Kingston Hospital NHS
NHS Foundation Trust

Learning From Deaths Policy

The purpose of this policy is to provide a systematic approach to ensure that the Trust has robust governance arrangements in place to review, report and learn from patient deaths, to use this information to further improve patient care and feedback to staff, and to ensure open and honest communication with relatives and carers.

Policy Authors	Dr. Farid Bazari, Consultant Respiratory Physician and Trust Lead for Mortality and Morbidity Anne Jones, Head of Clinical Audit and Effectiveness Clare Parker, Head of Litigation, Complaints and PALS Sarah Gigg, Deputy Director of Nursing
Version	1.1
Impact Assessment date	6th July 2017
Date ratified	19th July 2017
Ratifying body	Clinical Quality Improvement Committee
Reviewed	19th July 2017
Next review date	July 2020

1. INTRODUCTION

The review of factors involved in patient death has long been practised within NHS hospitals through morbidity and mortality (M&M) meetings. However, the output from these clinically led meetings has varied across the NHS. The Francis Report into Mid Staffordshire NHS Foundation Trust[1] found that mortality rates had been significantly higher than the average whilst no action was taken and noted *"a lack of …. mortality and morbidity meetings".* In 2013 a review was undertaken of fourteen hospitals in England which had higher than average mortality rates in the two years prior to the start of the review.[2] This review, led by Professor Sir Bruce Keogh, the National Medical Director for the NHS in England, resulted in eleven of these trusts being put under 'special measures' in order to improve the governance of issues resulting from patient death. The review identified actions which included the use by Trusts of mortality data to drive quality improvement, understanding the importance of genuinely listening to views of patients and staff and involving junior doctors in M&M meetings. The review, however, did point out that mortality in all NHS hospitals has fallen by around 30% over the last decade and that over 90% of deaths in hospital occur when patients are admitted as an emergency.

A year later, in April 2014, the Medical Director for NHS England commissioned the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) to conduct a review of the way in which M&M meetings are organised in hospitals in England.

NHS England then commissioned an examination of avoidable mortality, using established case note review methodology, which showed about 4% of deaths in hospitals were potentially avoidable.[2] At this stage, NHS England[3] also signalled its intention to implement a recommendation from the Francis Inquiry[1] to introduce Medical Examiners to improve accuracy of local reporting of death, and to mandate all trusts to publish avoidable mortality rates. NHS England also published a 'Mortality Governance Guide'[4] to support Trust Boards to ensure a systematic approach to the review of mortality data and link this to improvement work.

In December 2016, the Care Quality Commission (CQC) published a review of the way that NHS trusts review and investigate the deaths of patients in England: 'Learning, candour and accountability'.[5] This review has led to a number of new requirements which take effect from April 2017. These include *'strengthened governance and capability, increased transparency through improved data collection and reporting, and better engagement with families and carers'.* A key requisite is the collection and publication on a quarterly basis of specific information on patient death through the newly instituted National Mortality Case Record Review Programme, run by the Royal College of Physicians (RCP) and commissioned by the Healthcare Quality Improvement Partnership (HQIP)[6]. This data will also require reporting within NHS Quality Accounts from 2017/18.[7]

As a result of the 2014 Department of Health report on the recommendations made by the Confidential Inquiry into premature deaths of people with learning disabilities, the Trust is required to support the Learning Disabilities Mortality Review (LeDeR) Programme (Appendix A). The LeDeR programme, delivered by the University of Bristol, has been commissioned by NHS England to support local areas in England to review the deaths of people with a learning disability to:

- Identify common themes and learning points and
- Provide support to local areas in their development of action plans to take forward the lessons learned

The Trust will support the LeDeR Programme by:

- Notifying the death of **any** of their patients with a learning disability (Appendix A).
- Inputting into a review into the circumstances leading to the death of those aged 4 years and over. This may involve sharing information about a patient who has died or participating in a multi-agency review where knowledge and perspectives in primary care will be of significant importance.

The Trust also has a statutory duty to support the Child Death Review Process (for all deaths <18 years of age).This process, as outlined in working together to safeguard children, incorporates a review of all childhood deaths for lessons learned and a rapid response and review of any unexpected deaths [(defined as "the death of an infant or child (<18 years old) which: was not anticipated as a significant possibility for example 24 hours before the death; **or** where there was a similarly unexpected collapse or incident leading to or precipitating the events which led to the death)].

