cross-boundary shared care across the Local Maternity and Neonatal System (LMNS) and the East of England (EoE) region. Outcomes of case review presentations suggest preventative improvements, together with any learning gained from women who have experienced a late pregnancy loss, stillbirth or

neonatal death. Women's experiences of loss are disseminated to staff through the Maternity Improvement Committee (MIC) meetings.

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 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 midwife at the Divisional Specialty and TWNSQC meetings and at annual mandatory staff training days.

11.6. 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.

11.6.1. SACT Mortality review process

The SACT (Systemic Anti-Cancer Therapy) dataset is an NHS agreed mandated standard, and as part of that standard it needs to be reviewed. To support this, the national SACT team developed the Rapid Data Review (RDR) which provides trusts with patient information on 30-day deaths every quarter.

In response, the Cancer Division has established a mortality review process to review all the 30-day post-Systemic Anti-Cancer Therapy deaths to identify areas of good practice, learning and inadequate care. The approach is as follows:

- Treating consultant completes/returns a specially designed proforma
- A specialist MDT Team (both Lister and MVCC site) conduct an independent review of each case

- Collective case discussion takes place between reviewers to establish whether:
    - The proforma is complete?
    - From the detail are they able to rate the quality of care?
    - Is the standard of care satisfactory/unsatisfactory/insufficient information
- Cases meeting the following criteria are presented by the Treating Consultant at a quarterly Cancer Division Mortality Review Committee meeting:
    - All Neoadjuvant/adjuvant/radical cases
    - Cases where reviewers considered there was insufficient information, further clarity was required, or where the initial review identified unsatisfactory care
    - Cases where reviewers considered there was important general learning points, in particular complex/challenging cases.

Agreed actions are managed via an action log, which also allows for the identification of themes and trends. Cases where learning is identified are also presented at the Cancer Divisional Clinical Governance meeting for wider dissemination of learning. Any system issues identified, for example poor management at another Trust, are escalated to Divisional Leadership and the Executive team for support.

12. 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, the death is referred to the patient safety team.

Where concerns are identified but it is not clear that these constitute a patient safety incident, 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 then be raised as a patient safety incident, ensuring it is discussed at Divisional/Specialty level with appropriate remedial actions taken.

It is important to remember that the primary purpose of an SJR is to build data to enable identification and analysis of trends to support improvement planning. Ideally, sharing of outcomes with families and system partners is at this thematic level rather than on an individual case basis. That said, openness and transparency remain vitally important. Where information regarding the findings of an individual SJR are required in writing, the Mortality Support team are able to provide a letter outlining key details from the review. Please contact mortalitysupport.enh-tr@nhs.net.

Where a patient's family is involved, our preference, wherever possible, is for the SJR findings to be discussed with them, to provide them with the opportunity to ask questions and confirm their understanding. It is important to consider who is best placed to undertake that conversation. It may be the responsible consultant, the ward matron or the relevant DQM. These individuals are all well versed in carrying out any required duty of candour and understanding the clinical background to the patient's care. Who is best placed to speak with the family will be decided on a case-by-case basis. In these situations please liaise with the Mortality Support team.

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.

13. 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. A high-level representation of the Trust's formal assurance and governance structure regarding learning from deaths is provided at Appendix 7. A further chart outlining the key aspects of our learning, review and governance activity is provided at Appendix 8.

13.1. 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 which resulted in a patient safety incident escalation where: (i) PSII undertaken; (ii) the SJR reviewer considered the death to have been more than 50:50 likely to have been preventable; (iii) the SJR reviewer judged the care to have been very poor
- Approval of the quarterly Learning from Deaths report for submission to the Quality and Safety Committee and of the summary report to Board
- Consideration of quarterly 'Food for Thought' reviews which focus on themes identified from SJR outputs
- Commission and monitoring of the progress of improvement work undertaken by service areas where there have been recurrent mortality alerts or concerns
- 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.

13.2. 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:

- Key mortality metrics/CUSUM alerts
- Headline mortality data including the number of deaths, structured judgement reviews, (including review outcomes/learning)
- 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 as PSIIs under the patient safety investigation 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.

The Quality and Safety Committee also maintains oversight of all ongoing Patient Safety Incident Investigations (PSII) and a monthly update is provided. In addition, PSII learning responses are reviewed through PSERP.

13.3. 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. These meetings provide a forum for discussion, learning and the creation of appropriate Specialty specific actions plans. For this reason, they represent an important element of the Trust's Learning from Deaths framework.

Specialties are required to discuss SJRs at their M&M meetings, incorporating learning into Specialty specific quality improvement initiatives. As a prompt, copies of new SJRs are emailed to the relevant Clinical Governance Lead, the Responsible Consultant and the SJR reviewer, with a request to ensure it is discussed at the next M&M meeting/RHD.Other important opics covered include the outcomes of patient safety investigations together with Complaints and Claims. It is the responsibility of the Clinical Governance Leads to ensure all outcomes are appropriately discussed and triangulated with learning recognised, disseminated and where necessary improvement measures agreed.

13.4. 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.

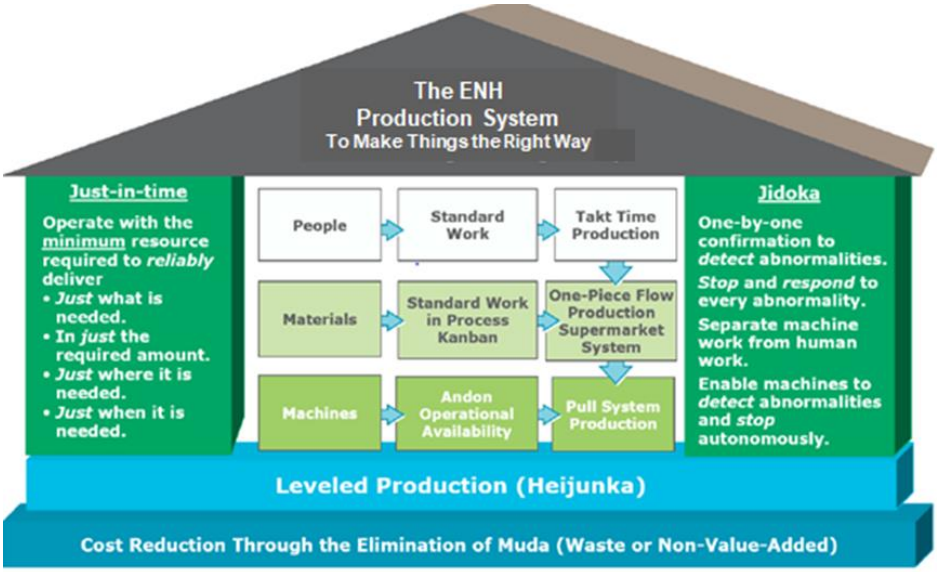
14. Our Approach to Continuous Improvement

