Mortality Review and Learning from Deaths Policy (Adults)

Classification :	Policy
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Authors Division:	Corporate
Departments/Groups This Document Applies to: Trustwide Clinicians	

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Scope: Trustwide Clinicians reviewing mortality	**Document for Public Display:** No	
To be read in conjunction with the following documents:		
Required CQC evidence? Yes	**Key CQC Question:** Safe/Effective/ /Well Led	

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Policy Statement

Concern about patient safety and scrutiny of mortality rates has intensified since February 2013, when the Prime Minister announced that he had asked Professor Sir Bruce Keogh, NHS Medical Director for England, to review the quality of care and treatment provided by those NHS trusts and NHS foundation trusts that were persistent outliers on mortality indicators.

It has become increasingly important for Trusts to evidence that they are systematically and continuously reviewing patient outcomes, especially mortality and morbidity, to meet Keogh's ambition: "*We will have made demonstrable progress towards reducing avoidable deaths in our hospitals, rather than debating what mortality statistics can and can't tell us about the quality of care hospitals are providing*".

In March 2017 the National Quality Board published 'National guidance on Learning from Deaths' as a framework for NHS Trusts for Identifying, Investigating and Learning from Deaths in Care. This framework included guidance on identifying groups of patients that require particular scrutiny including deaths in patients with learning disabilities, mental health disorders, all deaths where bereaved families and carers have raised significant concerns. The guidance also proposed a 2 stage process (termed 1st and 2nd Structured Judgement Reviews (SJRs)) in which those deaths chosen for greater review are further scrutinised by a common nationally adopted methodology. The aim is to achieve objective and independent reviews of deaths allowing Trusts to identify areas of learning from deaths. Deaths undergoing a 2nd Structured Judgement Review will also be required to be scored on the degree of 'avoidability'. All Trusts are to be mandated to publish data via public meetings including;

1. Numbers of deaths undergoing review
2. Numbers of deaths investigated as Serious Incidents
3. Numbers of deaths caused by problems in care
4. Numbers of avoidable deaths
5. Themes and Trends emerging from review and investigations

There are a number of important national drivers around the mortality agenda:

- Longstanding controversy around the use and interpretation of standardised ratios for comparison of mortality over time and across organisations (HSMR, SHMI, RAMI)
- Emerging consensus about the concept of 'avoidable mortality' in hospitals (likely accounting for around 4% of all deaths) http://www.bmj.com/content/351/bmj.h3239
- Emerging view that an organisation's position in respect of standardised mortality ratios (derived from routine HES data) and avoidable deaths (derived through independent case note review) may not be correlated
- Heightened public expectations in relation to the review of deaths which take place in the healthcare setting (for example, experience at Southern Health NHS Foundation Trust reported in 2016)
- Reforms to the process of death certification and the introduction of the role of 'Medical Examiner' in April 2018
- National Quality Board guidance 'National guidance on Learning from Deaths' published in March 2017

Changes to this policy in September 2016 standardised a multidisciplinary approach for Departmental and Divisional Morbidity and Mortality (M&M) meetings and Trust template documentation to improve the qualitative and quantitative reviews of deaths. Recent guidance by the National Quality Board has further reiterated the importance of objective reviews of deaths using a standardised national Royal College of Physicians (RCP) methodology (in the form of 1st and 2nd Structured Judgment Reviews) to achieve appropriate learning from deaths.

The aim of this policy is to ensure:

- A standardised approach to the review of patient mortality and morbidity within MKUHFT and for that approach to be multi-disciplinary, as appropriate. The updated standard Trust documentation is included in the appendices of this document. It incorporates the methodology proposed by the National Quality Board and Royal College of Physicians (RCP). This documentation must be used by all specialties in their M&M meetings.

- The opportunity for next of kin to contribute to the process of reviewing deaths

- Outputs of any such reviews are clearly documented and archived including scores on phases of care as outlined in Trust documentation.

- Any actions required to learn lessons from deaths must be fully documented in a Departmental Mortality Action Log which will be reviewed at each departmental and Divisional M&M and Clinical Improvement Group meeting.

- Clear reporting mechanisms are in place, to escalate any areas of concern identified by M&M meetings, so that the Trust is aware and can take appropriate action.

- The Trust encourages shared learning across specialties.

Definitions

Mortality – for the purpose of M&M meetings, mortality relates to any deaths within 30 days of a procedure in a surgical specialty or any in hospital death for non-surgical specialties.