2. **POLICY STATEMENT/OBJECTIVE**

The purpose of this policy is to provide a systematic approach to ensure that the Trust has robust governance arrangements in place to review, report and learn from patient deaths, to use this information to further improve patient care and feedback to staff, and to ensure open and honest communication with relatives and carers.

3. TRUST POLICY EQUALITY STATEMENT

This Policy forms part of Kingston Hospital Trust's commitment to create a positive culture of respect for all individuals including staff, patients, their families and carers as well as community partners. The intention is to identify, remove or minimize discriminatory practice in the areas of race, disability, gender, sexual orientation, age and religion, belief, faith and spirituality' as well as to promote positive practice and value the diversity of all individuals and communities.

4. SCOPE

This policy applies to all medical and nursing staff and others named in the Roles and Responsibilities section.

Where an incident /error occurs this should be reported as per the Trust policy within the timescales stated as Duty of Candour may apply.

5. DEFINITIONS

Morbidity and Mortality (M&M) meetings are a routine, structured forum for the "open examination and review of cases which have led to illness or death of a patient, in order to collectively learn from these events and to improve patient management and quality of care" (definition from Health Department, Victoria, Australia).

Structured Judgment Review (SJR)
A national system to introduce a standardised methodology for reviewing case records of adult patients who have died in acute general hospitals in England and Scotland. The primary goal of this review system is to improve healthcare quality through qualitative analysis of mortality data.

Serious Incident (SI)
Serious incidents in healthcare are adverse events, where the consequences to patients, families and carers or staff, organisations are so significant, or the potential for learning is so great, that a heightened level of response is justified (Serious Incident Framework, March 2015). SI's in the Trust are investigated in accordance with the Trust's policy for the 'Identification and Management of Serious Incidents' using a root-cause-analysis (RCA) methodology.

Root Cause Analysis (RCA)
An evidence based, structured investigation process which utilises tools and techniques to identify the influencing and underlying factors that led to an incident or problem, by understanding what, why and how a system failed. Analysis of these system failures and causes enables targeted and, where possible, failsafe actions to be developed and implemented which demonstrate significantly reduced likelihood of reoccurrence (Taylor-Adams, 2011)

6. ROLES AND RESPONSIBILITIES

6.1 All staff: Where an incident/error occurs this is reported as per the Incident Reporting Policy and within the timeframes stated, as Duty of Candour may apply.

6.2 **Chief Executive** is ultimately responsible for the implementation of this policy.

6.3 **Non-Executive Director responsible for learning from deaths.** A specified non-executive director on the Trust Board is responsible for the oversight of the process of learning from the mortality review process and for ensuring that the Trust responds appropriately.

6.4 **Medical Director** is responsible for the overall Mortality and Morbidity agenda and for reporting to the Trust Board on a quarterly basis.

6.5 **Trust Lead for Mortality and Morbidity** is responsible for the process of reviewing deaths within the Trust and ensuring that records are kept of these reviews to inform the Trust Board via the Medical Director. They will also ensure that individuals undertaking reviews have the competence to do so. They will oversee the Structured Judgment Review (second stage process)

6.6 **Service Line Clinical Directors** are responsible for either chairing the M&M meetings or appointing a Chair, for instance the Service Line's Risk Lead, and for creating a robust system to ensure adequate discussion, action planning and serious incident (SI) reporting where necessary. They will also ensure that actions are put in place in their Service Lines in response to learning from the process.

6.7 **Service Line Risk Leads/M&M Chair** is responsible for ensuring appropriate attendance by all relevant disciplines and professional groups, reporting M&M findings to service line governance meetings and the Quality Improvement Lead for Patient Safety, escalating any areas of concern, ensuring SIs are reported where necessary, and disseminating learning points as required. They are expected to ensure that the discussions/decisions within M&M meetings are recorded appropriately.

6.8 **Medical staff** are expected to fully participate in all M&M meetings that are relevant to their practice and to notify the deaths of all children <18 years to the child death overview panel via the form on the intranet and to contribute necessary information for this review process (which may include specific clinical information and/or copies of local morbidity review) **and** to report all "unexpected" child deaths on Ulysses, even if there are no issues concerning clinical care.

6.9 **Nursing staff and AHPs** should attend and fully participate in M&M meetings where patients they have cared for are being discussed.

