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Royal Cornwall Hospitals NHS Trust

Learning from Deaths Policy

V11.0

May 2023

Summary

1. Inpatient deaths are reviewed by the Medical Examiner function, with any key findings that represent an opportunity to improve care being identified.

2. Specialties augment the Medical Examiner reviews with their own focus on cases that present an opportunity for learning and improving care.

3. Any significant concerns relating to deaths, or deaths in certain nationally mandated categories, then prompts a more detailed review which is carried out using the Structured Judgement Review (SJR) methodology.

4. The Learning from Deaths framework is intrinsically linked into the Patient Safety Incident Response Framework. This ensures that any significant patient safety concerns prompt a review into mortality, where appropriate, with findings from this forming part of a holistic view of concerns and learning.

5. Findings from SJRs are reviewed at the Mortality Review Oversight Group (MROG). This identifies any trends or themes, and then drives learning across the organisation.

6. The Trust reports every quarter to Trust Board on the performance regarding deaths, along with learning.

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Data Protection Act 2018 (General Data Protection Regulation – GDPR) Legislation

The Trust has a duty under the Data Protection Act 2018 and General Data Protection Regulations 2016/679 to ensure that there is a valid legal basis to process personal and sensitive data. The legal basis for processing must be identified and documented before the processing begins. In many cases we may need consent; this must be explicit, informed, and documented. We cannot rely on opt out, it must be opt in.

Data Protection Act 2018 and General Data Protection Regulations 2016/679 is applicable to all staff; this includes those working as contractors and providers of services.

For more information about your obligations under the Data Protection Act 2018 and General Data Protection Regulations 2016/679 please see the Information Use Framework Policy or contact the Information Governance Team

Royal Cornwall Hospital Trust rch-tr.infogov@nhs.net

1. Introduction

As part of its commitment to providing the best possible quality of patient care, and in line with Trust Strategy, this policy sets out how the organisation monitors patients' deaths, picking up any aspect or themes of care that might be a concern and responding to this appropriately.

2. Purpose of this Policy/Procedure

2.1. This policy ensures that the Royal Cornwall Hospitals Trust (RCHT) follows the requirements outlined in the Learning from Deaths Framework[1].

2.2. The governance arrangements set out in this document also set our how the Medical Examiner process integrates with the overall approach regarding Learning from Deaths.

2.3. This policy sets out the procedures for identifying, recording, reviewing, and investigating the deaths of people in the care of RCHT. It also recognises the ongoing need to consider mortality rates and national mortality indicators, available at diagnosis and individual patient level, to ensure that deaths are reviewed, and patients are safe.

2.4. The Trust Board will provide visible and effective leadership to foster a culture of learning from deaths and to ensure that issues are identified, addressed and improvements are embedded. This includes the sharing of good practice, led by the Mortality Review Oversight Group and including measures such as compiling a regular Newsletter.

2.5. This policy compliments processes described in the:

- Incident Management Policy (including strong links with the Patient Safety Incident Response Framework Process Map)
- Risk Assessment and Management Strategy and Policy
- Bereavement Care and After Death Policy
- Being Open and Duty of Candour Policy and Procedure
- Palliative and End of Life Care Strategy
- Complaints Policy
- Medical Examiner Service processes

[1] https://www.england.nhs.uk/wp-content/uploads/2017/03/nqb-national-guidance-learning-from-deaths.pdf
National Guidance on Learning from Deaths, National Quality Board, March 2017.

3. Scope

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

4. Definitions / Glossary

4.1. Deaths considered as being a priority for an SJR*

As described in the national requirements, the following categories will trigger an SJR:

- Complaints: where quality of care issues have been highlighted involving the death of a patient – see page 33/34 of the national guidance
- Learning disabilities see page 44 of the national guidance
- Autism - see page 44 of the national guidance
- Severe mental health - see page 44 of the national guidance
- Paediatric deaths - see page 35 of the national guidance
- Alerts: where the Trust considers there is cause for concern in specific services areas - see section 5.5 of this Policy
- Safety incidents: where there are significant concerns that a patient safety incident could have potentially contributed to patient harm (mortality) - see section 6.1.5 of the Incident Management Policy
- Concerns: raised from screening tool/Medical Examiner – in line with the operating procedure for the Medical Examiner Service, stating that all deaths that occur on RCHT sites will be reviewed/.
- *Stillbirth/Neonatal or a maternal death: these deaths are reviewed using the Perinatal mortality review tool - see Annex F of the national guidance