Morbidity – relates to adverse outcomes

Complication: an additional problem that arises following a procedure, treatment or illness and is secondary to it / complicates the situation. Details of 'Clinically coded complications' are available from the Coding Manager or Acting Head of Outcomes and Effectiveness.

Misadventure - Any injury or adverse reaction resulting from any medical treatment. Some examples are medication errors, IV infection, surgical mistakes and postoperative septicaemia. Details are available from the Coding Manager or Head of Outcomes and Effectiveness.

Serious Incident (SI) - an incident occurring on NHS premises that resulted in serious injury, and or permanent harm, an unexpected or avoidable death (ref Incident Reporting Policy)
http://portal.mkhospital.nhs.uk/Guidelines/Non Clinical Documentation/Risk Management/Risk Management Polices and Guidelines/**Incident reporting** policy.doc

Avoidable/Preventable – these terms are used interchangeably in the NHS and for the purpose of this policy 'avoidable' or 'unavoidable' will be used with reference to whether anything could have been done to change the outcome.

Mortality & Morbidity Meetings (M&Ms)
M&M meeting is where a multidisciplinary group review and discuss clinical cases, outcome data (clinician and patient reported) and related information (eg SI, complaints, Dr Foster or other benchmarking data).

M&M meetings - may be joint M&M/Audit meetings, as audit plays an important party in the M&M process. If separate meetings, there will need to be an agreed process for ensuring the findings from both are shared across specialties and Divisions, and any actions suitably co-ordinated.

MRG – Mortality Review Group – To review and monitor monthly trend figures currently supplied by Dr Foster/Health and Social Care Clinical Indicator previewer/Hospital Standardised Mortality Ratios (HSMR) and Summary Hospital-level Mortality Indicator (SHMI) and sign off data

MB – Mortality Board - is authorised to monitor and review information associated with the wider remit of mortalities, including associated information such as the deteriorating patient.

MSG - Mortality Surveillance Group (same as MRG)

HSMR – Hospital standardise mortality ration. The HSMR scoring system works by taking a hospital's crude mortality rate and adjusting it for a variety of factors – population size, age profile, level of poverty, range of treatments and operations provided, etc.

HES – Hospital episode statistics. HES is a data warehouse containing details of all admissions, outpatient appointments and A&E attendances at NHS hospitals in England

SHMI - Summary Hospital level Mortality Indicator, and is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there

RAMI - Risk-Adjusted Mortality Index that allows an understanding of the variances across the rating systems

1.0 Roles and Responsibilities:

1.1 Patient Safety Director (a Non-Executive Trust Board member):

- Responsible for oversight of the Trust's leaning from deaths agenda.
- Ensures a high quality of care record review and investigations of deaths.
- Ensures mortality data (suitably anonymised) is discussed at public Trust Board meetings.

Medical Director (supported by the Associate Medical Director):

- Responsible for assuring the Board that the mortality review process is functioning effectively.
- Ensures that arrangements are in place so all clinical staff, as appropriate, are aware of their responsibilities in relation to the processes in monitoring mortality.

Associate Medical Director (Trust Lead for Mortality Review Group and Mortality Board:

- Offer advice to colleagues involved with the review process
- Chair the Trust Mortality Review Group (MRG) and Mortality Board
- Feedback concerns raised at MRG to relevant specialties – usually via specialty governance leads
- Use the Trust Datix system to report incidents identified during mortality review so that it can be reviewed as part of the risk management process
- Raise any identified risk onto the Trust Risk Register where it will be reviewed as part of the risk management process.
- Prepare a monthly report for the Trust Quality and Clinical Risk Committee
- Include monthly trend data provided by Dr Foster downloads on the agenda for discussion at the MRG
- Ensure actions or concerns are identified in mortality data
- Review and sign off the NHS Health and Social Care data regarding the Trust i.e. Hospital Standardised Mortality Ratios (HSMR) and Summary Hospital-level Mortality Indicator (SHMI)

1.2 Divisional Directors are responsible for:

- Ensuring that appropriate multi-disciplinary M&M meetings take place in all specialities (or CSUs) and for holding a list of M&M/audit meetings within their Divisions
- Ensuring that Trust standardised reporting processes are in place from M&Ms (see Appendix 3) for escalating to the MRG as appropriate.