Improve

We are committed to consistently delivering excellent services and continuously looking to improve through a creative workforce that feels empowered to act in service of our shared purpose

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

The Trust has adopted the Virginia Mason Production System. The 'house' (see below) is a visual representation of the improvement method which captures over twenty years of experimentation and learning as part of the Virginia Mason journey.



It is a lean management methodology based on the principles of the Toyota Production System which has since been successfully transferred and adopted into healthcare systems across the world.

A fundamental principle of the method is that improvement is led by those that do the work, where the work is done. This requires a different approach to traditional 'superhero' leadership styles, as leaders instead coach their teams through problem framing, empowering teams by building their capability to make improvements for themselves.

'Lean' in healthcare is about creating value and reducing the burdens that patients and staff experience every day. Rather than focusing on saving money, lean organisations focus on

sustaining high levels of quality, safety, satisfaction and morale. They do this by aligning the entire workforce around a consistent improvement method and use that approach to promote, test and implement process improvements on an ongoing basis.

This approach provides a unified way of thinking and acting through a set of philosophies and practices that have been tested for over fifty years. It is built on an underlying philosophy that embraces:

- Putting the patient first
- Focussing on highest standards of quality and safety
- Respect for people
- Engagement with all employees
- Striving for the highest levels of satisfaction.

As the ENHT Production system becomes embedded in the Trust, ways in which its approach to quality improvement can be used to enhance our learning from deaths work will be considered.

14.1. Learning from Deaths Strategy

In recognition of the fundamental importance of the Trust's Learning from Deaths work, from 2022 a standalone Learning from Deaths strategy has been created and refreshed every two to three years. It is closely aligned with the Trust's strategic aims and values together with those embodied in the Trust's PSIRF Plan and Quality Improvement work. Notice is also taken of NHS England's overarching planning priorities. 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.

14.1.1. Key Performance Indicators

Central to the strategy is a set of objectives, including key performance indicators, with corresponding outcome measures.

Progress against this strategy is monitored via the Mortality Surveillance Committee. Performance against KPIs is reported every 6 months, and progress against the full list of objectives every 12 months.

15. 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. The Trust is committed to continuing to seek and embed new processes to capitalise on and share learning in order to further enrich the quality of its learning and quality improvement work via greater collaborative analysis across internal Trust processes.

15.1. Forums for sharing and learning

Principal forums for sharing learning are those referenced under section 12 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. Key developments are outlined below.

15.2. Better Tomorrow

"Better Tomorrow" is an initiative developed by NHSE on the FutureNHS platform, whose aim is *"To support effective learning from deaths in order to improve care for the living"*. It aims to provide a forum for discussion, learning and the promotion of best practice in the learning from deaths arena. While still accessible via the FutureNHS platform, the Better Tomorrow programme has moved from NHSE to the Advancing Quality Alliance (Aqua).

15.3. Systems support

15.3.1. SJRPlus/NHS England Apps

A key aspect of the Better Tomorrow initiative was the development of a mortality e-review form, based on the RCP Structured Judgement Review format, named SJRPlus. Following Better Tomorrow's move to Aqua, the online tool has been migrated to Arden & GEM CSU's Azure Platform.

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

15.3.2. In Phase: 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.

The potential for the development of a mortality module has been discussed and will be considered in detail once the embedding of all key Trust modules is complete.

15.3.3. 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 continues to be developed to provide easily accessible data to other interested parties across the Trust. As the Trust transitions to the use of Power BI, appropriate mortality data will be transferred and further developed on this platform.

15.4. 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 is also a sharing point for important documents and learning outputs, including case studies with links to useful internal and external resources.

15.5. 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.

Now that the Medical Examiner function has expanded to incorporate scrutiny of all community deaths, it will be important to continue to develop processes for sharing identified concerns with the Community to foster system-wide learning.

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.

15.5.1. Hertfordshire and West Essex Mortality Network

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 informal group convenes quarterly to discuss learning from deaths topics of mutual interest, enabling the sharing of learning and experience.

15.5.2. HWE Learning from Deaths Forum

At the end of 2023, the ICB initiated conversations with a broad spectrum of system partners aimed at developing a system-wide Learning from Deaths Forum.

This initiative links with ICB responsibilities under the National Patient Safety Strategy in relation to oversight of Medical Examiners and Learning from Deaths system together with its need to gather certain data as part of the NHSE Quality Functions paper requirements.

Discussions are currently focussed on how it can link into and build on existing processes such as CDOP and LeDeR and other key mortality improvement work relating to areas such as end of life and frailty. With many processes already in place across the system, the challenge of ensuring the forum adds value at a system level by improving the sharing of information and learning has been recognised.