5. Ownership and Responsibilities

This section describes the specific responsibilities of key individuals and of relevant committees under this policy. Roles and responsibilities for incident management, complaints handling and Incident management, quality improvement are detailed in the relevant trust policies.

5.1. Chief Medical Officer

- To hold Executive-level responsibility for the learning from deaths agenda.
- To provide assurance to Trust Board on on-going compliance with national legislation and mandatory requirements.

5.2. Medical Examiner

- Meet the mandatory requirements of the national guidance, notably to review all inpatient deaths.
- The Medical Examiner to perform an independent review of all patient deaths that occur on RCHT sites.
- Any concerns relating to the quality of care provided to the patient, or support to the bereaved, are identified and recorded as an incident on the RCHT incident system.
- In the event of any such concern being considered serious, for the Medical Examiner Service to notify the Clinical Effectiveness Team.
- The Clinical Effectiveness Team to commission an SJR to fully investigate the concern and report to the Mortality Review Oversight Group. Opportunities for learning are identified and accordant improvement actions approved and tracked to completion.

5.3. Deputy Chief Medical Officer

- Has delegated authority from the Chief Medical Officer to provide the overall operational leadership on Learning from Deaths on behalf of the Chief Medical Officer.
- To ensure that arrangements are in place so that all clinical staff as appropriate are aware of their responsibilities to contribute to the process.
- To chair the monthly Mortality Review Outcomes Group.

5.4. Trust Clinical Mortality Lead

- As directed by the Chief Medical Officer's office, to provide the clinical leadership on engagement with colleague clinicians.
- To be a key member of the monthly MROG meetings, assisting in the specialties providing assurance on their respective Learning from Deaths.
- To deputise for the Deputy Chief Medical Officer, including the chairing of MROG.

5.5. Trust Board

- To provide challenge as to the integrity of financial, clinical, and other information, and that clinical quality controls and systems of risk management, for example, are robust and defensible.
- Quality improvement remains the purpose of the exercise, championing and supporting learning, leading to meaningful and effective actions that improve patient safety and experience, and supporting cultural change; and the information the provider publishes is a fair and accurate reflection of its achievements and challenges.

5.6. Mortality Review and Oversight Group

- The Group will comprise of a multi-disciplinary, cross divisional group of individuals with a particular interest in mortality, drawn predominantly from medicine, surgery, anaesthetics and nursing.

- The purpose of this Group is to ensure that the Trust learns lessons, and improves the quality of care where appropriate, from patient deaths. Additionally, this Group requests and receives assurance that the Trust is responding appropriately to all concerns relating to patient mortality.

- The Group has delegated responsibility and authority to ensure the Trust fulfils the national requirements of Clinical Effectiveness, and drive and govern innovation from our own staff.

- Strategic functions:

    - Ensure the organisation remains compliant with all national requirements on Learning from Deaths.

    - Provision of assurance, quarterly, to Trust Board, on Learning from Deaths, in line with national guidance.

    - Develop excellent and close working relationships with other organisations, notably the other providers of care in Cornwall and the Isles of Scilly.

- Operational functions:

    - Review monthly the benchmarked mortality rate of the Trust.

    - Consider the mortality data in conjunction with other qualitative clinical data and identify areas for future investigation.

    - Oversee the investigation of any alerts received from the Care Quality Commission (CQC) or identified by the mortality monitoring information systems e.g., Dr Foster, HED, National Audits, and sign off all regulatory mortality responses.

    - Oversee the development of data collection systems to ensure the Trust's mortality data is timely, robust and in line with national and international best practice.