1.3 Clinical Service Unit (CSU)/Specialty M&M Leads/chairs are responsible for:

- Ensuring multi-disciplinary monthly M&M meetings take place in their Specialty/CSU where **all** their specialty's deaths are reviewed, except in the departments where the number of deaths exceeds 50 per year
- Identifying an M&M meeting Chair and minute-taker
- Ensuring the collation of review findings, learning points and actions for improvement are documented at each M&M meeting
- Ensuring actions are collated into an action log that is reviewed at each M&M meeting. Any lack of progress on actions should be escalated via the Clinical Governance Facilitators (CGFs) to the MRG.
- Ensuring that reviews of deaths are completed by nominated consultants that have not been directly connected with the patient to provide objectivity and transparency.
- In departments with >50 deaths per year, ensuring that screening Form 1 part B is utilised to screen out deaths which responsible named consultants were satisfied to close without discussion.
- Arranging to review cases within 3 months of receiving the notification of death, unless extenuating circumstances can be evidenced.
- Ensuring that 1st Structured Judgement Review (SJR) are undertaken using Trust paperwork (Appendix 3) for all deaths reviewed and that these are fully completed including the scoring of all phases of care.
- Returning the completed 1st SJR forms to their Clinical Governance Facilitator (CGF)/Governance Administrator who will arrange for the details to be entered into a central database and highlighting any cases that meet criteria for further review by 2nd SJR.
- Identify and escalate to the CGFs any deaths that require a 2nd SJR or may meet criteria for a Serious Incident.
- Receiving reports and letters from the MRG and ensuring learning outcomes and action points are included in the Specialty Governance Audit plans as appropriate
- Sharing outcomes within the Specialty and at Divisional governance meetings
- Escalating any areas of concern to the Mortality Board, Trust Lead and Associate Medical Director leading on mortality
- Undertaking 2nd SJRs when requested by the Head of Risk & Clinical Governance or Associate Medical Director

1.4 The Bereavement Team is responsible for:

- Identifying all deaths
- Ensuring the cause of death is recorded in the case notes of all patients
- Raising a mortality review form for all adult in-hospital deaths (except maternal) by affixing a patient label and completing the "consultant at death" box
- Ensuring next of kin receive information regarding the Trust policy of reviewing and learning from deaths and contact details if they have concerns (appendix 4)
- Sending case notes to the mortuary

1.5 Head of Risk & Clinical Governance is responsible for:

- Receiving and circulating notification of post mortems from the Bereavement Team/HM Coroner's Office
- The circulation of the SI weekly live log, monthly claims spreadsheet and other inquest information and mortality data
- Supporting the Trust Lead for Mortality Review in the preparation of monthly quality reports
- Receiving communications from concerned next of kin in relation to the hospital review of patient deaths and ensuring appropriate investigation and feedback

- Triangulate Datix incidents, serious incidents (SIs) and complaints into the M&M processes

1.6 Clinical Governance Facilitators are responsible for:

- The dissemination of mortality review forms within the specialty
- Ensuring that these are completed by nominated consultants. Following up Form 1 Part Bs that have not been returned
- Tasking the Governance Administrator with updating the central governance database for monitoring the mortality and review forms
- Arranging for a random selection of deaths screened using Form 1 part B, per quarter which will be presented in highlights for review at MRG
- Receiving reports and letters from the MRG and ensure learning outcomes and action points are included in the specialty audit plans and shared/disseminated as appropriate to ensure lessons are learnt
- Sharing outcomes within the specialty M&M groups
- Ensuring any 1st SJRs that meet criteria for a 2nd SJR are escalated to the AMD and the Head of Risk and Governance and Datix form is submitted
- Submitting a quarterly report to the MRG highlighting any concerns they have and actions to take forward as part of learning and Trust wide shared learning
- Providing support and co-ordination of actions to be escalated to other CSU/divisions
- Supporting the Trust Lead for Mortality Review in the preparation of quarterly reports for the corporate committees
- Preparing divisional level summary information as required for regular reporting by the Compliance Manager/Head of Risk & Clinical Governance as required/requested
- Reviewing the minutes and action plans that come from all specialty M&M meetings to pick up any cases, which they should have been made aware, that due to concerns regarding levels of care or avoidability require further scrutiny by a 2nd SJR or that should be escalated as a Serious Incident
- Death of any patient with a significant mental health disorder or considered to have significant learning difficulties to be escalated to the Divisional CIG or MRG
- Completing a Datix for any deaths reviewed at M&M meetings and escalated as a significant concern

1.7 Medical staff are responsible for:

- Participating fully in the M&M process (consultant medical staff).
- Participating fully in all M&M meetings that are relevant to their practice

1.8 M&M Coordinator are responsible for:

- Collate data from the Bereavement Office and input on the M&M tracking spreadsheet
- Update the spreadsheet post screening reviews by consultants
- Flag those for requiring discussion at the M&M meetings

Records Management

The Health Records Department will ensure that medical records in relation to mortalities are scanned onto the Electronic Data Management system within 2 working days of receipt.

