NHS
Milton Keynes University Hospital
NHS Foundation Trust

Learning from Deaths Policy

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Policy to be followed by (target staff):
To be read in conjunction with the following documents:
CQC Fundamental standards: Regulation 9 – person centred care Regulation 10 – dignity and respect Regulation 11 – Need for consent Regulation 12 – Safe care and treatment Regulation 13 – Safeguarding service users from abuse and improper treatment Regulation 14 – Meeting nutritional and hydration needs Regulation 15 – Premises and equipment Regulation 16 – Receiving and acting on complaints Regulation 17 – Good governance Regulation 18 – Staffing Regulation 19 – Fit and proper

Disclaimer

All information is provided in this document on the basis that the healthcare professionals responsible for patient care will retain full and sole responsibility for decisions relating to patient care; the document is intended to supplement, not substitute for, the expertise and judgment of physicians, pharmacists or other healthcare professionals and should not be taken as an indication of suitability of a particular treatment for a particular individual.

The ultimate responsibility for the use of the policy and correct following of instructions as well as the interpretation of the published material **lies solely with you** as the medical practitioner.

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Abbreviations

AMD – Associate Medical Director
CDOP – Child death Overview Panels
CIG – Clinical Improvement Group
CQC – Care Quality Commission
CSU – Clinical Service Unit
EqIA – Equality Impact Assessment
HSMR – Hospital Standardised Mortality Ratio
ICB- Integrated Care Board
LeDeR – Learning Disability Mortality Review Programme (LeDeR)
M&M – Morbidity and Mortality
MEO – Medical Examiners' Office
MRG – Mortality Review Group
NCEPOD – National Confidential Enquiries into Patient Outcomes and Death
OPCS – Operations and Procedures Classification in Surgery
PALS – Patient Advice and Liaison Service
PSB – Patient Safety Board
PSIRF – The Patient Safety Incident Response Framework
QCRC – Quality and Clinical Risk Committee
RCP – Royal College of Physicians
SHMI – Summary Hospital-level Mortality Indicator.
SJR – Structured Judgement Review

1. Introduction

The National Guidance on Learning from Deaths (March 2017) has driven a national endeavour to improve and further strengthen systems of mortality case review with emphasis on learning. At Milton Keynes University Hospital NHS Trust, this has involved the strengthening of governance processes, skills and training in case review, with defined data collection and reporting to board level.

Learning from deaths begins with a quantitative review of Trust mortality statistics undertaken monthly, with quarterly reports to the Trust Board. Hospital Episode Statistics data are processed and displayed as mortality indices such as Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital-level Mortality Indicator (SHMI). These are compared to national peer values to indicate variation from expected outcomes. Alerts are raised in diagnostic groups which lie outside 2 standard deviations of median values. These can be used to focus mortality review and quality improvement in specific areas.

While risk-adjusted mortality statistics provide a quantitative overview of mortality in an organisation, they do not accurately reflect quality of care. Case note review is an important method to identify area where care may be improved or learned from. It is essential that problems of care are identified, and actions taken to prevent recurrences, and that families are well supported in the process.

Within Milton Keynes University Hospital NHS Trust, all deaths are reviewed by the Medical Examiner Body. Trust-wide case note review, mortality monitoring and the management of mortality alerts are undertaken by the Mortality Review Group (MRG). Medical examiners provide objective scrutiny on all deaths at MKUH. Any deaths within the mortality alerts identified through routine monitoring of published statistics and local benchmarking are reviewed though the Structured Judgement Review system and are also taken to the MRG where required actions are identified. The role of the MRG is to establish if there are any factors that may have contributed to individual deaths or an increase in mortality within a specific area. The remit of the MRG is to identify areas where there may be an underlying problem that affects patient care, and to help pinpoint shortfalls in the management or care of patients via escalation of concerns to the risk team. In such cases a Patient Safety investigation is considered.

This policy describes the specific processes in the Trust to fully comply with the Learning from Deaths framework and is additional to and complements local service mortality monitoring processes and other work undertaken by the MRG. It is anticipated that by adherence to the policy we will help achieve greater understanding of factors contributing to death, increased collaboration with the care groups, a greater degree of reflection on cases that have not proceeded according to plan, and better timely escalation of concerns to the risk and other teams. The policy will also support the identification of points of learning and help support families with questions or concerns following death.

2. Status

This document is part of the Milton Keynes University Hospital policies and is applicable to all staff.

The Learning from Deaths Policy describes the process by which all care deaths are identified, reported and investigated. The purpose of reviews and investigations of deaths which problems in care might have contributed to is to learn to prevent recurrence.

This policy outlines processes necessary to support the aims and ambitions of the Learning from Deaths framework (March 2017) and shows how the Trust responds to, and learns from, deaths of patients under its management and care.

3. Definitions

The *National Guidance on Learning from Deaths* includes a number of terms, defined below.

Alert Data indicates that outcomes are significantly different to expected and therefore investigation is required to determine the cause of this difference.

Diagnosis group Each diagnosis group is made up of one or more ICD10 diagnosis codes. (ICD-10 Version:2019, 2019) A patient's diagnosis group is assigned from the primary diagnosis, usually from the first two Finished Consultant Episodes within a single hospital admission.

Procedure group Each procedure group is made up of one or more Operations and Procedures Classification in Surgery (OPCS) procedure codes. A patient's procedure group is assigned from the dominant procedure in the patient's spell of care.