6.10 **Quality Improvement Leads for Patient Safety** provide advice on the SI process where necessary.

6.11 **Lead Quality Business Analyst** provides data on all patients who have died in hospital to the Service Lines via the DISCO system and produces relevant data for discussion at the Mortality Surveillance Group and for reporting to the Trust Board.

6.12 **Mortality Surveillance Group** provides a forum for discussion and monitoring of mortality and a mechanism for providing assurance to the Trust Board. It reviews data on patient deaths, decides whether in-depth reviews are required and considers strategies to improve care and reduce avoidable mortality. The Group reports up to the Trust Board through the Clinical Quality Improvement Committee.

6.13 **Clinical Quality Improvement Committee** will receive information from the Mortality Surveillance Group through the committee structure and forward this to the Trust Board where appropriate.

6.14 **Serious Incident Group** will review any case where a 'second stage' review shows the need for a serious or moderate harm incident investigation.

6.15 **Trust LeDeR reviewer** works in collaboration with the CCG and relevant multiagency partners to review, in accordance with the LeDeR guidance, all deaths of patients with a learning disability (aged 4 and over) irrespective of whether the death was expected or not.

7. PROCESS FOR UNDERTAKING CASE RECORD REVIEWS

7.1 The two stage process

At Kingston Hospital NHS Foundation Trust, a two stage process has been adopted.

Stage	Type of case	Responsibility	Process
Stage 1	Mortality - patient death*	Service Line M&M meeting	Completion of DISCO form on a per patient basis. This is a structured review of diagnosis, coding, issues of care and treatment, death classification, adverse incidents, learning points and actions. Any patient death which is classified as 'Avoidable' or 'Unavoidable with issues' proceeds to a Stage 2 (SJR) review or alternatively an SI/RCA investigation (see flow chart).
	Morbidity		Completion of form at Appendix C in this policy.
Stage 2 SJR review	Mortality – patient death*	Clinician(s) trained in SJR methodology	Where a 'Structured Judgment Review' is the method decided, this is carried out as part of the National Mortality Case Record Review Programme provided by the Royal College of Physicians[8,9] If the care is judged to be poor or very poor, a second independent SJR review will occur.
		Clinician(s) trained in RCA methodology	Where an SI/RCA investigation is decided, this is carried out as per the Procedure for the Indentification and Management of Serious Incidents

*Data from these stages/reviews forms the report to the Trust Board

A LeDeR review and child death review (CDOP)will be informed by and run in parallel to the above process until such point as the programme concludes or recommendations inform a change in practice. For more information please see Appendix A.

7.2 Meeting content and attendance

- M&M meetings should be held at least monthly and an attendance record should be kept (template available at Appendix B).
- Working arrangements with other specialty M&M groups and frequency of joint meetings, if necessary, should be agreed.
- Membership should be from the wider multidisciplinary team.
- The meeting should be chaired by a Consultant who should ensure that all appropriate patients (morbidity cases as well as mortality) have their cases presented.
- A note-keeper should be appointed at each M&M meeting and notes kept. For patients who have died, the DISCO form should be completed. For other patients, the form at Appendix C can be used to record learning and the Minutes template at Appendix B can detail any actions to be taken.
- Senior doctors and the wider MDT involved in the care of the patient to be discussed must be made aware of the intention to discuss the case to ensure their attendance.

7.3 Case Identification

- All hospital deaths, post discharge deaths reported back to the Trust by community or other partners, and patients with complications/misadventure should be included.
- The meetings should not just focus on patients who have died but include other cases where learning needs to take place, eg never events, serious incidents, prolonged length of stay, unexpected complications or unexpected ITU admission. This should take place within one month of the patient's discharge/death.
- The list of cases provided by the Business Intelligence Team using the DISCO system should be cross-checked against patients known to have died during the period under review.
- It is good practice to check all complaints or concerns regarding patients care. PALS lead will inform the consultant in charge of patients care of any concern or complaint reported by family or cares.