Nurses, allied health professionals and other clinical staff

All healthcare professionals should be involved in M&M reviews, as part of their clinical practice. This involvement could range from simply being aware of the outcome of such reviews insofar as

they affect their area of practice, to full involvement in the production of reports and implementation of recommendations.

2.0 Monitoring Groups

2.1 Trust Mortality Review Group:

- Review and monitor monthly trend figures currently supplied by Dr Foster/Health and Social Care Clinical Indicator previewer/Hospital Standardised Mortality Ratios (HSMR) and Summary Hospital-level Mortality Indicator (SHMI) and sign off data
- Ensure that possible adverse trends are discussed and undertake further investigation where this is indicated
- Ensure the delivery of the mortality review process on behalf of the Quality & Clinical Risk Committee and Management Board
- Report quarterly to the Clinical Quality Board
- Address issues that may arise where the process of care has involved more than one Specialty
- Feedback learning and action points to the Clinical Governance Facilitators for them to update the action logs and share lessons.
- Develop learning and action points to be included in reports generated by the Trust Lead for Mortality Review
- When considered appropriate, escalate learning and action points to the Medical Director
- Reviewing any specialty M&M investigations escalated from M&M meetings and determined as requiring a 2nd SJR
- Review deaths of any patients with a significant mental health disorder or considered to have significant learning difficulties
- Review 2nd SJRs to determine any themes requiring Trust wide learning or escalation

2.2 Mortality Board

The Mortality Board is accountable to the Management Board. Its terms of reference and constitution are approved by the Management Board. It discusses Mortality issues across the Milton Keynes Area and membership includes Patient Safety Lead from the Clinical Commissioning Group (CCG), GPs, 2 Public Health consultants from Milton Keynes Council and Clinical Governance representatives from MK hospital.

The MB has the authority to monitor and review information associated with the wider remit of mortalities, including associated information such as the deteriorating patient.

2.3 Management Board

- Receive reports from Mortality Board

2.4 Quality and Clinical Risk Committee

- Receive a quarterly assurance report on mortality from the Medical Director

2.5 Serious Incident Review Group

- Review root cause analysis (RCA) reports to determine if escalation for serious incident reporting and investigation is required
- Oversee the SI processes including external reporting on the STEIS data base and communications with the Clinical Commissioning Group (CCG)
- Oversee RCAs completed for HM Coroner inquests

- Review all 2nd SJRs completed for a decision of degree of avoidability

3.0 Mortality Review process (Appendix 1)

The aim is to have a standardised overarching process with some flexibility to screen out certain deaths for departments who have >50 deaths a year. All deaths must be reviewed at some level and there must be opportunities for departmental and Trust learning. Specialties with fewer than 50 deaths per year would be expected to review all deaths in detail, without the opportunity for screening exclusions.

In areas with a high volume of deaths, a process of screening can be utilised (Appendix 2) whereby a significant proportion of deaths can be diverted away from undergoing a 1st SJR. This requires the responsible clinician (Consultant) to make a positive affirmation as to the quality of care across a number of domains, with the screening Form 1 Part B providing a clear evidence trail for accountability in the decision. To enhance this process and as additional assurance there will be a quarterly subset of deaths either randomly chosen by the CGFs from deaths that had been screened out or from HSMR outlier categories that will require presentation at M&M meetings for validation and assurance of the process. All deaths of patients identified as having significant mental health issues, significant learning difficulties or any deaths in which next of kin have raised concerns will also automatically undergo review by 1st SJR.

The composition of M&M specialty review groups should as a minimum involve at least one Consultant not directly involved in the patient's care and should be multi- professional involving trainee doctors where possible and other members of the Multi-Disciplinary Team (MDT) as appropriate.