Hospital standardised mortality ratio (HSMR) The ratio of the observed number of inpatient deaths to the expected number of inpatient deaths, for conditions accounting for approximately 80% of inpatient mortality.

Summary Hospital Mortality Indicator (SHMI) The Summary Hospital Mortality Indicator is the ratio between the observed number of patients who die following hospitalisation at the Trust and the number that would be expected to die based on average England figures, given the characteristics of the patients treated there. The SHMI includes deaths which occurred in hospital or within 30 days of discharge. If the patient is treated by another trust within 30 days of discharge, their death is attributed to the last non-specialist acute trust to treat them. The figures are calculated using administrative data supplied by trusts, Hospital Episode Statistics (HES) data linked to Office for National Statistics death registrations data. A three-year dataset is used to create the risk-adjusted models and a one-year dataset to score the SHMI and calculate the contextual indicators presented alongside.

The expected number of deaths is calculated from statistical models derived to estimate the risk of mortality based on the characteristics of the patients and adjusts for the mix of patients in terms of case-mix, age, gender, method and month

of admission, year index, Charlson Comorbidity Index and diagnosis grouping. Actual deaths can then be expressed as a percentage of 'expected', case mix, and to provide a result that is easy to understand: A score higher than 100 per cent suggests more deaths than expected.

Structured Judgement Review (SJR) A standardised approach to clinical judgement-based case record review. The categories of death for which the Trust undertake an SJR are outlined in Section 8.

Learning Disability Mortality Review Programme (LeDeR) Aims to make improvements to the lives of people with learning disabilities. It clarifies any potentially modifiable factors associated with a person's death and works to ensure that these are not repeated elsewhere.

Death certification. The process of certifying, recording and registering death, the causes of death and any concerns about the care provided. This process includes identifying deaths for referral to the coroner.

Medical Examiners Medical examiners are senior doctors contracted for a number of sessions per week to undertake medical examiner duties, outside their usual clinical duties. They are trained in the legal and clinical elements of death certification. They work in this role as independent practitioners, rather than trust employees.

Case record review A structured desktop review of a case record/note, carried out by clinicians and other professionals directly involved in patient's care pathway, to determine whether there were any problems in the care provided to a patient. Case record review is undertaken routinely to learn and improve in the absence of any concerns about care. This is because it can help find problems where there is no initial suggestion anything has gone wrong. It can also be done where concerns exist, such as when bereaved families or staff raise concerns about care.

Mortality review A systematic exercise to review a series of individual case records using a structured or semi-structured methodology to identify any problems in care and to draw learning or conclusions to inform any further action that is needed to improve care within a setting or for a particular group of patients.

Patient Safety Incident Patient Safety Incidents in healthcare are adverse events occurring during the delivery of healthcare. These include acts or omissions in care that result in unexpected or avoidable death, unexpected or avoidable injury resulting in serious harm – including those where the injury required treatment to prevent death or serious harm – abuse, Never Events, incidents that prevent (or threaten to prevent) an organisation's ability to continue to deliver an acceptable quality of healthcare services, and incidents that cause widespread public concern resulting in a loss of confidence in healthcare services. Investigation of these incidents should focus on learning from these incidents rather than apportioning blame or focussing purely on patient harm. The Patient Safety Incident Response Framework (PSIRF), which includes incident investigation as part of a multi-pronged approach to improving

safety in healthcare settings has replaced the Serious Incident Framework for responding to patient incidents.

Investigation A systematic analysis of what happened, how it happened and why, usually following an adverse event when significant concerns exist about the care provided. Investigations draw on evidence, including physical evidence, witness accounts, organisational policies, procedures, guidance, good practice, and observation, to identify problems in care or service delivery that preceded an incident and to understand how and why those problems occurred. The process aims to identify what may need to change in service provision or care delivery to reduce the risk of similar events in the future. Investigation can be triggered by, and follows, case record review, or may be initiated without a case record review happening first.

Death due to a problem in care A death that has been clinically assessed using a recognised method of case record review, where the reviewers feel that the death is more likely than not to have resulted from problems in care delivery/service provision. (Note, this is not a legal term and is not the same as cause of death'). The term 'avoidable mortality' should not be used, as this has a specific meaning in public health that is distinct from 'death due to problems in care'.

Death Classification:
Score 1 Definitely avoidable
Score 2 Strong evidence of avoidability
Score 3 Probably avoidable (more than 50:50)
Score 4 Possibly avoidable but not very likely (less than 50:50)
Score 5 Slight evidence of avoidability
Score 6 Definitely not avoidable

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.

Patient safety incident A patient safety incident is any unintended or unexpected incident which could have led or led to harm for one or more patients receiving NHS care.

4. Purpose
Milton Keynes Hospital 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.

This policy sets out the procedures for identifying, recording, reviewing and investigating the deaths of people in the care of Milton Keynes Hospital.
It describes how Milton Keynes Hospital will support people who have been bereaved by a death at the Trust, and how those people should expect to be informed about and involved in any further action taken to review and/or investigate the death. It also describes how the Trust supports staff who may be affected by the death of someone in the Trust's care.

It sets out how the Trust will seek to learn from the care provided to patients who die, as part of its work to continually improve the quality of care it provides to all its patients.