7.4 Conduct of Service Line M&M meetings

- Cases should be presented using the SBAR (Situation, Background, Assessment and Recommendation) methodology. A template is available at Appendix D for presentation of cases, if required.
- Cases must not be discussed in the absence of the senior doctor(s) with primary responsibility for care of the patient or a nominated deputy.
- The chair is responsible for ensuring that all cases identified for discussion are presented at the meeting.
- The chair must encourage open discussion amongst the MDT, focusing on improving patient care as well as on learning.
- The chair should ensure that any discussion relates to the facts of the case only and that an individual's performance is not focused on .Should this be a concern, the chair should cease the discussion and refer the matter to the relevant clinical lead or manager.
- Chairs should follow up actions at subsequent meetings until actions have been implemented.

7.5 Service Line Reporting

- The note-keeper should complete the DISCO report for each patient who has died and the template at Appendix C for other patients discussed. Completion of these templates, together with the M&M agenda and minutes template (Appendix B) provide the minutes of the meeting.
- Any actions identified at the meeting should be recorded on the template(s) and the chair should appoint a lead to ensure these actions are completed within timelines. An action log should be kept to review through the Governance channels.
- Where a death is classified as 'Avoidable' or 'Unavoidable with issues', this should be flagged to the risk managers to classify level of investigation required (see Figure 1).
- Avoidable deaths or those with issues will also be flagged within the DISCO reporting system, to trigger a Structured Judgement review, to independently assess the quality of care and feed back to the service line
- Significant issues and identified actions will be fed back to the relevant service line performance board.
- The meeting notes should be stored electronically within the service line's designated folder and sent to the Service Manager for collation and dissemination of appropriate learning through the service governance process. The notes may be disclosable in a subsequent inquest.

- The death of any patient with a learning disability (aged 4 years and over) should be referred to the safeguarding lead for adults and children according to the patient's age at death, who will then in turn notify the LeDeR programme and NSH England via; http://www.bristol.ac.uk/sps/leder/notify-a-death/.
- The death of any young person aged <18 should be notified to the 'Single Point of Contact' for Child Death using the relevant form available on the intranet (link to child death notification form)

7.6 'Structured Judgement Review'

Where a death has been reported as 'Avoidable' or 'Unavoidable with issues' on the DISCO reporting form, a further review will be undertaken using the Royal College of Physicians (RCP)' 'Structured Judgement Review Method' as part of the National Mortality Case Record Review Programme[8,9], unless it is the opinion of the Service Line Clinical Director/Risk Lead that the case requires SI/RCA investigation Additionally, all deaths of patients with procedural or surgical complications, deaths after elective surgery, or where there is coronial involvement, complaint or concern raised by family/carers or issues of safeguarding, must go through the Structured Judgement Review process. *All such cases that go to Inquest are expected, by the Coroner, to have had robust investigation at Trust level.*This will be carried out by a clinician(s) trained in this methodology and be recorded in the RCP provided tool using Datix. Any death noted at SJR to have had poor or very poor care, should be reviewed by a second independent reviewer.

Any death occurring in a patient with learning disability will need to be reported through the LeDeR process (Learning Disability Mortality Review Process for Adults) as well as discussed at the Service Line M&M meeting and the DISCO form completed.[10]

Reports of Structure Judgement Reviews will be brought to the Mortality Surveillance Group for discussion, with collated outcomes fed back at the Trust board quarterly.