All M&M meetings must reviews deaths by 1st SJR using the Trust standardised meeting template as documentation (Appendix 3) to ensure the appropriate information is captured in relation to the guidance requirements produced by NHS England, supported by Monitor/TDA (now NHS Improvement), in December 2015. This outlines expectations in respect of mortality review within provider organisations with the key points including:

- Trusts must have a mortality surveillance group (MSG/MRG) with appropriate constitution reporting through to the Board
- A process of review must be applied to **all** deaths which occur within a Trust. That process should lead to a standardised judgement being made as to any concerns regarding quality of care and to the (potential) avoidability of each of those deaths
- The MSG/MRG should consider both the outcome of reviews of individual patient deaths (qualitative) and data arising from the standardised ratios (quantitative)

Completed meeting templates must be stored on the Trust mortality shared drive, in the relevant CSU folders.

If any death undergoing a 1st SJR receives a score of 1 (very poor care) or 2 (poor care) in any 1 of the 7 phases of care (see section 5.0) then a Datix incident form must be completed (if the death was not reported at the time) to ensure a 2nd SJR takes place.

A 2nd SJR will require a more detailed investigation of a death and may include, but not be limited to, a review of the medical and nursing notes and statements from any staff and next of kin

involved in the death. The author(s) of a 2nd SJR will propose a score of the degree of avoidability attributable to the case following RCP methodology. 2nd SJRs and the score of avoidability will be reviewed by the Serious Incident Review Group (SIRG) for a final decision. All 2nd SJRs will be scrutinised at MRG to identify themes or Trust wide issues requiring action and Trust wide learning.

4.0 Minimum Standards for Mortality & Morbidity Review meetings

4.1 **Each M&M Group** should identify and confirm with CSU/Speciality Medical Lead

- Chairman
- Terms of Reference/Objectives
- Templates for documenting mortality reviews (standardised Trust templates)
- Frequency of meetings, should ideally be monthly but as a minimum no less frequently than every 6 weeks
- Membership – (multi-disciplinary and multi-professional)
- Working arrangements with other Specialty M&M groups and frequency of joint meetings
- Working arrangements with other Governance Groups within CSU/Division eg
- CSU/Speciality Audit Group or Clinical Improvement Group

5.0 Data to be reviewed and escalation of concerns

All in-hospital deaths as part of a 1st SJR will receive explicit judgements on quality of care and receive a score on the standard of care for each of the 7 separate phases of care as outlined by RCP methodology. These phases of care are;

A. Admission and initial management (approximately 1st 24hours)
B. Ongoing care
C. Care during a procedure (excluding IV cannulation)
D. Perioperative care
E. End-of-life care
F. Overall Assessment
G. Quality of patient record

The score for each phase will be ranked 1 to 5 where;

1 = very poor care
2 = poor care
3 = adequate care
4 = good care
5 = excellent care

Any death review that receives a score of 1 or 2 in any of the 7 phases of care will automatically undergo a 2nd SJR. A Datix report must also be completed for any death scoring a score of 1 or 2 in any phase of care. The 2nd SJR is a detailed investigation of the death that may include, but not be limited to, a review of the medical and nursing notes and statements from any staff and next of kin involved in the death. In addition to a commentary on standards of care, the author(s) of a 2nd SJR will propose a score of the degree of avoidability attributable to the case following RCP methodology. 2nd SJRs and the score of avoidability will be reviewed by the Serious Incident Review Group for a final decision.

The RCP score of avoidability is;

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

Some specialties may also opt to investigate deaths where patients have received prior hospital care at MKUHFT and have been transferred out to a tertiary centre, where they subsequently died.

In normal circumstances, all individual reviews of in-hospital deaths should be carried out within 3 months of a patient's death.

6.0 Process for Monitoring Compliance

6.1 Key performance indicators

- Each CSU/Speciality will hold M&M Meetings and have agreed Terms of Reference
- Minutes of M&M Meetings will be available for each Specialty on the shared drive
- All areas of concern will be escalated to the Mortality Board and/or the Medical Director as appropriate

6.2 Process and timescales for monitoring compliance

- Each CSU will provide an annual report to their Division summarising the findings of reviews carried out and actions taken as a result of lessons learnt. The CGF will support the Divisional Mortality Lead in the facilitation of the report.
- Each Division will provide an annual report to the Mortality Review Group summarising the above

7.0 Statement of evidence/references

References:

The Mid Staffordshire NHS Foundation Trust Public Inquiry (Francis Report, 2013)

Review into the quality of care and treatment provided by 14 hospital trusts in England (NHS Chief Medical Director, Sir Bruce Keogh)