This policy should be read in line with:

- Milton Keynes University Hospital NHS Foundation Trust (2023) Being Open (Duty of Candour), RM/GL/19, Version 5 [Accessed 09 October 2024]

- Milton Keynes University Hospital NHS Foundation Trust (2018) Bereavement Policy (including after death care), NURS/GL/29, Version 3 [Accessed 09 October 2024]

- Milton Keynes University Hospital NHS Foundation Trust (2021) Complaints and Pals Policy,
- ORG/GL/14, Version 9 [Accessed 09 October 2024]

- Milton Keynes University Hospital NHS Foundation Trust (2024) Incident Reporting Policy and Procedure, RM/GL/17, Version 9.3 [Accessed 09 October 2024]

- Milton Keynes University Hospital NHS Foundation Trust (2024) Managing the Death of a Child, PAED/GL/21, Version 6.2 [Accessed 09 October 2024]

- Milton Keynes University Hospital NHS Foundation Trust (2023) Patient Safety Incident Response Plan, October 2023-March 2025, Version 1 [Accessed 09 October 2024]

- Perinatal Mortality Review Tool [Online]. Available from: https://www.npeu.ox.ac.uk/pmrt
- [Accessed 09 October 2024]

- Milton Keynes University Hospital NHS Foundation Trust (2021) Risk Management Framework, RM/GL/11, Version 9.2 [Accessed 09 October 2024]

- Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (2023) Saving Lives, Improving Mothers' Care 2023 - Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2019-21 [Online]. Available from: https://www.npeu.ox.ac.uk/assets/downloads/mbrrace-uk/reports/maternal-report-2023/MBRRACE-UK_Maternal_Compiled_Report_2023.pdf

5. New requirements

There is a national requirement to collect data on deaths as set out in the National Medical Examiners guidance for England and Wales – Quarterly Data Submission Requirements[i]
Collect specific information every quarter on:

- the total number of inpatient deaths in an organisation's care
- the number of deaths the Trust has subjected to case record review (desktop review of case notes using a structured method) (NB: information relating to deaths reviewed using different methodologies – for example, inpatient adult deaths, child deaths, deaths of patient with learning disabilities – may be separated in the report to provide distinction/clarity where required)
- of those deaths subject to case record review or investigated, estimates of how many deaths were more likely than not to be due to problems in care
- the themes and issues identified from review and investigation, including examples of good practice
- how the findings from reviews and investigations have been used to inform and support quality improvement activity and any other actions taken, and progress in implementation.
- Publish this information quarterly from December 2017 by taking a paper to public board meetings.

6. Roles 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 Serious Incident management, other processes are detailed in relevant policies mentioned above.

Role	Responsibilities
Chief executive	This individual has overall responsibility and final accountability for ensuring that the Trust has appropriate mortality review procedures in place; and that the Trust works to best practice as defined by relevant regulatory bodies.
Medical director	This individual is the executive lead with a key role in ensuring learning from problems of healthcare identified through reviewing or investigating deaths. They are responsible for ensuring the organisation has robust processes with focus on learning by providing challenge and support. They are responsible for ensuring quality improvement is at the centre of these processes and that the Trust publishes a fair and accurate reflection of achievements and challenges.
Patient Safety Team	The Patient Safety Team is responsible for discussing and documenting investigations directed because of concerns raised by case note review. Case note review processes are aligned to other Trust risk management processes including Patient Safety Incident declaration processes. There is a need to ensure all adverse incidents identified are recorded on RADAR and all moderate and severe harm incidents following Duty of Candour expectations. These individuals are responsible for monitoring raw mortality and case note review data and provides operational support

	with mortality governance processes from case identification to review, identification of learning, and dissemination of outcomes to individuals, teams and trust wide.
Learning disability lead	This individual is responsible for using the LeDeR review process and submitting all deaths with Learning disabilities online. All Learning Disability Deaths must have an SJR. The learning from these cases must be presented to monthly MRG meetings.
Mortality Review Group	The Mortality Review Group (MRG) reports directly to Patient Safety Board, and is responsible for coordinating reviews of deaths, and mortality signals, and escalating concerns about potentially avoidable deaths directly to the risk team for urgent clinical review and possibly safety incident investigation. The MRG support clinical teams in their local mortality governance processes to strengthen learning, and support directly the bereavement office in ensuring timely and accurate death certification, Coroner's referral and support of families where necessary. The clinical team, with bereavement services, are primarily responsible for supporting relatives at this time. All incidents identified as moderate severity or above are bound by Duty of Candour processes.
Medical Examiner Team	These individuals provide greater safeguards for the public by ensuring proper scrutiny of all non-coronial deaths. They ensure the appropriate direction of deaths to the coroner and provide a better service for the bereaved and an opportunity for them to raise any concerns to a doctor not involved in the care of the deceased. They improve the quality of death certification and improve the quality of mortality data.
Associate Medical Director (Mortality)	Chairs the MRG and is responsible for co-ordinating case note review and collating learning in keeping with the Learning from Deaths framework and expectations. The AMD is responsible for identifying areas for learning and actions and escalates clinical concerns to the teams involved and to the risk processes of the Trust. This individual will monitor and ensure notification of deaths to the national learning disability mortality review programme. The AMD will notify the service and risk team of concerns raised by families to promote better support and timely investigation /explanation. Is responsible for statutory reporting in line with national policy including annual Quality Account

* The board is required to ensure that its organisation has a board-level leader acting as patient safety director to take responsibility for the learning from deaths agenda. This section should specify which post-holder has this remit.