    - Assign clinical leads to address raised mortality in particular clinical areas by the deployment of strong evidence-based interventions such as care bundles and receive regular reports on implementation and the measurable impact of these interventions on hospital mortality.

    - Monitor and consider the information from the review of all in hospital deaths.

    - Sign off action plans and methodologies that are designed to reduce mortality across the Trust.

    - Develop and maintain a good relationship with the Medical Examiner function, respectively its independence whilst working alongside in the interest of learning from deaths and supporting the bereaved.

- Oversight of mortality review processes:
    - Ensure all specialties have a robust and timely mortality review process.
    - Receive assurance that actions arising from mortality reviews are actioned in a timely manner.
    - Obtain feedback from specialities regarding their mortality review meetings.
    - Review “concerns” deaths from specialties.
    - Receive regular assurance that particular attention is paid to mortality reviews relating to patients with a learning disability or mental health condition.
- Ensure Trust-wide learning from mortality review:
    - Ensure learning from reviews and investigations is effectively disseminated across the organisation and more widely where appropriate, including through the mortality newsletter.

5.7. Care Group Management Teams

- The Care Group Management teams, with the Clinical Director taking the prime leadership within this team, will:
- Ensure that specialties carry out their responsibilities regarding statutory mortality reviews.
- Ensure that specialties feedback the learning from specialty morbidity and mortality meetings to MROG to facilitate dissemination of learning.

5.8. Specialty Governance Leads

- Provide the clinical leadership to ensure mortality reviews are carried out by a clinician that is independent from the care that was given to a patient.
- Ensure that regular specialty morbidity and mortality meetings are held, keeping a summary of the cases discussed, the findings and the agreed action plan.
- Receive (and provide) feedback and learning points from/to MROG and ensure learning outcomes and action points are included in the specialty governance audit plans as appropriate.
- Share outcomes within the specialty and at Care Group governance meetings.

5.9. Clinical Effectiveness (Head of, supported by the Team)

- Support MROG, clinicians undertaking SJRs, the Trust Clinical Mortality Lead and the Chief Medical Officer to discharge their respective responsibilities as outlined in this Policy.

6. Standards and Practice

The Trust requirement is to be compliant with the National Guidance on Learning from Deaths[2] and the National Medical Examiner System[3].

The standard expected is described in the schematic (see Appendix), including:

- Following the Trust agreed process for every diagnostic-based mortality alert.
- To ensure all requests for SJRs that are relating to Priority Deaths are carried out in a timely manner.
- To have an agreed schedule for the reporting to and from specialties regarding the governance of specialty-based Learning from Deaths.

7. Dissemination and Implementation

7.1. This policy document will be approved by the Trust Board, and all Specialty Governance Leads will be informed that the document has been updated and available to view on the Documents Library. The policy will be held in the public section of the Documents Library with unrestricted access, replacing the previous version, which will be archived in accordance with the Trust Information Lifecycle and Corporate Records Management Policy.

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[2] https://www.england.nhs.uk/wp-content/uploads/2017/03/nqb-national-guidance-learning-from-deaths.pdf National Guidance on Learning from Deaths, National Quality Board, March 2017.

- [3] The national medical examiner system, April 2019, **https://improvement.nhs.uk/resources/establishing-medical-examiner-system-nhs/**

7.2. The Clinical Effectiveness Team will co-ordinate the processes covered by this policy, on behalf of the Trust Lead for Mortality Review and the Deputy Chief Medical Officer (Chair of MROG) and will ensure that all those involved in the process are aware of their responsibilities and the requirements of the policy.

7.3. A summary of the results will be published on the Trust's web site

8. Monitoring compliance and effectiveness

Information Category	Detail of process and methodology for monitoring compliance
Element to be monitored	Detail of process and methodology for monitoring compliance
Lead	Priority deaths that require an SJR - Board reporting
Tool	Trust Clinical Lead for Mortality
Frequency	Priority Deaths Tracker - Trust Clinical Lead for Mortality
Reporting arrangements	Monthly (MROG) – Quarterly (QAC and Trust Board)
Acting on recommendations and Lead(s)	MROG (assurance then provided to the Clinical Effectiveness Group). Trust Board (sourced via MROG-CEG-QAC)
Change in practice and lessons to be shared	Actions arising from the reviews will be identified and monitored by the MROG led by the Trust Mortality Lead and the Deputy Chief Medical Officer (Chair of MROG).