National Quality Board Guidance on Learning from Deaths

Royal College of Physicians National Mortality Case Record Review Programme resources

http://www.bmj.com/content/351/bmj.h3239
https://www.england.nhs.uk/south/wp-content/uploads/sites/6/2015/12/mazars-rep.pdf
https://www.rcpath.org/discover-pathology/public-affairs/medical-examiners.html
http://southtees.nhs.uk/content/uploads/BoD-January-2016-agenda-item-11-appendix-3.pdf
https://www.england.nhs.uk/wp-content/uploads/2017/03/ngb-national-guidance-learning-from-deaths.pdf

https://www.rcplondon.ac.uk/projects/outputs/national-mortality-case-record-review-nmcrr-programme-resources

9.0 Governance

9.1 Record of changes to document

Version number: 1		**Date:** New Policy		
Section Number	**Amendment**	**Deletion**	**Addition**	**Reason**
7.0			Escalation process	Clarity
1.0			Role/responsibility of the M&M Coordinator	Clarity
			Changes in relation to the National Quality Board guidance	Change in processes

9.2 Consultation History

Stakeholders Name/Board	**Area of Expertise**	**Date Sent**	**Date Received**	**Comments**	**Endorsed Yes/No**
Dr I Mehdi	Associate Medical Director	Jan 2015			
Mr Martin Wetherill	Medical Director	Jan 2015			
Clinical Service Unit leads		Jan 2015			
Divisional Directors		Jan 2015			
Angus Molyneux		Jan 2015			
Anne Marie James	Coding Manager	Jan 2015			
Felicity Maple	Health Records Manager	Jan 2015			
Dr Jane Wale	Consultant	Jan 2015			
Joy Halliday	Consultant	Jan 2015			
Tina Worth	Head of Risk & Clinical Governance	Jan 2015			
Kim Weston	Bereavement Officer	Jan 2015			
CSU Mortality leads		Jan 2015			
Mortality Review Group		June 2016			
Dr James Bursell	Associate Medical Director	July 2017		Changes to reflect National Quality Board guidance	

9.3 Audit and monitoring

This Policy outlines the process for document development will be monitored on an ongoing basis. The centralisation of the process for development of documents will enable the Trust to audit more effectively. The centralisation in recording documents onto a Quality Management database will ensure the process is robust.

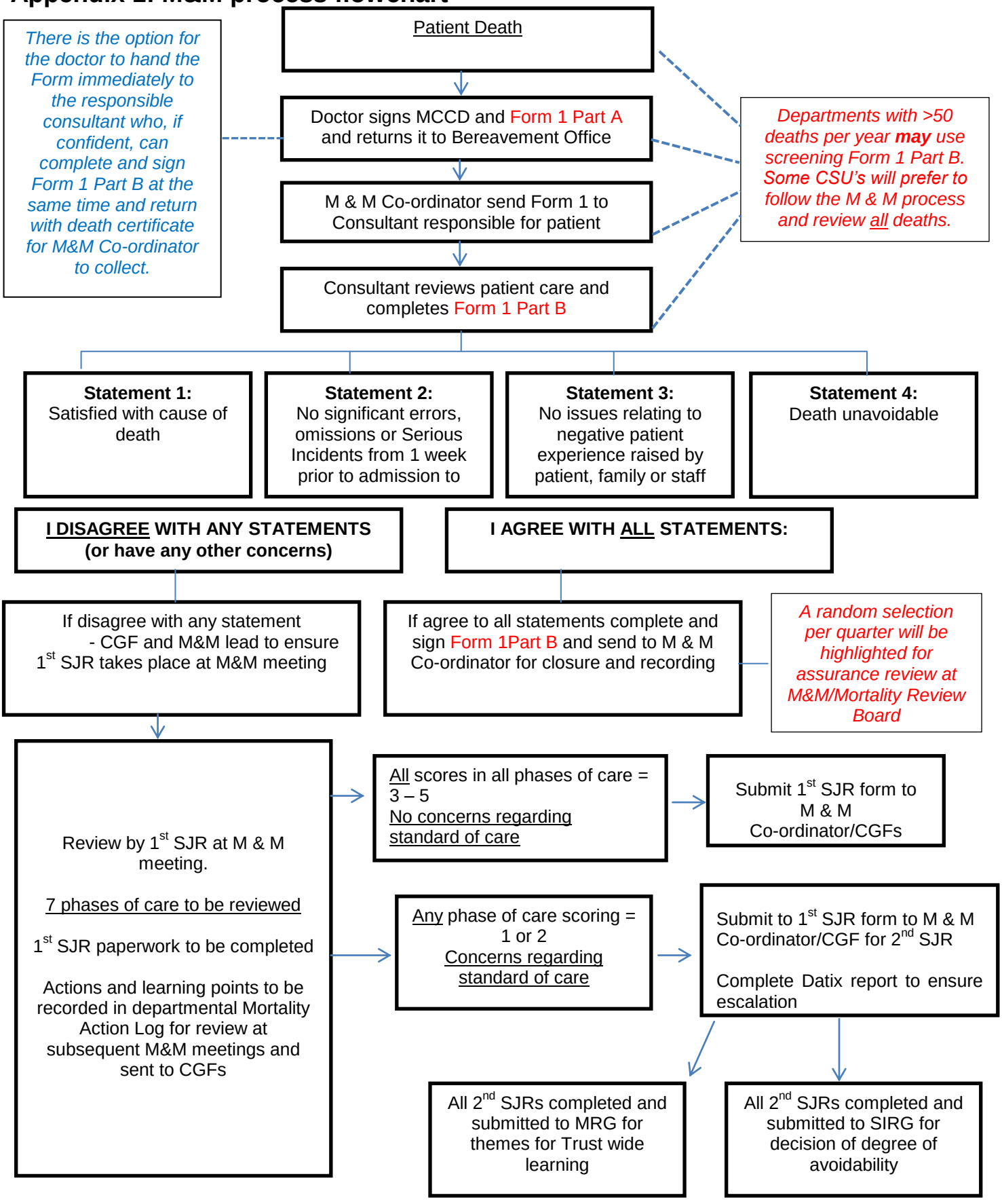
Audit/Monitoring Criteria	Tool	Audit Lead	Frequency of Audit	Responsible Committee/Board
Monitoring will be via the Trust mortality form	M&M Review form	CSU leads	Monthly	Mortality Board
Quarterly random sample of screened Form B deaths – quality assurance audit.	M&M Review Form	Divisional Mortality Lead	Quarterly	MRG
Annual Monitoring Report summarising number of deaths, number of avoidable deaths and action outcomes and trends in concerns raised.	Audit of M+M data tracking spreadsheets	Divisional Mortality Lead	Annual	Mortality Board