Committee	Responsibilities
Trust board	The *National Guidance on Learning from Deaths* places particular responsibilities on boards, as well as reminding them of their existing duties. Organisations must refer to Annex A of the *National Guidance on Learning from Deaths*
Mortality Review Group	Mortality Review Group monitors and reviews information associated with the wider remit of mortalities and monitors departmental reports and data in respect to mortality.
Patient Safety Board	Receives escalation report from MRG and provides oversight and scrutiny, acts as a dissemination point for any learning and /or recommends additional work streams. This board feeds up to Management Board/ Clinical Quality Board
Patient Safety Incident Review Group	Review of all patient safety incidents relating to mortality & morbidity to help identify learning.

7. The process for recording deaths in care

MKUH has access to Hospital Episode Statistics (HES) data and the Spine. NHS Digital is available within the organisation. These should be effective systems for capturing robust data on patient deaths.

All deaths recorded on bespoke database. The Trust has purchased a Mortality Platform which will align and allow for centralised collection of data.
- The process for recording deaths notified to the Trust from other sources (for example, other care providers, coroners, families, etc.).
- The process for informing the coroner including at time of death and when this is a late report following a review which has identified possible problems in care.

All investigations are logged on to the mortality database with a unique reference number. All reviews associated with the investigation are tagged to this reference number. The MRG receives service level mortality reviews and summaries of mortality meetings and uses these data to develop greater understanding of quality and outcomes across the organisation. Issues identified by case note review are fed directly to the service governance lead for inclusion in their mortality reviews and discussions. Service level reviews shared with or available to MRG are logged on the mortality database with the unique identifier and collated alongside independent review.

8. Selecting deaths for investigation or case record review

To gain oversight of Trust care processes Medical Examiners carry out independent case note review of all deaths. This is in addition to, and feeds into, service lead mortality monitoring processes. All deaths are identified by the Medical Examiners' Office and confirmed by Information team data.

The Trust undertakes full case record Structured Judgement Review of the following categories of deaths:

- All deaths where bereaved families and carers, or staff, have raised a concern about the quality-of-care provision;
- All in-patient and community deaths of those with learning disabilities and current mental health diagnose
- All deaths in a specialty, diagnosis or procedure group where an 'alert' has been identified, either internally or externally. Internal alerts may be generated through local analysis of risk-adjusted mortality data such as the SHMI or HSMR, or through other internal governance processes such as national clinical audits, or analysis of incidents/risk, complaints and inquest data. External alerts may be received from the Care Quality Commission, national clinical audit projects, the Dr Foster Unit at Imperial or other stakeholders/regulators.
- All surgical deaths.
- All deaths in areas where people are not expected to die, for example in all patients following elective admission.
- Deaths where learning may inform the Trust's existing or planned improvement work.
- A further sample of other deaths that do not fit the identified categories, so that providers can take an overview of where learning and improvement is needed most overall.

In addition, as described in the national requirements, stillbirth or neonatal deaths are reviewed using the Perinatal Mortality Review Tool.

The Trust will respond to requests from other organisations to review the care provided to people who are its current or past patients but who were not under its direct care at time of death through investigation system under the Serious Incident Review Group. The Trust will collaborate with others to carry out reviews and investigations when a person has received care from several health and care providers.

The Trust ensures the deceased's relatives or carers are asked whether they have any significant concerns with the care provided by the Trust (this will then trigger a review or investigation). The information from Mortality Review Group will be used to inform where case record review should take place (for example, if work is planned to improve sepsis care, relevant deaths should be reviewed, as determined by the provider).

9. Review methodology & reviewing outputs from review and investigation to inform quality improvement

Case record review is a method used to determine whether there were any problems in the care provided to a patient within a particular service. It is undertaken routinely to learn and improve in the absence of any concerns about care. This is because it can help identify problems where there is no initial suggestion anything has gone wrong. It can also be done where concerns exist, such as when bereaved families/carers or staff raise concerns about care.

Medical examiner offices at acute trusts will be staffed by a team of medical examiners, supported by the Bereavement team. The role of these offices is to examine deaths to:

- agree the proposed cause of death and the overall accuracy of the medical certificate cause of death.
- discuss the cause of death with the next of kin/informant and establish whether they have any concerns with care that could have impacted/led to death
- act as a medical advice resource for the local coroner.
- inform the selection of cases for further review under local mortality arrangements and contribute to other clinical governance procedures.

Medical examiners will follow good practice guidelines as set out by the National Medical Examiner.

The Trust has adopted the Royal College of Physicians (RCP) SJR for case record review of the categories of deaths defined above. A number of fields have been added to the form to gather local intelligence and context to support the effective identification and sharing of learning.

For patients with a learning disability, in addition to completing an SJR locally, all eligible deaths of patients, over 4 years of age, are reported to the national Learning Disability Mortality Review Programme (LeDeR). The LeDeR review process is managed by the Integrated Care Board (ICB) and appropriately trained staff from MKUH are required to lead or participate in mortality reviews as requested by the ICB. MKUH has a named clinical lead for this process and is fully engaged with the local steering group.

The MRG receives service level mortality reviews and summaries of mortality meetings and uses this data to develop greater understanding of quality and outcomes across the organisation. Issues identified by case note review are fed directly to the service governance lead for inclusion in their mortality reviews and discussions.