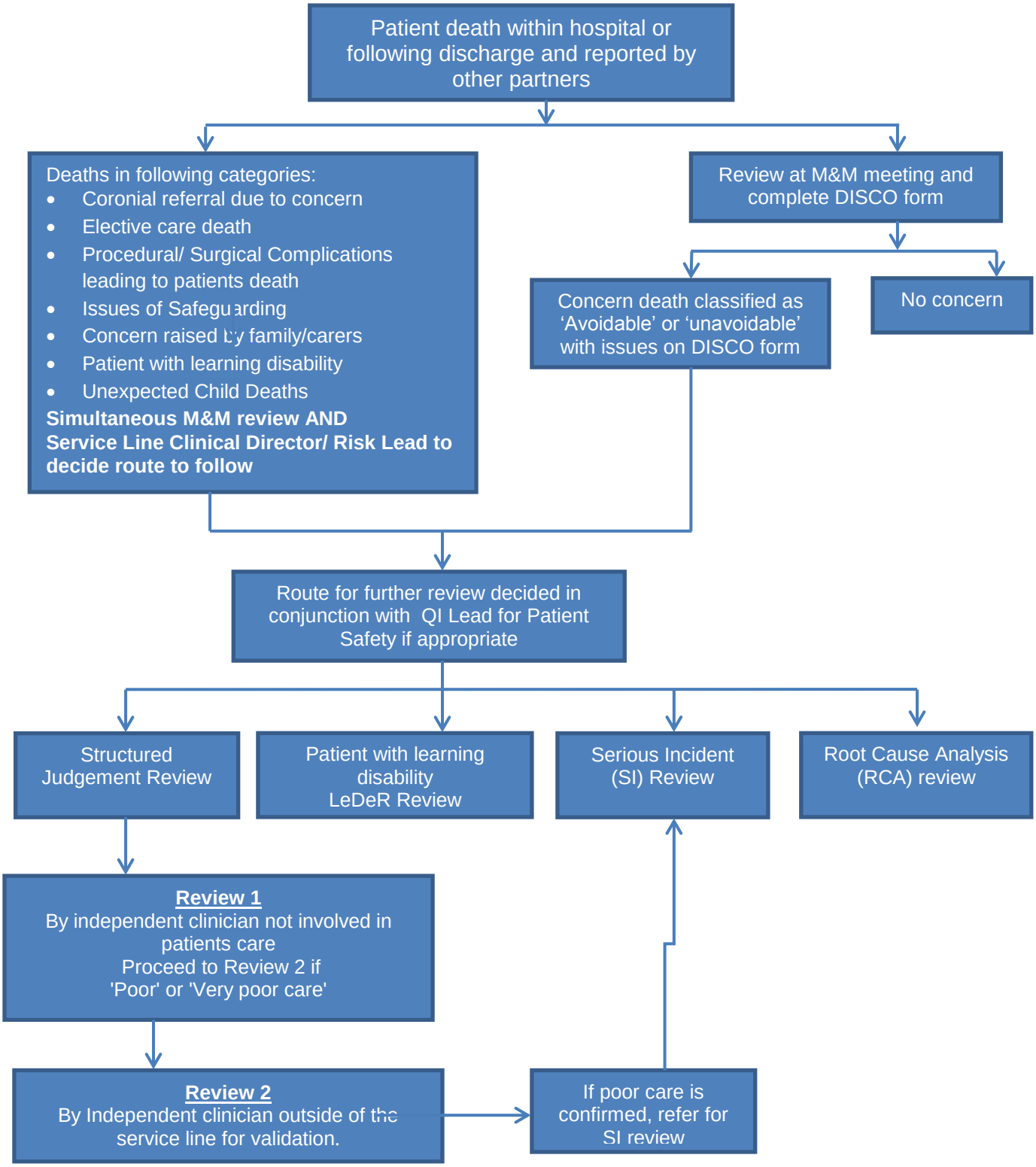
7.7. Serious Incident/Root Cause Analysis investigation

Where the Clinical Director/Risk Lead decides that a death merits escalation as an SI/RCA investigation, the Trust policy should be followed. If the escalation is accepted then review of the case using the Structured Judgement Review is not required. Such cases will be presented to the Serious Incident Group.

If following the second Structured Judgement Review, poor care is identified then this will need escalation as an SI/RCA investigation, following the Trust policy.

7.8 Flowchart of Mortality review process

Figure 1: Learning from deaths review process



7. 9 Dissemination of learning and improvement

- Learning from M&M meetings should be disseminated through the service line's Risk/Clinical Governance process as well as at service line M&M meetings.
- Trust-wide learning from collation of completed DISCO mortality forms and other information from M&M meetings will be discussed at the Mortality Surveillance Group, with any issues forwarded to the Clinical Quality Improvement Committee and fed back to the Service Lines. This will include generic themes analysis. Such issues that may be forwarded include requirements for a serious incident investigation, quality improvement project or further structured review of a cohort of cases.
- Where themes analysis suggests that improvement in treatment or care is required, a specific quality improvement workstream may need to be initiated.

8. RESPONDING TO MORTALITY ALERTS OR FLAGS

Any alert or flag regarding mortality received by the Trust will be discussed at the Mortality Surveillance Group, where a decision will be taken regarding further review and response. This will include any alert on HSMR statistics, CQC alerts or national audit outlier data.