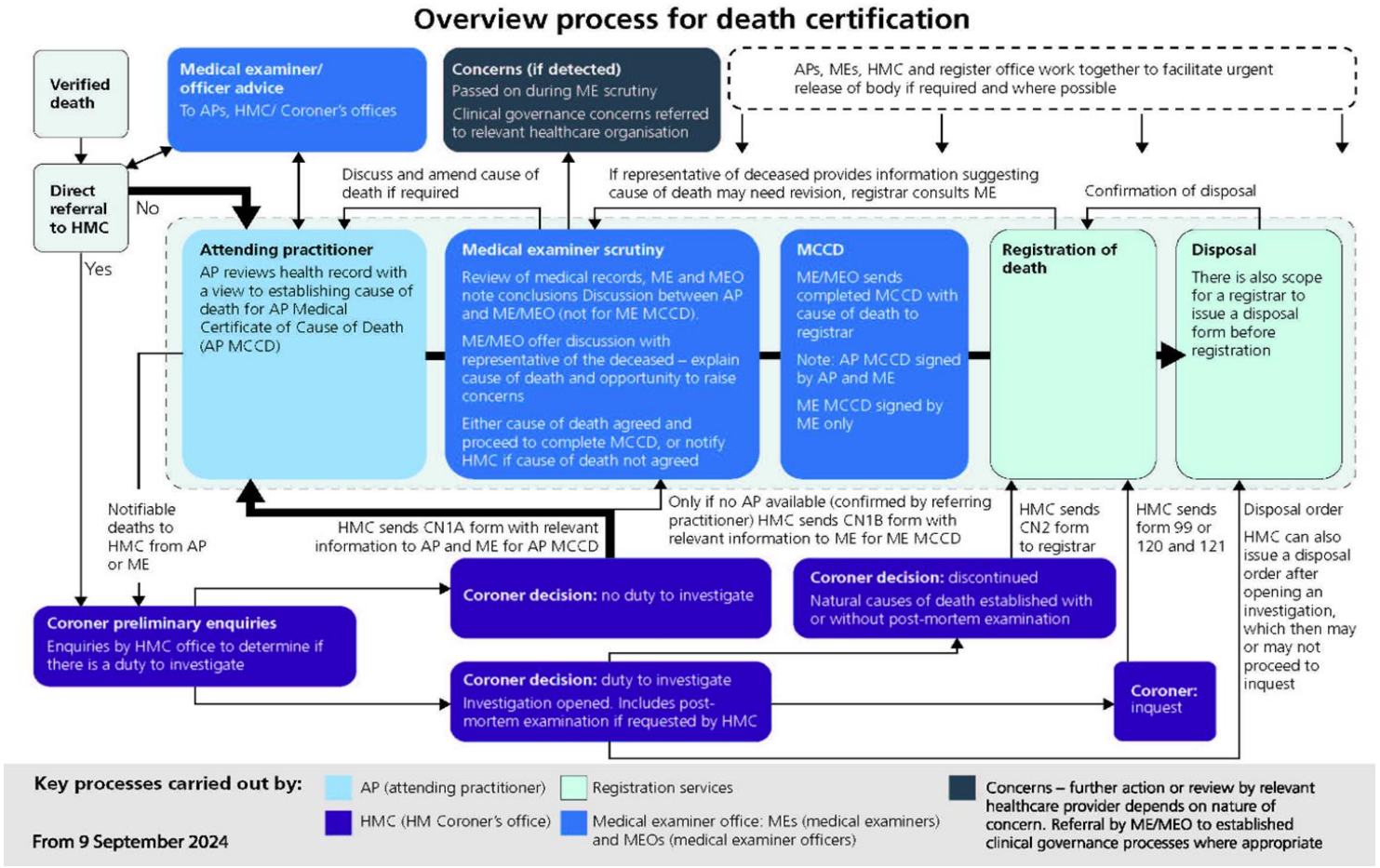
The Trust is committed to participation in the forum and to working with partners across the system in its development.

15.5.3. National Trust Mortality Leads Community of Practice

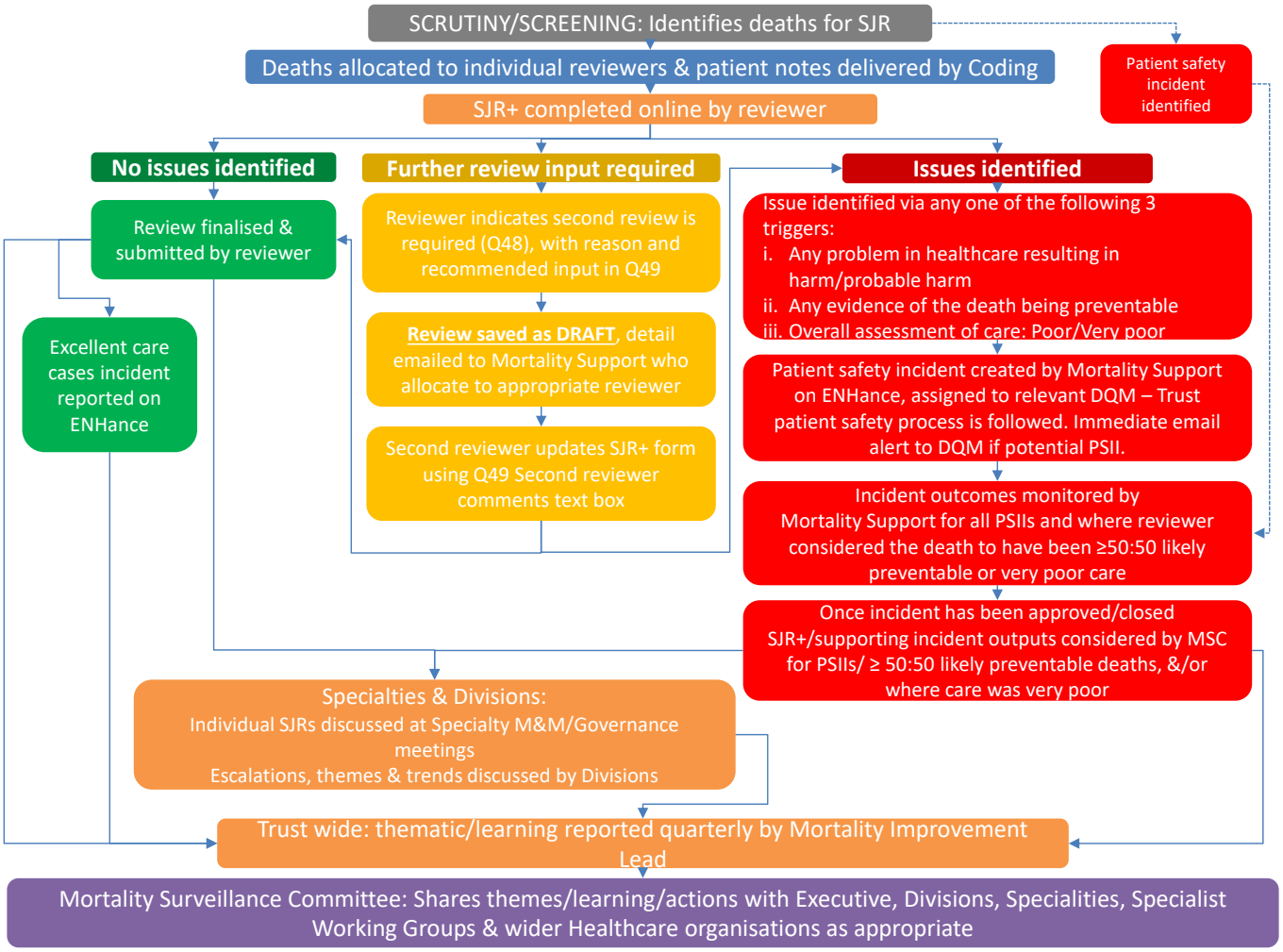
When the Better Tomorrow initiative was created by NHSE, of particular value was a monthly Mortality Leads Forum, where ideas, challenges and potential solutions could be discussed and shared among mortality leads from different Trusts across the country. When funding for the initiative was withdrawn by NHSE, the mortality leads involved committed to creating a legacy Community of Practice. The group meets every two months, with an invite extended to the Better Tomorrow Leads to maintain the link to the work ongoing via Aqua. This forum continues to provide an invaluable arena for discussion of emerging developments and ongoing challenges.