Phases of Process	Mechanism	Commentary
Identification of Deaths	Bereavement Office Daily Report Information Team	These reports enable 'real time' identification of all inpatient deaths. Daily review of cases identified.
Death Certification and Referral to Coroner	Medical Examiner Team and daily support of bereavement services.	A trained senior doctor from the medical examiner team attends and performs case note review in the bereavement office each working day. They support Bereavement Services staff in ensuring timely and accurate Death Certificate completion and advise clinicians where there is uncertainty. All Coroners' referrals are now emailed and placed in the clinical record. The case reviewers may inform clinical teams about the need to refer to the coroner's services. The Bereavement Office database records all Coroners' referrals.
Case note review	Daily case note review by trained senior doctors from Medical Examiner Group	Case note review occurs in the Bereavement Office within 48-72 working hours of death where notes are available. All deaths undergo review by the Medical Examiner System. The system will offer a point of contact for bereaved families or clinical teams to raise concerns about care prior to the death. Concerns may also be raised by the Medical Examiner following medical record review. Deaths with concerns will undergo a formal Structured Judgement Review. Notes review is undertaken, and outcomes recorded on an electronic 2-page review proforma for all deaths. A case with concern is escalated for SJR2 review. SJRs should be completed within a 90-day period. A judgement about avoidability is made on SJRs. Although such a judgement is known to be highly subjective it is used as a start of conversations to aid escalation and clinical improvements where necessary. This process identifies specific patients where records require further scrutiny by other processes e.g. vulnerable patients including those with learning disability (notification to National LeDeR process),

		current mental health diagnoses, children and young people (Child death overview panel and developing National Child Mortality Programme). (National Child Mortality Database, No date)
Support of families	Bereavement services and clinical teams	The Medical Examiners' Office provides support to all bereaved families. If the MEO identify families in need of additional information and support, they can be referred to the clinical team and Trust wide governance processes or PALS to provide families necessary support and information.
Data storage	Keypoint database	The case reviews are held on a secure database enabling easy further review of cases. It also enables calculation of numbers reviewed, numbers of patients with learning disability, and other specific patient groups. A further database collates case note review information from local M&M meetings, or other local review sources.
Mechanism of information sharing	Via reviewer and MRG Chair	All concerns about significant issues of care are documented and reported back to the service to review and consider in their M&M meetings.
Escalation of concerns if significant care issues identified or death considered potentially avoidable.	Referral immediately to risk team for consideration, including safety incident investigation. Triangulation of RADAR adverse incident reports and learning. Triangulation with complaints process.	There is immediate escalation to the risk team of significant care issues identified, or potential avoidable factors. All deaths where first review suggests potential avoidable factors are referred to the risk team so they can be appropriately reviewed and investigated. All incidents that meet moderate or severe criteria are bound by Duty of Candour policy that involves appropriate openness and support of families affected.
Identification and escalation of deaths in vulnerable patients	Children, patients with learning disabilities, and those with mental health diagnoses are identified by this case note review process	All deaths in patients with learning disability are referred to the National Learning Disability Mortality Review Programme (NHS LeDeR - Learning from lives and deaths). All child deaths are referred to child death overview panels (CDOP) panel by clinical teams. Direct and early case note review is essential for this as such patients may not be identified by clinical coding alone.

		Patients with mental health diagnoses are identified and care scrutinised. Cases where there are potential issues of care outside MKUH will be discussed with the risk team, and concerns discussed with the relevant provider to promote cross-sector learning. The Learning from Deaths Framework acknowledges that in the future national processes need to be strengthened in this area once basic processes are more consistent across the UK.
Deaths following elective admission	Service-level information from deaths following elective admission is reviewed case by case at MRG	The named M&M Lead is contacted with a request to complete an SJR. The case is presented at the next M&M meeting for discussion. Any queries arising from the discussion are addressed to the care group and any lessons learned are shared as appropriate.
Collation of findings and learning	Information and learning from reviews are returned to the clinical teams Information collated in MRG and learning identified Learning from adverse or serious incident reports is collated and disseminated through current Trust and Divisional processes along with action plans.	The MRG will develop a quarterly trust-wide report summarising the main learning points identified. This is addition to learning identified and published currently from risk management and governance teams Dissemination of learning from SJRs and Mortality Screening will be via Specialty and Joint Specialty M&M meetings and Trust wide through clinical improvement groups (CIG) meetings. Learning from M&M meetings is shared via M&M feedback forms with the Patient Safety Team and shared with other departments.
Reporting and quality improvement	MRG reports to Patient Safety and Quality Board (PSB), the Quality and Clinical Risk Committee (QCRC), and provides	These modes of reporting enable the outputs of this work to contribute to local, or trust-wide improvement activity, and be triangulated with other intelligence. The MRG will publish the mortality data as suggested in the draft template published in 'Learning from Deaths'

	quarterly reports to the public board. MRG is also invited to the Clinical Quality Review Meeting to report progress to commissioning colleagues regularly. The Trust is required to summarise learning and actions in the annual quality report.	including the provisional 'avoidable deaths data' for all deaths that have a case note review where a judgement is made. This will include cases who have a full SJR completed and those where case note review is documented on the abridged proforma. This will be included in the Board report alongside summaries of issues identified and learning.
Monitoring of Actions	Actions are determined at local- and trust wide level.	The monitoring of actions and outcomes occurs at several levels from care group to the Board. The Divisions are responsible for developing and monitoring plans and actions.