9.4 Equality Impact Assessment

This document has been assessed using the Trust's Equality Impact Assessment Screening Tool. No detailed action plan is required. Any ad-hoc incident which highlights a potential problem will be addressed by the monitoring committee.

Impact	Age	Disability	Race	Gender	Religion or Belief	Sexual Orientation
Do different groups have different needs, experiences, issues and priorities in relation to the proposed policy?	No	No	No	No	No	No
Is there potential for or evidence that the proposed policy will not promote equality of opportunity for all and promote good relations between different groups?	No	No	No	No	No	No
Is there potential for or evidence that the proposed policy will affect different population groups differently (including possibly discriminating against certain groups)?	No	No	No	No	No	No
Is there public concern (including media, academic, voluntary or sector specific interest) in potential discrimination against a particular population group or groups?	No	No	No	No	No	No

Appendix 1: M&M process flowchart



Appendix 2: FORM 1:
NOTIFICATION OF DEATH TO THE CLINICAL SERVICE UNIT (CSU)

Part A) – To be completed by DOCTOR PROVIDING Death Certificate (or referring on)

Date of death: _____

Age at death: _____

Consultant (at time of death): _____

Ward: _____

Patient Details/Sticker

CSU:

Acute/Care of Elderly/Stroke □	**Internal Medicine □**	**Specialty Medicine □**
Emergency Department □	**Gynaecology/Maternity □**	**Paediatric □**
Oncology/Haematology □	**General Surgery □**	**Trauma & Orthopaedics □**

Certified Cause of Death as entered on death certificate
1a.
1b.
1c.
2.

Death referred to Coroner and Coroner Form 100/A issued	Death referred to coroner to establish cause of death No certificate provided as yet	Post-Mortem Requested and results pending	If applicable DNACPR Form counter Signed by Consultant?