Part 3 – Appendices

Appendix 1 – Death certification process

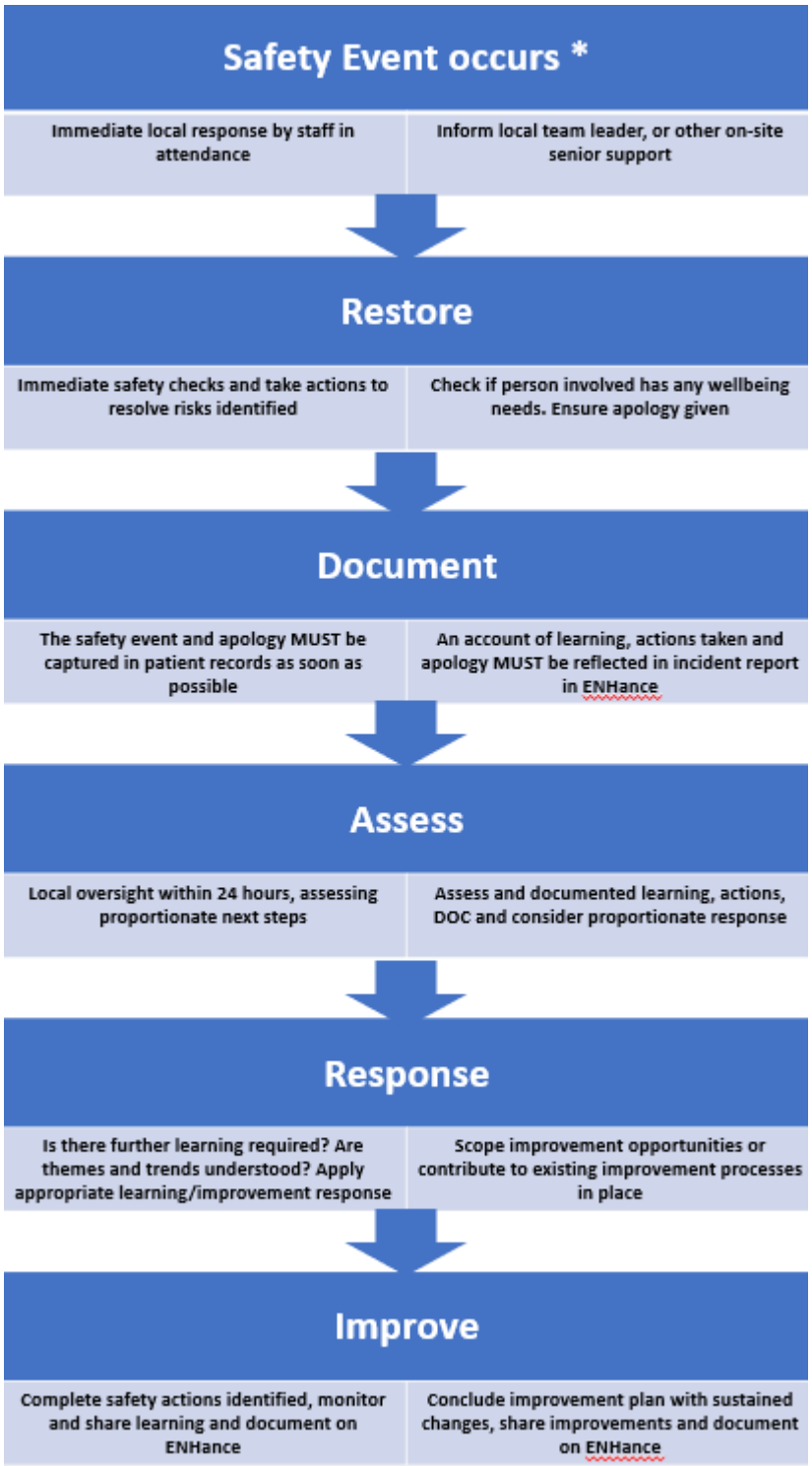


Appendix 2 – Structured Judgement review process