Patient group	Methodology
Adult inpatient	Medical Examiner review, discussion at Departmental Morbidity and Mortality meetings and Structured Judgement Review
Mental health	Trusts can use a modified SJR or another relevant method to review the care of those with severe mental illness. NHS England, NHS Improvement and the Royal College of Psychiatrists are developing a standardised methodology for case record review of the care of those who die with severe mental illness
Child (under 18)	Reviews of these deaths are mandatory and should be undertaken in accordance with *Working together to safeguard children* (2015) and the current Child Death Overview Panel Processes (CDOP). NHS England is leading work to update the latter
Learning disability	Trusts must have systems to flag patients with learning disabilities. All trusts should adopt the LeDeR method to review the care of individuals with learning disabilities, once it is available in their area. It is also strongly recommended that trusts conduct an initial case note review of all deaths of people with learning disabilities using structured judgement review or another robust and evidence-based methodology.
Perinatal and maternity	All perinatal deaths are reviewed using the new perinatal mortality review tool[1] . Maternal deaths and many perinatal deaths are very likely to meet the definition of a Patient Safety Incident and should be investigated accordingly

10. Bereavement Support

The Medical Examiners Officers ensure that bereaved relatives are made aware of the appropriate steps to take if they have outstanding questions about the care and treatment of relatives.

The Trusts bereavement literature has been updated to ensure that families are signposted to the Patient Advice and Liaison Service (PALS) in the first instance. The PALS team can provide confidential advice, information and support for relatives who contact them. They are best placed to resolve local queries and outstanding issues regarding care and treatment of loved ones. If those queries and concerns cannot be resolved they will provide advice and support in the next steps available to the family, including referral for Structured Judgement Review, and / or the formal complaints procedure if appropriate.

Bereaved families and carers should be asked if they had concerns about the quality of care received by the deceased to inform decisions about the need to undertake a case record review or investigation.

Where families have raised significant concerns a structured judgement review will be undertaken. This will run concurrently to any other investigations that are required because of the concerns raised (e.g. formal complaint or Patient Safety Incident investigation).

Reviews

If the care of a patient who has died is selected for Structured Judgement Review the Trust will:

- Ensure that the views of the family and carers have been considered. The trust will review cases where family and carers have raised a significant concern about the quality-of-care provision

- Communicate to the family and carers the findings of the review if any problems with care are identified and any lessons the review has contributed for the future.

Investigations

- Where the Trust feels that a structured judgement review is needed, early contact will be made with bereaved families and carers so that their views help to inform the decision and remit of the review.

- Provided the family or carer is willing to be engaged with the investigation, an early meeting should be held to explain the process, how they can be informed of progress, what support processes have been put in place and what they can expect from the investigation. This should set out realistic timescales and outcomes. There should be a named person as a consistent link for the families and carers throughout the investigation.

Bereaved families and carers should:

- Be made aware, in person and in writing, as soon as possible of the purpose, rationale and process of the investigation to be held

- Be asked for their preferences as to how and when they contribute to the process of the investigation and be kept fully and regularly informed in a way that they have agreed on the progress of the investigation

- Have an opportunity to be involved in setting any terms of reference for the investigation which describe what will be included in the process and be given expectations about the timescales for the investigation including the likely completion date

- Be provided with any terms of reference to ensure their questions can be reflected and be given a clear explanation if they feel this is not the case

- Have a single point of contact to provide timely updates, including any delays, the findings of the investigation and factual interim findings

- Be informed not only of the outcome of the investigation but what processes have changed and what other lessons the investigation has contributed for the future
- Have an opportunity to respond to the findings and recommendations outlined in any final report and to express further concerns or ask any subsequent questions.

11.0 Governance

11.1 Document review history

Version number	Review date	Reviewed by	Changes made
	Aug 2024	**N Makris**	Updated to reflect statutory changes to ME process and change from Serious Incident Review Framework to Patient Safety Incident Review Framework.

11.2 Consultation History

Stakeholders Name/Board	Area of Expertise	Date Sent	Date Received	Comments	Endorsed Yes/No
Mortality Review Group		Jun 2020			
MRG		Aug 2024			

11.3 Audit and monitoring

Audit/Monitoring Criteria	Tool	Audit Lead	Frequency of Audit	Responsible Committee/Board
Quantitative Trust Mortality Data	HSMR/SHMI	N Makris	Quarterly	PSB & QCRC
Qualitative Trust Mortality Data	MEO and M&M reports	N Makris	Quarterly	PSB & QCRC

11.4 Equality Impact Assessment

As part of its development, this policy and its impact on equality has been reviewed. The purpose of the assessment is to minimise and if possible, remove any disproportionate impact on the grounds of race, gender, disability, age, sexual orientation, religion or belief, pregnancy and maternity, gender reassignment or marriage and civil partnership. No detriment was identified.

