Imperial College Healthcare
NHS Trust

Trust-Wide Policy	
Version:	V4.0
Policy Category:	Patient Safety
Target Audience:	All Trust Staff
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Learning from Deaths Policy

Contents

1. Introduction

1.1 The National Quality Board published National Guidance on Learning from Deaths: A Framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care. The First Edition was published in March 2017. One of the regulations set out in this guidance (Chapter 1 sections 6, 12 and Annex C – Responding to Deaths) states that "Each Trust should have a policy in place that sets out how it responds to the deaths of patients who die under their management and care."

1.2 This document is the latest version of our Learning from Deaths policy and has been updated to reflect recent changes in practice, including the implementation of the Death Review Panel and associated case review processes, changes to the triggers and outcomes for structured judgment reviews and the inclusion of standards for Specialty Mortality and Morbidity meetings in the Trust.

2. Purpose & Scope

2.1 The purpose of the Learning from Deaths policy is to set out how we scrutinise the manner in which all deaths in our care occur, identify any learning and implement actions in response. It seeks to ensure the Trust engages meaningfully and compassionately with bereaved families and carers and supports staff to find all opportunities to improve the care the NHS offers by learning from deaths.

3. Roles and Responsibilities

3.1 **Trust Board** is collectively responsible for ensuring the quality and safety of healthcare services delivered by the Trust. Boards must ensure robust systems are in place for recognising, reporting, reviewing or investigating, and learning from any avoidable deaths or care and service delivery issues identified.

3.2 **Chief executive** has overall responsibility and final accountability for ensuring that the Trust has appropriate mortality review procedures in place, and that we work to best practice as defined by relevant regulatory bodies.

3.3 **Medical director** has been designated as the executive lead with responsibility at board level for mortality review procedures and learning from deaths processes, and as such will ensure that a robust system is in place which provides collated Trust level data on mortality rates, reviews of deaths, ratings of care and avoidability of deaths, and actions taken to address deficiencies in care and/or processes.

3.4 **Designated associate medical director** has responsibility for:

- Overall assurance that the mortality review process is in line with national standards
- Assuring the medical director that divisional processes are in line with the policy
- Statutory reporting in line with national policy, including in the annual Quality Account
- Chair of the Learning from Deaths Forum
- Chair of the Death Review Panel

3.5 **Lead Medical Examiner** is responsible for overseeing the Medical Examiner service and ensuring that all Medical Examiners are provided with the knowledge, skills and support to review deaths at the Trust. The Lead Medical Examiner is jointly accountable to the Trust Medical director and Regional medical examiner.

3.6 **Medical Examiners** are responsible for reviewing every inpatient death before the medical certificate cause of death (MCCD) is issued, or before referral to the coroner in the event that the cause of death is not known or the criteria for referral has been met. The Medical Examiner will request a Structured Judgement Review if required or if necessary refer a case for further review and possible investigation through our incident reporting process via the quality and safety team. The ME will also discuss the proposed cause of death including any concerns about the care delivered with bereaved relatives.

3.7 **Head of quality compliance and assurance** is responsible for ensuring that the reporting systems are fit for purpose, that the key deliverables of the policy are regularly monitored and reported, and for ensuring data is available for necessary reporting.

3.8 **Divisional directors** are responsible for ensuring the policy is implemented throughout the divisions and directorates. They are responsible for monitoring compliance with the policy and for ensuring structures are in place within clinical services to review deaths in accordance with this policy.

3.9 **Divisional governance directors** are responsible for ensuring that divisional mortality data and learning is reported to local governance forums, as well as escalating identified issues to the monthly learning from deaths forum.

3.10 **Heads of Specialty** are responsible for ensuring Specialty Mortality and Morbidity processes are operating in their specialties. This responsibility may be delegated to specialty mortality lead nominated by the Head of Specialty.

3.11 **Patient Advice and Liaison Service (PALS)** is responsible for ensuring relatives that make contact with the service are appropriately managed in accordance with approved policies.

3.12 **Quality and safety team** is responsible for reviewing mortality records and assigning Structured Judgement Reviews to reviewers within the parameters of this policy, as well as supplying mortality performance data to enable reporting in accordance with this policy.

3.13 **Structured judgement reviewers** are responsible for conducting objective case note reviews of identified cases. They will seek, when required, specialist input and advice from clinical colleagues, including members of the multi-disciplinary teams to ensure high quality, comprehensive review is undertaken, using the full range of medical records available to them. They meet weekly to discuss their findings and identify any themes for learning which will be presented at the monthly learning from deaths forum.