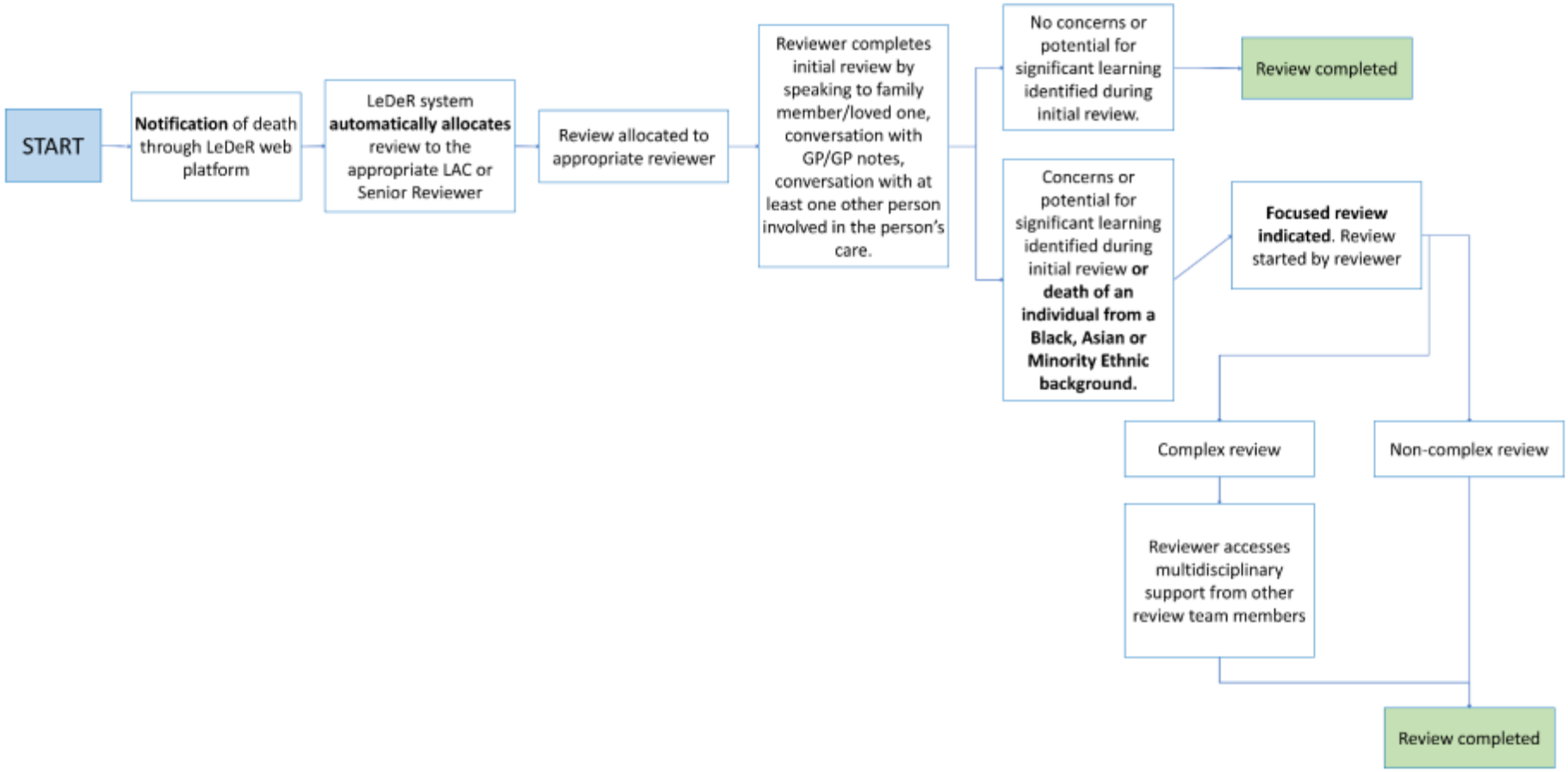


Appendix 3 – SJR/PSIRF

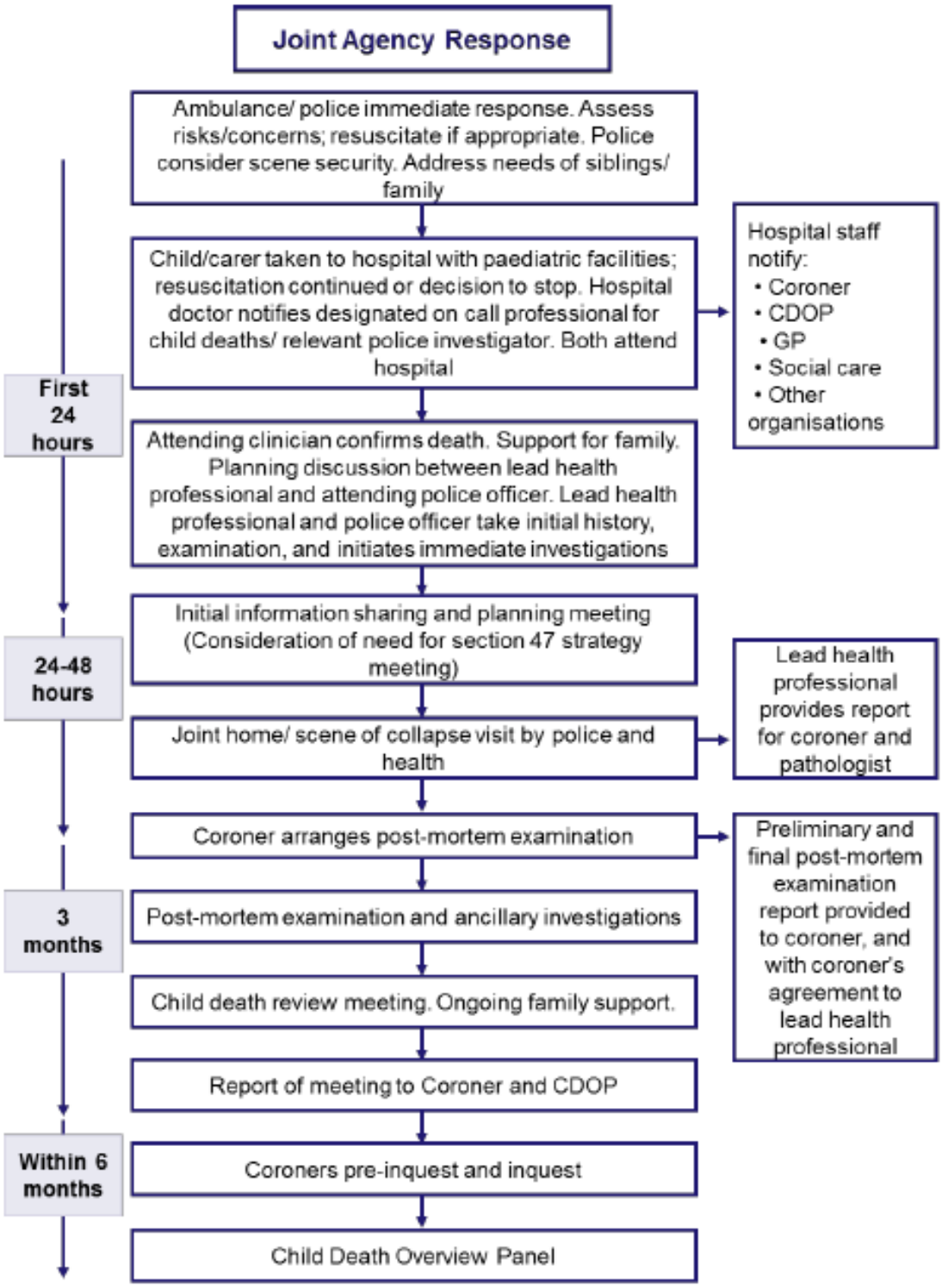
Appendix 4 – Patient safety response process: A visual summary