Equality Impact Assessment			
Division		**Department**	
Person completing the EqIA	Nikolaos Makris	**Contact No.**	Ext 86240
Others involved:		**Date of assessment:**	14/08/2024
Existing policy/service		**New policy/service**	
Will patients, carers, the public or staff be affected by the policy/service?	Staff		
If staff, how many/which groups will be effected?	All staff		

Protected characteristic	Any impact?	Comments
Age	YES	Positive impact as the policy aims to recognise diversity, promote inclusion and fair treatment for patients and staff. Additional, external layers of review and scrutiny are applied to deaths in neonates, children and pregnant women in line with national guidance.
Disability	YES	
Gender reassignment	NO	
Marriage and civil partnership	NO	
Pregnancy and maternity	YES	
Race	NO	
Religion or belief	NO	
Sex	NO	
Sexual orientation	NO	

What consultation method(s) have you carried out?	Distributed to members of MRG, Patient Safety Specialists, MEOs and MEs
How are the changes/amendments to the policies/services communicated?	Updated policy will be emailed to M&M Leads, MEs and MEOs and will be available on the Intranet

What future actions need to be taken to overcome any barriers or discrimination?			
Who will lead this?	Who will lead this?	Who will lead this?	Who will lead this?
Review date of EqIA			

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Appendix 1 Mortality and Morbidity Review Meetings.

Concerns about patient safety and an increased level of scrutiny of hospital mortality rates have led to a drive for NHS Trusts to review and implement appropriate changes to ensure the delivery of safe, quality care.

In response to this, NHS England published the 'National guidance on Learning from Deaths' in March 2017 (National Quality Board, 2017), which outlines general principles around mortality reviews; it is expected that acute trusts and other health care organisations should incorporate this guidance, aligning Mortality and Morbidity Reviews with their governance systems, in order to measure assurance of the provision of safe, effective care focusing on the systems and processes used in the service.

Purpose and objectives of Departmental/Specialty Mortality & Morbidity Meetings

The purpose of the Mortality Group meetings is to establish a consistent and robust process to identify and reduce all avoidable in-hospital mortality by:

- Systematically reviewing care through a structured analysis of patient records
- Focusing on reducing complications
- Improving patient pathways (reducing variability of care)
- Improving early recognition and escalation of care for deteriorating patients
- Learning from problems that contribute to avoidable patient death and harm
- Sharing the learning; promoting best practice and behaviours across the organisation

Note: this process does not include reviews for stillbirths/neonatal/maternal deaths. Please refer to the Terms of Reference for Perinatal Mortality and Morbidity which can be found on the Trust's intranet site.

Membership:

Core representation at Department M&M meetings should include:

- All consultants within the speciality
- Junior Doctors
- Senior nursing staff (Speciality specialist nurses, speciality ward and matrons where appropriate)
- Junior Nursing staff
- Key Allied Health Care Professionals – where relevant to department/speciality

  Other invitees can include:
- Doctors– where relevant from other specialist groups (e.g. anaesthetics for surgical patients or ITU)
- Clinical Audit
- Clinical Coding
- Representation from the Information Team

Quorum

To be agreed by individual speciality M&M as this will vary depending on the size of each department and grades within each team.
For example, it could be agreed that for X department this will consist of the Speciality M&M Lead and XYZ members (of which, will include at least an agreed minimum number of consultants).

Frequency of Meetings

In general, to discuss deaths soon after they occur, meetings will be held monthly. For specialities with high numbers of deaths, more frequent meetings may be required to ensure a mechanism for good quality discussion and regular learning is in place.

For departments with low death rates, meetings may be held less frequently but they should still be held as they represent an opportunity to discuss morbidity and to learn and improve patient pathways. Meetings that are required less frequently could be incorporated in departmental governance meetings.

For the xxxxxxxx department, the meeting frequency will be xxxxxxxx (e.g. fortnightly, monthly, or quarterly)

Commented [MD1]: The following document is newer, suggest using this instead and updating the text accordingly: https://www.england.nhs.uk/wp-content/uploads/2017/03/nqb-national-guidance-learning-from-deaths.pdf

Also, please add the following in-text reference: (National Quality Board, 2017)

Operational Functions:

- To work towards the elimination of all avoidable in-hospital mortality.
  The responsibility of department/clinical teams' mortality and morbidity reviews should be distributed amongst ALL consultants/senior members for them to understand the outcomes of their clinical practice. Each department/speciality should identify a Mortality and Morbidity Lead who will be the department/specialty representative and will be required to attend the monthly Mortality Group meetings.
- To share learning from department Mortality and Morbidity meetings across the wider system.
- To consider mortality data specific to the department in conjunction with case note review and identify areas for investigation and areas for improvement. For the xxxxx department this will include data from yyyyy and zzzz.
- To lead on in depth review where concerns are highlighted; with an identified lead for the review and writing up results
- To learn from reviews; develop ideas and formulate proposals for implementation.
- To develop M&M minutes/reports/dashboard; provide assurance to the Mortality Group / Division / Trust Board on patient mortality
- To ensure that the departmental M+M meeting is aligned with the operational functions of the
- Mortality Group as listed in the Terms of Reference for that group

Roles and Duties of Department/ Team M&M Lead

- To support the alignment of department Mortality and Morbidity meetings for the purpose of reducing all avoidable deaths
- To provide senior leadership, support and overview of the Departmental/Team Mortality and Morbidity meetings
- To support the implementation of mortality reduction strategy that aligns hospital systems such as audit, information services and training
- Sign off action plans and methodologies that are designed to reduce Mortality and Morbidity across the department/speciality
- Sign off regulatory mortality responses
- To report on Mortality performance to the Mortality Group
- To review the effectiveness of the Mortality and Morbidity Meeting annually.
- Accountability/Reporting

- Discussions and outcomes from the meeting should be recorded including the conclusions around sub-optimal and/or outstanding care. Associated minutes should be produced for circulation to the Divisional Board and Mortality Group.