9. Updating and Review

9.1. This policy document will be reviewed no less than every three years, or more frequently following any significant process changes or national policy instruction (NHS England or Department of Health).

9.2. Consultation, approval, and dissemination of subsequent revisions will follow the guidance set out in the Trust organisation-wide Policy for the Development and Management of Knowledge and Procedural Documents (The Policy on Policies).

9.3. All revision activity is recorded in the Version Control Table in the Appendices of this document as part of the document control process.

10. Equality and Diversity

10.1. This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement which can be found in the Equality Diversity And Inclusion Policy or the Equality and Diversity website.

10.2. Equality Impact Assessment

The Initial Equality Impact Assessment Screening Form is at Appendix 2.

Appendix 1. Governance Information

Information Category	Detailed Information
Document Title:	Learning from Deaths Policy V11.0
This document replaces (exact title of previous version):	Learning from Deaths Policy V10.0
Date Issued / Approved:	April 2023
Date Valid From:	May 2023
Date Valid To:	May 2026
Author / Owner:	Richard Johnson Head of Clinical Effectiveness
Contact details:	01872 25 2279
Brief summary of contents:	This policy confirms the process that has been developed to ensure a process consistent with the recommendations of the National Guidance for Learning from Deaths
Suggested Keywords:	Mortality, Learning from Deaths
Target Audience:	**RCHT:** Yes **CFT:** No **CIOS ICB:** No
Executive Director responsible for Policy:	Chief Medical Officer
Approval route for consultation and ratification:	Signed off at: Mortality Review Oversight Group (MROG) February 2023 Clinical Effectiveness Group (CEG) April 2023 Quality Assurance Group (QAC) April 2023
Manager confirming approval processes:	Head of Clinical Effectiveness
Name of Governance Lead confirming consultation and ratification:	Head of Clinical Effectiveness
Links to key external standards:	CQC Regulation 17 ‘Good Governance’

Information Category	Detailed Information
Related Documents:	None
Training Need Identified:	No
Publication Location (refer to Policy on Policies – Approvals and Ratification):	Internet and Intranet
Document Library Folder/Sub Folder:	Clinical / Patient Safety and Clinical Effectiveness

Version Control Table

Date	Version Number	Summary of Changes	Changes Made by
12 Mar 2016	V7	Changes to reflect new processes for mortality review	Lydia Harris, Clinical Effectiveness Facilitator Mandy Gorton, Clinical Effectiveness Co-Ordinator
09 Sept 2017	V8	Changes to reflect the recommendations of the National Guidance for Learning form Deaths	Dr Paul Johnston Mortality Lead Dr Frances Keane, Deputy Chief Medical Officer
28 Nov 2018	V9	Changes to reflect new local processes	Kelly Perrin, Clinical Effectiveness Coordinator
10 Apr 2019	V9.2	Changes to reflect RCHT reorganisation and changes in Paediatric mortality review policy	Richard Johnson, Head of Clinical Effectiveness
01 May 2019	V9.3	Minor change following feedback from Director of Integrated Governance	Richard Johnson, Head of Clinical Effectiveness
30 Apr 2020	V10.0	Significant change – introduction of Medical Examiner role – plus other minor updates reflecting changed structures at the RCHT.	Richard Johnson, Head of Clinical Effectiveness
26 April 2023	V11.0	Revised as required by Trust Standing Orders (3 year anniversary of last version).	Richard Johnson, Head of Clinical Effectiveness

All or part of this document can be released under the Freedom of Information Act 2000

All Policies, Strategies and Operating Procedures, including Business Plans, are to be kept for the lifetime of the organisation plus 6 years.

This document is only valid on the day of printing.