9. REPORTING TO THE TRUST BOARD

The Trust must collect and publish, on a quarterly basis from October 2017, specified information on deaths, including those that are assessed as more likely than not to be due to problems in care. Evidence of learning and actions being taken as a consequence of these findings will also need to be published. The data to be published must include:

- Total number of in-patient deaths
- The subset of the total number that have been subject to case review
- Estimates of the number of deaths thought more likely than not to have been related to problems in care
- Relevant qualitative information, interpretation of data, learning for the Trust and the actions to be taken.

The process for providing this data at Kingston Hospital NHS Foundation Trust is as follows:

- All patient deaths will be reviewed at local Service Line Mortality and Morbidity (M&M) meetings as in Section 7 above.
- A DISCO form will be completed for each patient.
- Any death where the initial review indicates that the death was 'Avoidable' or 'Unavoidable with issues' will receive a second line review by a trained reviewer using the Structured Judgement Review method designed by the Royal College of Physicians. Any death under investigation by the Coroner will also receive a second stage review, as will other cases as detailed in Section 7.6.
- The data collected as part of the process above will then be presented as a paper at a public meeting of the Board on a quarterly basis. The publication will include relevant qualitative information, interpretation of the data, including learning for the Trust, and actions taken.
- The data for the year will then be summarised in the annual Quality Accounts and will also include an assessment of the impact that the actions taken have had within the hospital.

10. ENGAGEMENT WITH BEREAVED FAMILIES AND CARERS

The Trust recognises the importance of ensuring that the next of kin understand why a patient died, and have the opportunity to ask any questions and raise any concerns. Such communication will most commonly occur during the time of the patient's death or soon afterwards, and will be organised by the staff involved in the patient's care.

In order to ensure that the opportunity for such a discussion is offered for each deceased patient, the Bereavement Officer will routinely, as part of the death certification process, check that families have had adequate communication with staff about the patient's death. If it becomes apparent that more communication is needed, the Bereavement Officer will advise the PALS team of the details of the next of kin. The PALS team will log the patient's details on the Ulysses risk management database, and will make contact with the designated next of kin/contact to discuss how best to provide information or investigate concerns.

Any complaints/concerns the next of kin have will be logged and managed either informally via PALS, or through the formal complaints process. The PALS team will liaise with the clinician team to address any simple requests for information about a patient's condition and death.

If such a case is referred to a Consultant team, the possible requirement for the concern triggering a case record review will be raised with the Consultant. This relates to a possible opportunity to remind the Consultant team that such a death needs a proper review at an M&M in line with deaths where a family have a concern being investigated at some level.

11. TRAINING

The Royal College of Physicians has been commissioned to provide training in case record review skills to all acute NHS providers. A cohort of clinical staff will be trained in the appropriate methodology to enable them to train their peers and provide capacity for the 'Second Stage' review.

Training of LeDeR reviewers is provided by NHS England. The Trust will ensure at least one staff member is trained according to the LeDeR process.

12. IMPLEMENTATION

The policy will be placed on intranet and a global email sent out highlighting the policy to staff. The policy will also be published on the Trust's website on the publication page.

13. MONITORING

Element	Position responsible for monitoring	Method	Frequency	Reporting arrangements
Total number of adult in-patient deaths; subset of the total number that have been subject to case review; estimates of number of deaths thought more likely than not to have been related to problems in care	Mortality Surveillance Group Medical Director	Structured review of mortality	Quarterly	Trust Board

14. ASSOCIATED DOCUMENTATION

M&M guidelines
Informal and Formal Complaints Management Policy and Procedures
Procedure for the identification and management of Serious Incidents

15. REFERENCES

1. The Mid Staffordshire NHS Foundation Trust Public Inquiry (Francis Inquiry) (2013) Chaired by Robert Francis QC
2. Keogh, Professor Sir Bruce (2013) Review into the quality of care and treatment provided by 14 hospital trusts in England: an overview report.
3. Letter from Dr. Mike Durkin, Director of Patient Safety and Professor Sir Bruce Keogh, National Medical Director, NHS England to Medical Directors of Acute, Mental Health and Community Trusts (17.12.2015)
4. NHS England (2015) Mortality Governance Guide
5. Care Quality Commission (2016) Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England
6. Letter from Dr. Kathy McLean, Medical Director, NHS Improvement and Professor Sir Mike Richards, Chief Inspector of Hospital, Care Quality Commission to Medical Directors of acute, mental health and community trusts (22.02.2017)
7. Letter from Professor Sir Bruce Keogh, National Medical Director, NHS England and Dr. Kathy McLean, Medical Director, NHS Improvement to NHS Acute Trust CEs (06.01.2017 Gateway reference 06251)
8. Royal College of Physicians (2016) Using the structured judgement review method: A clinical governance guide to mortality case record reviews.
9. Royal College of Physicians (2016) Using the structured judgement review method: Data collection form
10. NHS England (February 2017) Learning Disability Mortality Review Process for Adults. Letter to Chief Executives of NHS Provider Services from Jane Clegg, Director of Nursing, NHS England, Sean Mclaughlin, Director of Housing and Adult Social Services Islington/ADASS Regional LD Lead, and Oliver Shanley, Chief Nurse, NHS England/NHS Improvement.