There should be a standard scale to classify the care delivered for each mortality case reviewed and discussed. The NCEPOD (National Confidential Enquiries into Patient Outcomes and Death) Classification should be used as below:

- Good Practice – The standard you would expect from yourself, your trainees and your institution.
- Room for Improvement – Aspects of Clinical care could have been better.
- Room for Improvement – Aspects of Organisational care could have been better.
- Room for Improvement – Aspects of both Clinical & Organisational care that could have been better.
- Less than Satisfactory – Several aspects of clinical and/or Organisational care that were well below what you would accept from yourself, your trainees and your institution.

Appendix 2 Child Death Flow Chart

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                          ┌─────────────────────┐
                          │     Child Death     │
                          └─────────────────────┘
                                     │
┌──────────────────────┐  ┌─────────────────────────────┐
│ There is the option  │  │ Doctor signs MCCD and form 1│
│ for the doctor to    │..│ (Notification Of Death To   │
│ hand the form        │  │ The Clinical Service Unit   │
│ immediately to the   │  │ (CSU)) part A and returns it│
│ responsible          │  │ to Bereavement Office       │
│ consultant who, if   │  └─────────────────────────────┘
│ confident, can       │              │
│ complete and sign    │  ┌─────────────────────────────┐
│ form 1 part B at the │  │ M&M Coordinator to be sent a│
│ same time and return │  │ copy of the form 1          │
│ with death           │  │ (Notification Of Death To   │
│ certificate for M&M  │  │ The Clinical Service Unit   │
│ Coordinator to       │  │ (CSU)) to ensure M & M      │
│ collect.             │  │ takes place.                │
└──────────────────────┘  └─────────────────────────────┘
```

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┌────────────────────────────────────────────────┐
│ All child deaths (as there are < 50 a year) will │
│ follow the child death (M & M) process -DATIX,   │
│ 72 hours report                                  │
└────────────────────────────────────────────────┘
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┌────────────────────────────────────────────────────────────┐
│ Summary of 1st SJR presented at M&M meeting                  │
│                                                             │
│ 7 phases of care and scores to be reviewed                  │
│                                                             │
│ 1st SJR paperwork to be finalised and completed             │
│                                                             │
│ Actions and learning points to be recorded in departmental  │
│ Mortality Action Log for review at subsequent M&M meetings   │
│ and sent to CGFs                                            │
│                                                             │
│ Child Death Overview Panel (CDOP) form to be completed      │
└────────────────────────────────────────────────────────────┘
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Statement 1	Statement 2	Statement 3	Statement 4
Satisfied with cause of death	No significant errors, omissions or serious incidents prior to admission to	No issues relating to negative patient experience raised by patient, family or staff	Death unavoidable

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┌─────────────────────────────────────┐   ┌─────────────────────────────────────┐
│ M and M DISAGREE WITH ANY STATEMENTS│   │ M and M AGREE WITH ALL STATEMENTS   │
│ (or have any other concerns)        │   │                                     │
└─────────────────────────────────────┘   └─────────────────────────────────────┘
                │                                          │
┌─────────────────────────────────────┐   ┌─────────────────────────────────────┐
│ Submit 1st SJR form to M&M          │   │ If agree to all statements complete │
│ Coordinator / Clinical Governance   │   │ and sign form 1 part B and send to  │
│ Facilitators (CGF) for 2nd SJR      │   │ M&M Coordinator for closure and     │
│ Complete datix report to ensure     │   │ recording along with completed      │
│ escalation                          │   │ CDOP form                           │
└─────────────────────────────────────┘   └─────────────────────────────────────┘
                │                                          │
┌─────────────────────────────────────┐   ┌─────────────────────────────────────┐
│ All 2nd SJRs completed and          │   │ Submit 1st SJR form to M&M          │
│ submitted to MRG for themes for     │   │ Coordinator / CGFs                  │
│ Trust wide learning                 │   └─────────────────────────────────────┘
│                                     │
│ All 2nd SJRs completed and          │
│ submitted to SIRG for decision of   │
│ degree of avoidability              │
└─────────────────────────────────────┘
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Appendix 3 Adult Death Flow Chart

Learning from Deaths

Structured Judgement Review Case Process

Patient Death

Medical Examiner Review Process

Family/ClinicalTeam/Medical Examiner Concerns

Concerns during care prior to deaths. Failure to recognise or rescue/Delay in investigationor treatment/Fall leading to death/Inpatient fall within 3 days/Medical or Surgical procedure/Unplanned theatre return/Hospital acquired thrombosis/Drug Error/Hospital acquired infection/IV fluid/Blood error/Cardiac arrest during care/Neurological deficit not present on admission/Unplanned transfer to higher level of care

Unexpected Death/Elective Death/Learning Disability/Mental Health - Specialty SJR Review

Immediate /External Flags National Clinical Audit Outliers, HSMR/SHMI Alerts, Selection of random deaths per month.

Any concerns investigated by first stage SJR

SJR 1st Stage

Score 1 Definitely avoidable
Score 2 Strong evidence of avoidability
Score 3 Probably avoidable (more than 50:50)
Score 4 Possibly avoidable but not very likely (less than 50:50)
Score 5 Slight evidence of avoidability
Score 6 Definitely not avoidable

Second Stage review upholds score of 3 or less

MRG Review case and assess for Trust Wide Learning
Recommendations and Action Plan shared with SIRG
Outcome Shared with patients' family and carer

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