Controlled Document

This document has been created following the Royal Cornwall Hospitals NHS Trust The Policy on Policies (Development and Management of Knowledge Procedural and Web Documents Policy). It should not be altered in any way without the express permission of the author or their Line Manager.

Appendix 2. Equality Impact Assessment

Section 1: Equality Impact Assessment (EIA) Form

The EIA process allows the Trust to identify where a policy or service may have a negative impact on an individual or particular group of people.

For guidance please refer to the Equality Impact Assessment Policy (available from the document library) or contact the Equality, Diversity, and Inclusion Team rcht.inclusion@nhs.net

Information Category	Detailed Information
Name of the strategy / policy / proposal / service function to be assessed:	Learning from Deaths Policy V11.0
Department and Service Area:	Clinical Governance
Is this a new or existing document?	Existing
Name of individual completing EIA (Should be completed by an individual with a good understanding of the Service/Policy):	Richard Johnson, Head of Clinical Effectiveness
Contact details:	01872 25 2279

Information Category	Detailed Information
1. Policy Aim - Who is the Policy aimed at? (The Policy is the Strategy, Policy, Proposal or Service Change to be assessed)	This policy ensures that Royal Cornwall Hospitals Trust (RCHT) will implement the requirements outlined in the Learning from Deaths framework as part of the organisation's existing procedures to learn and continually improve the quality of care provided to all patients.
2. Policy Objectives	As part of its commitment to providing the best possible quality of patient care, and in line with Trust Strategy, this policy sets out how the organisation monitors patients' deaths, picking up any aspect or themes of care that might be a concern and responding to this appropriately.
3. Policy Intended Outcomes	To provide assurance to Trust Board on on-going compliance with national legislation and mandatory requirements and ensure that any learning that results from the Learning from Deaths programme is shared appropriately with Trust staff.
4. How will you measure each outcome?	Specialty Participation Rates are monitored and analysed to ensure that all specialties are following the Learning from Deaths programme in line with national guidance.

Information Category	Detailed Information
5. Who is intended to benefit from the policy?	Learning from the care delivered prior to death (both historical and recent) enables the Trust to improve future care for patients, families and carers. Staff will also benefit as identification of unsatisfactory care prior to death can lead to improvements that provide staff with greater clarity on the best course of action for future patients.
6a. Who did you consult with? (Please select Yes or No for each category)	• Workforce: Yes • Patients/ visitors: No • Local groups/ system partners: No • External organisations: No • Other: No
6b. Please list the individuals/groups who have been consulted about this policy.	**Please record specific names of individuals/ groups:** Mortality Review Oversight Group.
6c. What was the outcome of the consultation?	Comments received, then approved.
6d. Have you used any of the following to assist your assessment?	**National or local statistics, audits, activity reports, process maps, complaints, staff or patient surveys:** No.

7. The Impact
Following consultation with key groups, has a negative impact been identified for any protected characteristic? Please note that a rationale is required for each one.

Where a negative impact is identified without rationale, the key groups will need to be consulted again.

Protected Characteristic	(Yes or No)	Rationale
Age	No	
Sex (male or female)	No	
Gender reassignment (Transgender, non-binary, gender fluid etc.)	No	
Race	No	
Disability (e.g. physical or cognitive impairment, mental health, long term conditions etc.)	No	As set out in national guidance

Protected Characteristic	(Yes or No)	Rationale
Religion or belief	No	
Marriage and civil partnership	No	
Pregnancy and maternity	No	
Sexual orientation (e.g. gay, straight, bisexual, lesbian etc.)	No	

A robust rationale must be in place for all protected characteristics. If a negative impact has been identified, please complete section 2. If no negative impact has been identified and if this is not a major service change, you can end the assessment here.

I am confident that section 2 of this EIA does not need completing as there are no highlighted risks of negative impact occurring because of this policy.

Name of person confirming result of initial impact assessment: Richard Johnson, Head of Clinical Effectiveness.

If a negative impact has been identified above OR this is a major service change, you will need to complete section 2 of the EIA form available here:
Section 2. Full Equality Analysis

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Appendix 3. Learning from Deaths Policy – Process schematic