3.14 **Learning from Deaths Forum (LfDF)** will oversee the mortality review process both Trustwide and within the divisions and report on the themes emerging for organisational learning. The LfDF will sign-off the Trust quarterly mortality report before it is presented to the Executive Management Board (EMB) Quality Group. Additional responsibilities of the forum include:

- Investigation of any external mortality alerts received such as those received from Dr Foster.
- Review of benchmarked mortality data and initiation of further investigations into relevant external alerts.
- Data from reviews should be triangulated with other information and evidence from other sources, for example, performance dashboard, clinical outcome data and alerts, complaints and audit results.
- Liaise with appropriate Trust services, most notably the end of life service, to ensure appropriate actions are identified and service improvements implemented from learning from deaths data.
- The membership and Terms of Reference (ToR) of the LfDF are included in Appendix 1. EMB quality group will review all data submission prior to any external reporting.

3.15 **Death Review Panel (DRP)** is responsible for triangulating the outcomes from SJR reviews and local investigations to identify learning and outcomes from the case and agree if the level of care received by the patient caused the death and the final harm level of the incident.

4. The process

4.1 All patients who die following admission to any of the Trust's sites are regarded as 'deaths in care' and will be subject to this policy.

4.2 Medical examiner (ME) review

4.2.1 A Summary of Death Certification is completed by the attending doctor independently to the review by the medical examiner so that a record of the attending doctor's view on the primary cause of death is recorded to ensure transparency.

4.2.2 The ME will independently scrutinise the clinical notes and care/treatment provided to the patient. They will formulate a cause of death and identify any concerns. The ME will advise on cases that require referral to HM coroner, however the attending doctor remains legally accountable for ensuring that referrals are made in a timely manner, with the support of the ME service.

4.2.3 The ME will speak with the attending doctor to agree the final cause of death, ensuring that it is a cause of death that will be accepted by the General Registry Office.

4.2.4 In the event a MCCD is to be issued, the ME will liaise with the bereaved to discuss the proposed cause of death, to establish that they understand and agree and also whether they have any concerns about the care provided.

4.2.5 The ME will carry out a pragmatic review of the patient record to identify any concerns about care.

4.2.6 The ME will, based on the above reviews, complete Section ME-1 (Part B) section of the incident reporting mortality module entry to document referral to the coroner or options for requesting:

- Structured Judgement review – automatic triggers or specific concern from ME.
- Governance review for identification and review of any incidents.
- Feedback to clinical teams from the bereaved comments.

N.B. Stillbirths are not reviewed by the ME.

4.3 **Specialty M&M review**

4.3.1 All deaths must be reviewed at specialty based multi-disciplinary Mortality & Morbidity (M&M) reviews.

4.3.2 In addition, clinical teams should undertake in-depth specialty M&M reviews and discussions of any case that demonstrates an opportunity for reflection or learning or any case where a Medical Examiner has identified potential concerns that require investigation.

4.3.3 M&M reviews must be objective and multidisciplinary, and must involve at least one consultant not directly involved in the care of the patient. Where relevant, the input of senior clinicians from other relevant specialities should be invited.

4.3.4 A record of the Specialty M&M review must be documented in the relevant section of the mortality module on our incident reporting system

4.3.5 The form adopts a standardised approach to M&M discussion utilising the SBAR approach (Situation, Background, Analysis, Recommendations). The case review should conclude with a clear identification of any learning points as a result of the review. If, following local M&M, any concerns are raised, the clinical team have an opportunity at this point to refer the case for Structured Judgement Review (SJR) or report the specific issue as an incident to be managed through this route.

4.3.6 The outcomes of Specialty M&M reviews must be disseminated through appropriate clinical governance structures.

4.3.7 A best practice guide for Specialty M&M reviews is in Appendix 2.

4.4 **Structured judgement review**

4.4.1 The Structured Judgement Review (SJR) is a clinical judgement based review method with a standard format. SJR reviewers provide a score on the quality of care provided through all applicable phases of care and will also identify any learning. The SJR will be completed within seven calendar days of referral. Phases of care are: 1: admission and initial management, 2: ongoing care, 3: care during a procedure, 4: perioperative care, 5: end-of-life care, 6: overall assessment of care.

4.4.2 SJR reviewers will make explicit written comments about each phase of care and then give a score using the Confidential Enquiry into Stillbirths and Deaths in Infancy (CESDI) grading system of 0 to 3:

- CESDI 0 = No Suboptimal care
- CESDI 1 = Suboptimal care, but different management would have made no difference to the outcome
- CESDI 2 = Suboptimal care where different care might have made a difference (possibly avoidable death),
- CESDI 3 = Suboptimal care would reasonably be expected to have made a difference to the outcome (probably avoidable death)

4.4.3 Outcome reports for all SJRs will be disseminated by the office of the medical director to divisional and directorate leads who will share with clinician's involved in the care/treatment of the patient and carry out a case review discussion at the next specialty M&M meeting.