Part B To be completed by RESPONSIBLE CONSULTANT

	Agree	**Disagree**	**Awaited**
I am satisfied with the cause of death as listed on the death certificate			
To my knowledge, there were no significant errors, omissions or Serious Incidents declared from 1 week prior to admission to today			
To my knowledge, there were no issues in relation to negative patient experience raised by the patient, family or carers (staff)			
I consider this death to have been unavoidable			

*If you disagree with **any** of the above statements, further review by 1st SJR **must** take place at M+M meeting.*

I do **not** consider that this death requires further investigation	
This death should be investigated more fully at M+M by 1st SJR	

Name & signature		Date

Submit to M & M Co-ordinator

Appendix 3: FORM 2:

Structured Judgement Review (SJR) Template

CSU: 1st SJR ☐ or 2nd SJR ☐

Morbidity and Mortality (M&M) Meeting date:

Death (pre-selected)	Death (randomly selected)	Complaint	Serious Incident (SI)	Post mortem (PM) or inquest

Name: Hospital number: D.O.B: (Sticker)	Date of admission: Date of death/transfer: Responsible consultant/firm: Learning disability: Yes No Mental health disorder: Yes No

Brief description of case:

Record explicit judgements on quality of care and also rate the standard of care (by circling/identifying score) for **each** Phase of Care

1 = very poor care 2 = poor care 3 = adequate care 4 = good care 5 = excellent care

Admission and initial management (approximately 1st 24hours)	Circle one score 1 2 3 4 5
Ongoing care	Circle one score 1 2 3 4 5
Care during a procedure (excluding IV cannulation)	Circle one score 1 2 3 4 5
Perioperative care	Circle one score 1 2 3 4 5
End-of-life care	Circle one score 1 2 3 4 5
Overall Assessment	Circle one score 1 2 3 4 5
Quality of patient record	Circle one score 1 2 3 4 5

Assessment of any problems in specific areas of care – circle/identify as appropriate

1. Was there are a problem with Hospital Acquired Infection?	No	Yes	
If Yes – did this problem lead to harm?	No	Probably	Yes
2. Was there are a problem with VTE?	No	Yes	
If Yes – did this problem lead to harm?	No	Probably	Yes
3. Was there are a problem with Nutrition?	No	Yes	
If Yes – did this problem lead to harm?	No	Probably	Yes
4. Was there are a problem related to Medications?	No	Yes	
If Yes – did this problem lead to harm?	No	Probably	Yes
5. Was there are a problem with Resuscitation?	No	Yes	
If Yes – did this problem lead to harm?	No	Probably	Yes
6. Was there are a problem with Pressure Sores?	No	Yes	
If Yes – did this problem lead to harm?	No	Probably	Yes
7. Was there are a problem with Falls?	No	Yes	
If Yes – did this problem lead to harm?	No	Probably	Yes
8. Was there are a problem with Communication?	No	Yes	
If Yes – did this problem lead to harm?	No	Probably	Yes
Was DNACPR completed?	Yes		No

Any death scoring a 1 or 2 for <u>any</u> Phase of care must have a 2nd stage Structured Judgement Review and a Datix completed

Action agreed	Person responsible	Date for completion

Any action points or learning points should be added to the Departmental and Divisional Mortality Action Logs for review at all M&M meetings and Clinical Improvement Group (CIG) meetings.

<u>Complete for 2nd Structured Judgment Reviews only</u>

Avoidability of death judgement score

We are interested in your view on the avoidability of death in this case.

Please choose from the following scale. Circle/identify a score.

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

Please explain your reasons for your judgment of the level of avoidability of death in this case, including anything particular that you have identified.

All completed 2nd SJRs must be given to Divisional Clinical Governance Facilitators (CGFs) for submission to the Serious Incident Review Group (SIRG) and the Mortality Review Group (MRG).

Appendix 4 – Bereavement pack letter

Milton Keynes University Hospital NHS
NHS Foundation Trust

Standing Way
Eaglestone
Milton Keynes
MK6 5LD
01908 660033
www.mkhospital.nhs.uk

For people who have hearing loss
Minicom 01908 243924

Milton Keynes University Hospital NHS Foundation Trust
Standing Way
Eaglestone
Milton Keynes
Bucks
MK6 5LD

Dear

Following the recent death of your relative, the hospital would like to advise you that the Trust has a process in place to ensure that the care provided to all patients who die within our hospital is reviewed. Whilst in the majority of cases death is not unexpected, this process aims to ensure that any possible lessons about care and/or treatment can be learnt by the healthcare team.

If you have any concerns in relation to the care of your relative, we are happy to ensure that these are included in the review, and we would welcome you raising these with us.

We appreciate this may be difficult for you, and we do not want to add to your distress at this time of grief. However we do feel it is important that the Trust is open and honest about processes that are in place. If you would like to share either any concerns or indeed positive feedback with us, please contact me on 01908 995100 or by e-mail at Tina.Worth@MKUH.NHS.UK to facilitate that for you.

Thank you.

Kind regards

Worth

Tina Worth, Head of Risk and Clinical Governance