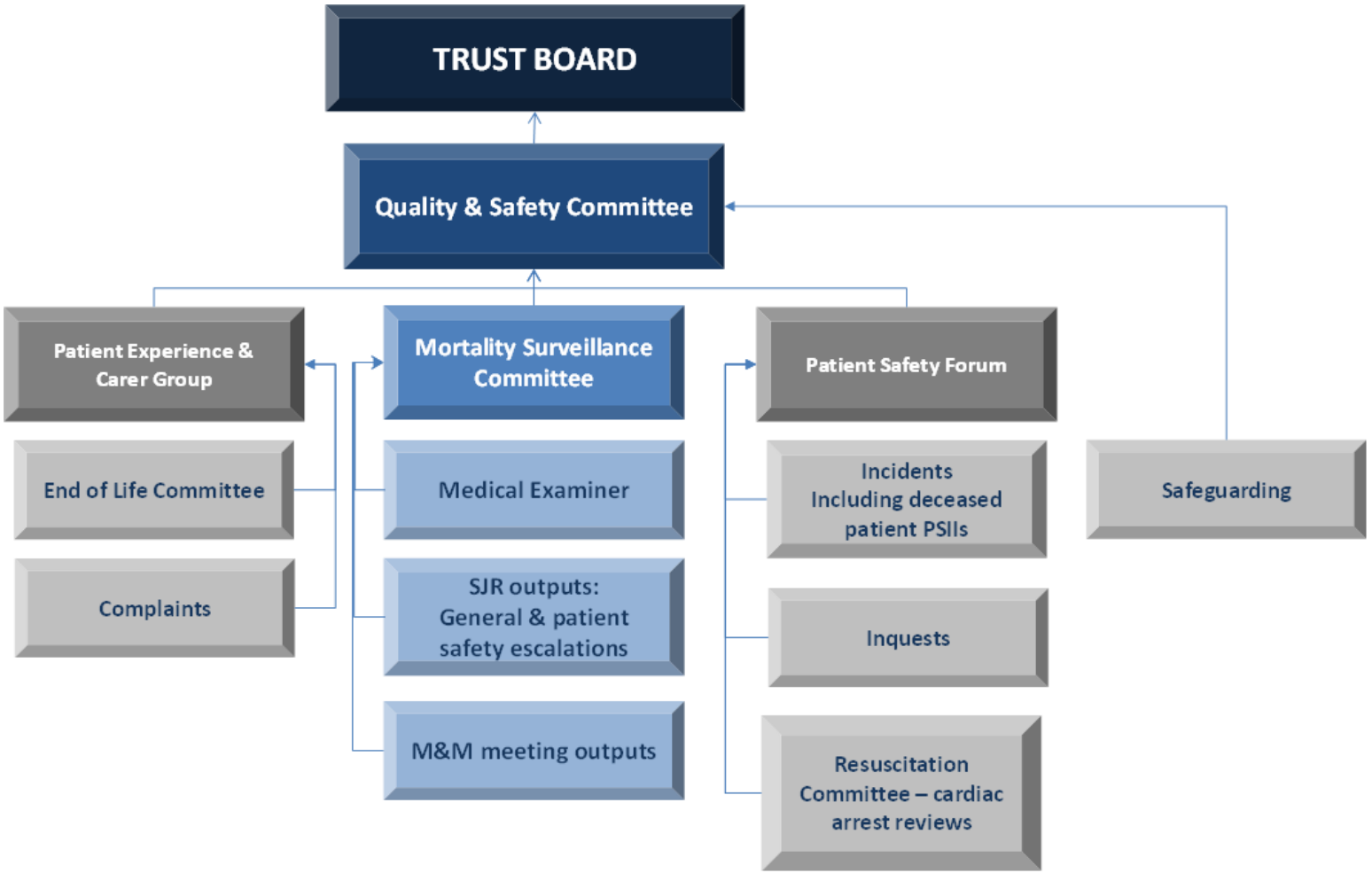
Appendix 5 – LeDeR review process overview



Appendix 6: Joint Agency Response Responsibilities



Appendix 7: Mortality Surveillance and other key relevant Committees/areas within the Trust Assurance and Governance Hierarchy relevant to learning from deaths



Appendix 8: Learning from deaths governance processes

RIP	Regulatory scrutiny	Review	Result	Response	Report	Revisit
Death: ED /IP	All non-Coronial deaths scrutinised by Medical Examiner to agree the COD for death certificate; discuss this with family; raise concerns. The following deaths are referred to the Coroner: i. Violent deaths ii. Sudden deaths of unknown cause iii. Deaths in custody (including sectioned MH patients)	Principal types of review which may be undertaken: i. Specialty M&M ii. SJR (including PMRT/MBRRACE for stillbirth, perinatal, maternity deaths) iii. Patient safety incident PSII/other learning response iv. Cardiac arrest review v. External LeDeR reviews of learning disability and autism deaths	Potential key outputs likely from review activity: i. Learning: case specific and thematic/trends ii. Identification of required actions iii. Issue requiring escalation	Potential appropriate responses will include the following: i. Management and completion of smart actions plans ii. Training to address gaps in competency iii. Creation or revision of policies &/or operating procedures to address process issues iv. Changes to, or development of, clinical pathways	Reporting for learning, quality & assurance purposes: i. Sharing of case specific and thematic/trend learning at specialty, divisional, Trust and local healthcare system wide levels as appropriate ii. Assurance reporting at specialty, divisional, Trust, local system and national levels as appropriate	Conduct further review or audit to evaluate: i. The effectiveness of the action taken ii. To demonstrate improvement iii. To identify remaining gaps in competency, capacity, clinical pathways or operational processes or controls