VERSION CONTROL

Version	Date	Author	Status	Comment
1.1	July 2017	A. Jones		Terminology of avoidable and unavoidable death, coroner input, inclusion of risk team, LeDer and child death review.

Appendix A: LeDeR death notification

Learning Disabilities Mortality Review (LeDeR) Programme

Process and Core Data Collection

Death notification information

Case ID: Click here to enter text.

Region of England: Click here to enter text.

1. Date on which you are notifying the death

Date: Click here to enter a date.

2. Name of the person notifying the death

Name: Click and type your name here.

3. Role and agency of person notifying the death

Details: Click here to enter text.

4. If/how the reporter knew the person who has died

Relationship: Click here to enter text.

Reporter's contact details

5. Telephone number: Click here to enter text.
6. Email address: Click here to enter text.
7. Postal address: Click here to enter text.

7a. Postcode: Click here to enter text.

8. Best way to contact them: Click here to enter text.
9. Reporter comments about death

Comment: Click here to enter text.

10. In which area of England was the person registered with a GP?

☐ North: Yorkshire & the Humber ☐ North: Lancashire & Greater Manchester

☐ North: Cumbria & the North East ☐ North: Cheshire & Merseyside

☐ Midlands & East: North Midlands ☐ Midlands & East: Central Midlands

☐ Midlands & East: West Midlands ☐ Midlands & East: East Midlands

☐ South: South West ☐ South: South East

☐ South: Wessex ☐ South: South Central

☐ London Region ☐ Unknown

Please note that from this point forwards, answers shown in red indicate that the case will require a full multi agency review.

---

11. Who else has been notified about the death? (Tick any that apply)

☐ No one else has been notified ☐ Coroner

☐ Safeguarding Board ☐ Child Death Review

☐ Police ☐ CQC

☐ I don't know

☐ Other: Click here to enter text.

If anyone else has been notified about the death, please give their contact details if you have them.

Contact details: Click here to enter text.

Details about the person who died

12. FIRSTNAME of the person who has died

Name: Click here to enter text.

13. SURNAME of the person who has died

Name: Click here to enter text.

14. Was the person known by any other name? If so, what was it?

Name: Click here to enter text.

15. Date of Birth

Date: Click here to enter a date.

16. Date of Death

Date: Click here to enter a date.

17. Age at Death

Age: Click or tap here to enter text.

18. Gender (Tick One)

☐ Male ☐ Female ☐ Other

19. Ethnic Group (Tick One)

☐ White ☐ Mixed / Multiple ethnic groups

☐ Asian / Asian British ☐ Black / African / Caribbean / Black British

☐ Other: Click here to enter text.

20. Marital Status (Tick One)

☐ Single ☐ Married / Partner

☐ Divorced / Separated ☐ Widowed

☐ Other: Click here to enter text.

21. NHS Number

NHS number: Click here to enter text.

22. Did they have any known conditions or health problems?

Details: Click here to enter text.

23. Usual address and postcode of the person who died

Address: Click here to enter text.

Postcode: Click here to enter text.

24. Did the person who died usually live alone?

☐ Yes ☐ No

25. Was the person who died in an out-of-area placement?

☐ Yes ☐ No

If yes, please state which area was their 'home' area: Click here to enter text.

26. Was the person subject to any restrictive legislation?

☐ DOLS ☐ Section of the Mental Health Act

☐ Detention in police custody/imprisonment

☐ Other: Click here to enter text.

If the person was subject to any restrictive legislation, please describe more fully: Click here to enter text.

Those who knew the person who died

27. Please can you provide the contact details of someone who knew the person well (e.g. postal address, email, telephone number)

Name: Click here to enter text.