Part 4 - Document record

As per policy **97 Trust policies and procedural documents**, this document is using the latest format of **Template for Trust-approved documents TMP 001.**

Document info	Doc ID: 78, Version – 04 Learning from Deaths Policy ADMIN ONLY Legacy DOC ID: CP 254
Document type	**Policy**
Document applicability across the organisation	SELECT ONE for each of the 3 items 1. **For use** ☒Trust wide (at corporate level for both clinical and non-clinical roles); ☐ clinical cross specialty; ☐ in multiple areas (non-clinical); ☐ locally 2. **For use by** (ROLES): ☒All roles, ☐clinical roles only, ☐non-clinical roles only 3. **For use at** (SITES): ☒All sites,☐ Lister Hospital, ☐New QEII, ☐Hertford County Hospital, ☐Renal Satellite sites, ☐Mount Vernon Cancer Centre, ☐Other: **Input your selection here:** **For use Trust-wide by all roles at all sites**
Review cycle	☒ Every 3 years (standard) ☐Annual review ☐ Other: **01 June 2028**
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 **(interim updates permitted if review is not overdue)** **Full review of document – various amendments**
Keywords	Mortality, Learning from Deaths
Version author/owner	Sarah El Sharnoubi, Mortality Improvement Lead, Medical Directors Office ☐Cancer ☐Planned ☐Unplanned ☐Women & Children ☒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 (ie process for password creation, locations of ligature risks for patients, etc). Such content has been identified on the following pages/sections: ☐ **Public website**: The document owner has an agreement with the Communications Dept that this document is held on the Trust website. The owner will provide Communications with the current version when updated. ☐ **Forms** - This document contains forms in use at the Trust and provides location where to find them.

	☒ None of the above

Consultation & review

In the checklist below, 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.

Trust stakeholder	Action required by author
1. **Equality, Diversity & inclusion**	Trust **policies** require an Equality Impact Assessment (EIA) as evidence that the protected characteristics under Equality Act 2010 have been considered, as per Part 1, section 6.1 in this document. If the initial EIA screening form determines a full EIA is required, visit the Equality, Diversity & Inclusion intranet section for next steps. It could take **3 to 4 weeks to receive approval.** EIA approval (supplied via email): Click or tap to enter a date.
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 State recommendations:
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 to request their **endorsement (formal agreement the document is fit for use at the Trust)** **Step 2**: Record consultation activity in item 10 in this list: **Other areas or stakeholders**

Trust stakeholder	Action required by author
	Step 3: TPC requires sign off on the final file and will be the final approver in the Record of agreement.
4. Nursing, Midwifery & AHP	This document contains processes that will have an impact on staff and care or that would affect work routines. ☐No – proceed to next item ☒Yes – please see following steps **Step 1:** For documents that are for Trust-wide use, **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. ☐Clinical skills group and/or ☐Clinical Board (formerly Nursing, Midwifery, AHP Quality Committee) and/or ☐The appropriate training team eg Nursing/Maternity Training Team (For documents for local use, contact in the first instance). ☐Other: **Step 2**: Record consultation activity in item 10 in this list: **Other areas or stakeholders** **Step 3**: If stakeholder requires sign off on final file, they can be an endorser in the Record of agreement.
5. Safeguarding	This document (either for local or Trust-wide use) contains processes or information that may have an impact on children or vulnerable adults using our services. ☐No – proceed to next item ☒Yes **Step 1**: Contact **Safeguarding** team for initial discussion. **Step 2**: Record consultation activity in item 10 in this list: **Other areas or stakeholders**
6. People (Human resources)	This document (either for local or Trust-wide use) contains processes or information about the recruitment or management of staff or other processes applicable to staff. ☒No – proceed to next item ☐Yes **Step 1**: Contact Trust Partnership committee, staff side and/or staff network groups for initial discussions. **Step 2**: Record consultation activity in item 10 in this list: **Other areas or stakeholders** **Step 3**: In most cases, for these Trust-wide documents owned by the People team, the **Trust Partnership** requires sign off on the final file and should be the **approver** in the Record of agreement
7. Finance	This document contains processes or information that affects the acquisition of resources (recurring or one-off) or payments of salaries

Trust stakeholder	Action required by author
	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**: Record consultation activity in item 10 in this list: **Other areas or stakeholders** **Step 3**: If the stakeholder requires sign off on final file, they can be an endorser in the Record of agreement.
8. 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 consultation activity in item 10 in this list: **Other areas or stakeholders** **Step 3**: If the stakeholder requires sign off on final file, they can be an endorser in the Record of agreement.
9. Digital (IT)	This document contains processes or information about the use of Trust computer hardware, software or systems. This includes systems either managed by our local Digital team or an external supplier. ☒No – proceed to next item ☐Yes **Step 1**: Involve/request input from the appropriate team in Digital services **Step 2**: Record consultation activity in item 10 in this list: **Other areas or stakeholders** **Step 3**: If the stakeholder requires sign off on final file, they can be an endorser in the Record of agreement.
10. Senior division/ directorate staff	Document owner must apprise senior staff in their relevant area of this new or fully reviewed document. **Step 1** **Divisions (clinical areas)**: Apprise **divisional clinical governance group** of document development or send final draft for the formal meeting record and so respective the clinical director is apprised at

Trust stakeholder	Action required by author
	that meeting. **Directorate (corporate/ non-clinical areas)**: Advise respective senior level group meeting of updated document so this activity is on the formal record. **Step 2** In item 11 below, record date and name of clinical governance meeting/ senior level group meeting as a stakeholder (select external). Select the activity type as "other" and indicate "for information only".
11. Document stakeholders	In the table below, please record evidence (ie date of meetings or email) of activity with departments, groups, stakeholders involved in the update/development of this document. A minimum of one stakeholder must be listed. Please delete unused rows.