Telephone number: Click here to enter text.

Email address: Click here to enter text.

Address: Click here to enter text.

Postcode: Click here to enter text.

28. Name and contact details of GP and surgery

GP name: Click here to enter text.

Surgery address and postcode: Click here to enter text.

Details of the Death

29. Place of Death

☐ Hospital ☐ Usual place of residence ☐ Hospice / palliative care unit
☐ Home of friend or relative

☐ Residential / nursing home that was not usual address

☐ Other: Click here to enter text.

Please give the name and contact details of the place the person died if it was not their usual place of residence: Click here to enter text.

30. Cause of death from Cause of Death Certificate 1a/1b/1c/2

Cause: Click here to enter text.

31. What did reporter think the case of death was?

Perceived cause: Click here to enter text.

32. Will there be a Post Mortem?

☐ Yes ☐ No ☐ I don't know

33. Will there be a Coroner's inquest?

☐ Yes ☐ No ☐ I don't know

34. Will there be any other investigation into the death?

☐ Yes ☐ No ☐ I don't know

If YES please describe: Click here to enter text.

35. Was the reporter surprised that this person died from this cause at this time?

☐Yes ☐No

If YES, why were they surprised: Click here to enter text.

Appendix B: Mortality and Morbidity (M&M) Meeting

Mortality and Morbidity Meeting Agenda and minutes template

Service Line	Ward	Date

Attendance list

Actions from previous meetings	Person responsible	Deadline	Progress

Review of CHKS data and trend	Time period reviewed:
SHMI	
Crude mortality	
HSMR	

Cases for discussion	Actions to be taken

Appendix C: Morbidity review form

Service Line		M&M date	
Patient's MRN		Patient's age	
Patient's date of admission		Patient's date of discharge	
Case category	☐ Morbidity	Mode of admission	☐ Emergency ☐ Elective
Does the patient have a learning disability?		Yes ☐	No ☐

DIAGNOSIS

Main diagnosis on admission	
Confirmed main diagnosis	

CODING

Coding inaccuracies?	Yes / No	Comment

ISSUES OF CARE/TREATMENT

Was there evidence of:	Yes / No	Comment
Delays in diagnosis, review, transfer, procedure, investigation, delivery of care or treatment		
Poor documentation		
Poor communication		
Drug error		
Unanticipated complication		
Failure to recognise or action a deteriorating patient (NEWS)		
Avoidable infection		
Inappropriate ward transfer		
Other		

SUMMARY

Summary of M&M discussion	

ADVERSE INCIDENTS

Adverse incident?	Yes / No	Already reported?	Yes / No

LEARNING POINTS AND ACTIONS

Learning point	Action to be taken	Person responsible	Deadline

Appendix D: **M&M presentation template**

Kingston Hospital NHS
NHS Foundation Trust

Mortality and Morbidity meeting	
Name of Service Line:	
Consultant team:	
Date:	
Presenter:	

Kingston Hospital NHS
NHS Foundation Trust

Patient details	
Patient identifier	
Sex	
Age	
Date of admission	
Date of death	
Cause of death	

On admission

Kingston Hospital NHS
NHS Foundation Trust

Situation: *Statement of the problem on admission*

- Presenting complaint
- Date of admission

Background: *Pertinent information*

- Past medical history
- Social history

Assessment:

- Working diagnosis
- Bloods and imaging

Recommendation**:**

- Plan

General course in hospital

Kingston Hospital NHS
NHS Foundation Trust

Day	Detail

Kingston Hospital NHS
NHS Foundation Trust

Adverse event / point of deterioration leading to death

Situation:

- Description of deterioriation / adverse event / problem

Background:

- Any relevant information on factors leading up to event

Assessment:

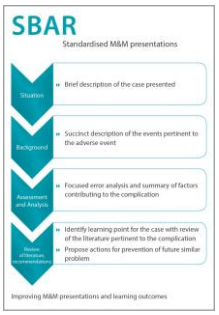
- Findings on examination and decisions made

Recommendation**:**

- Management of the patient and actions taken

Kingston Hospital NHS
NHS Foundation Trust

Case analysis
Initial learning points, if applicable
Proposed actions for prevention, if applicable



Reference: Safe Anaesthesia Liaison Group, Royal College of Anaesthetists