Document stakeholders

Document stakeholder	Date	Activity type
Theresa Murphy, Chief Nurse ☒**Internal*** ☐**External****	12-09-2024 ☐Meeting date ☒Email date	☐Content contribution ☒Read and agree fit for use ☐Other:
Dr Mark Hearn, Associate Medical Director for reducing unwarranted variation, Chair of Mortality Surveillance Committee ☒**Internal*** ☐**External****	14-05-2025 ☒Meeting date ☐Email date	☐Content contribution ☒Read and agree fit for use ☐Other:
Bridget Sanders, Medical Programme Director ☒**Internal*** ☐**External****	10-10-2024 & 14-05-2025 ☒Meeting date ☐Email date	☐Content contribution ☒Read and agree fit for use ☐Other:
Mandy Massey, Mortality Improvement Manager ☒**Internal*** ☐**External****	24-04-2025 ☐Meeting date ☐Email date	☒Content contribution ☒Read and agree fit for use ☐Other:
Margaret Mary Devaney, Director of Quality ☒**Internal*** ☐**External****	04-03-2025 ☒Meeting date ☐Email date	☐Content contribution ☒Read and agree fit for use ☐Other:
Sarah James, Hospital Director, MVCC ☒**Internal*** ☐**External****	05-02-2025 ☐Meeting date ☒Email date	☒Content contribution ☒Read and agree fit for use ☐Other:
Mel Gunstone, Deputy Chief Nurse, Mental Health Lead ☒**Internal*** ☐**External****	17-08-2024 ☐Meeting date ☒Email date	☒Content contribution ☒Read and agree fit for use ☐Other:

Document stakeholder	Date	Activity type
Lucinda Berry, Head of Legal Services, Safety and Learning ☒**Internal*** ☐**External****	03-10-2024 ☐Meeting date ☒Email date	☒Content contribution ☐Read and agree fit for use ☐Other:
Sophie Williams, Complaints PALS and Patient and Carer Experience Lead ☒**Internal*** ☐**External****	27-08-2024 ☐Meeting date ☒Email date	☒Content contribution ☐Read and agree fit for use ☐Other:
Dr Gunjan Jain, Consultant, Paediatrics ☒**Internal*** ☐**External****	25-10-2024 ☐Meeting date ☒Email date	☒Content contribution ☐Read and agree fit for use ☐Other:
Dr Marie Joseph, Consultant Lead, Palliative Medicine ☒**Internal*** ☐**External****	19-08-2024 ☐Meeting date ☒Email date	☐Content contribution ☐Read and agree fit for use ☐Other:
Josie Reynolds, Lead Midwife for Quality Assurance, Governance & Compliance ☒**Internal*** ☐**External****	27-01-2025 ☐Meeting date ☒Email date	☒Content contribution ☐Read and agree fit for use ☐Other:
Sarah Waterman, Divisional Quality Manager, Planned Care ☒**Internal*** ☐**External****	30-09-2024 ☐Meeting date ☒Email date	☒Content contribution ☐Read and agree fit for use ☐Other:
Clare Urbani, Lead Medical Examiner Officer ☒**Internal*** ☐**External****	05-09-2024 ☐Meeting date ☒Email date	☒Content contribution ☐Read and agree fit for use ☐Other:
Enda Gallagher, Adult Safeguarding Lead Nurse ☒**Internal*** ☐**External****	28-08-2024 ☐Meeting date ☒Email date	☒Content contribution ☐Read and agree fit for use ☐Other:
Ivy Erhahon, Mental Health Matron/Lead Nurse ☒**Internal*** ☐**External****	28-08-2024 ☐Meeting date ☒Email date	☒Content contribution ☐Read and agree fit for use ☐Other:

***Internal** – a stakeholder within document author's dept/service/area – a service manager, team meeting, etc.
****External** - a stakeholder outside of dept/service/area or outside the organisation

☒At least one of the above in the consultation list is a formal endorser in the Record of agreement. NOTE: An endorser and/or approver may request evidence of consultation (with any of the above or others not mentioned) before their sign off is granted.

Other consultation and stakeholder actions required

Not applicable.

Record of agreement

Full details of the **endorsement and approval process** can be found in policy **97 - Trust policies and procedural documents**.

DOC ID & title	78, Version: 04 - Learning from Deaths Policy
Due date of next full review	01 June 2028
Document type	Policy
Version type	Full review of document – various amendments
Applicability	For use Trust-wide by all roles at all sites
Version author	Sarah El Sharnoubi, Mortality Improvement Lead, Medical Directors Office
Legacy ID	CP 254

Endorsement	Record of formal agreement this version is fit for use at the Trust by the **Mortality Surveillance Committee** is in meeting minutes, held on **14/05/2025**
Additional endorsement	Record of formal agreement this version is fit for use at the Trust by the Dr Mark Hearn, Associate Medical Director is supplied in Mortality Surveillance Committee meeting minutes held on **14/05/2025**
Additional endorsement	Record of formal agreement this version is fit for use at the Trust by the Theresa Murphy, Chief Nurse supplied in email dated **12/09/2024**
Approval	Upon considering the above endorsements, the approver* **Dr Justin Daniels, Medical Director,** agrees this document is fit for use at the Trust. Confirmation of this agreement is supplied in email dated **27/05/2025**
Trust endorsement	Record of formal agreement this version is fit for use at the Trust by the **Policy Compliance Group** at meeting held on **05/06/2025**.
Document checks	Policy Officer – Policy Documents Management, 06/06/2025

*Types of approvers (as per policy 97):

- A member of senior leadership or divisional triumvirate, a Trust committee/group or Trust function stakeholder (including name, role, dept) can approve a fully reviewed and endorsed document.
    - The Trust delegation of standards cites specific policies that require board approval.
- A head of service, or stakeholder or committee chairperson (usually endorser listed at the last full review) can approve an interim update of a document.
- A head of service or department can approve documents for local use only (for all version types).
- All policies require “Trust endorsement” from the Policy Compliance Group.