4.4.4 All SJR cases with a score of CESDI 2 or CESDI 3 in the overall assessment phase of care will automatically trigger a 72 hour report to be completed by the directorate. The SJR and 72 hour report will then be presented to the weekly MD incident review panel, where the following will be decided:

- Either the panel decides that the case meets the criteria for reporting under the Serious Incident (SI) framework. A SI is then declared and investigated;
- Or the panel decides that it does not meet the criteria for reporting under the SI framework but a level one internal investigation should take place;
- Or the panel decides that it does not meet the criteria for reporting under the SI framework and that the directorate is to undertake a local investigation to be managed and overseen by local directorate arrangements.

4.4.5 Cases will be brought to the Death Review Panel once all required investigations have completed in order to triangulate the outcomes from these reviews and agree the final outcome for the case.

4.5 **Criteria for SJR referral**

4.5.1 SJRs are completed on all adult deaths (i.e. patients aged 18 or over) occurring within the Trust. The following is the current list of criteria for referral for a SJR:

- Requests made by a Medical Examiner
- Concerns raised by family / carers
- Patients with learning disabilities
- Patients with severe mental health issues
- Unexpected deaths
- Elective admission deaths
- Requests made by speciality mortality leads / through local Mortality and Morbidity review processes
- Service or diagnosis alarms as agreed by the acute provider collaborative mortality surveillance group

4.5.2 Deaths referred to the coroner or through the incident reporting process will be also be referred for an SJR if the above triggers are met.

4.5.3 Child deaths, neonatal deaths and stillbirths will continue to be excluded from the SJR process therefore these triggers do not apply for those patient groups. See sections 4.6 and 4.7 for further detail about review processes for child deaths, neonatal deaths and stillbirths

4.6 **Children and young people**: all child deaths are reported to and reviewed through Child Death Overview Panel (CDOP) which is an independent review aimed at preventing further child deaths. The ME service is aligned and works alongside the CDOP process. More detail on the CDOP process can be found in the Safeguarding Children & Young People Operational Policy here: https://intranet.imperial.nhs.uk/Interact/Pages/Content/Document.aspx?id=3249&SearchId=

4.7 **Still Births, neonatal and maternal deaths**: all stillbirths and neonatal deaths (up to 28 days) are reviewed through the Perinatal Mortality Review Tool (PMRT) process, with neonatal deaths also reviewed through the Child Death Overview Panel (CDOP) process. Maternal deaths (during pregnancy and up to 12 month post-delivery unless suicide) are reviewed by Healthcare Safety Investigation Branch and action plans to address issues identified are developed and implemented through the maternity governance processes. More detail on the PMRT process can be found in the PMRT SOP here: https://intranet.imperial.nhs.uk/Interact/Pages/Content/Document.aspx?id=3249&SearchId=

4.7.1 PMRT cases where it has been identified that care issues would have made a difference to the outcome for the mother or baby (PMRT outcomes C and D) are also referred to the Death Review Panel for further review.

4.8 **Patients with a learning disability**: all deaths of patients with a learning disability are reported to and reviewed through the Learning Disabilities Mortality Review (LeDeR) process. SJRs for patients with learning disabilities are undertaken within the Trust and will be reported through the Trust governance processes. Feedback from LeDeR reviews is provided to the Trust when concerns are identified. When this occurs, cases will be reviewed through the MD Panel and a decision made regarding any further investigation. Learning will be incorporated into the quarterly learning from deaths report.

5. Involvement of the bereaved

5.1 Good bereavement support starts on the ward prior to a person dying and continues through the death into the post bereavement phase. Bereavement support is given by the specialist palliative care team but mostly by staff, particularly nurses, on the ward.

5.2 Following any death, bereavement support is provided through the Patient Affairs Service. They offer a caring and empathetic service at a time of distress and sadness for families and will guide and support relatives through the practical aspects of dealing with bereavement

5.3 It is important that the Trust engage with bereaved families and carers, including giving them the opportunity to ask questions or raise concerns in relation to the quality of care received. In the first instance, this contact is made by the Medical Examiner Officer who will pass on their concerns as detailed above and recommend their connection with Patient Advice & Liaison Service (PALS), governance processes or request for a SJR.

5.4 Should a further investigation through the Trust governance processes take place the family will be given the opportunity to be involved in the process and for any of their comments or concerns to form part of the terms of reference, as per the Serious Incident Policy. A single point of contact will be identified to keep the family updated on the progress of the investigation. Once the investigation has been completed the findings of the investigation will be shared with the family. The family should be offered a copy of the report along with a meeting with the lead investigator to take them through the findings and actions.

6. Organisational learning from SJRs and other investigations

6.1 The purpose of the review is to identify areas of organisational learning for the Trust to improve patient care and treatment, and prevent avoidable deaths.

6.2 The outcome of every death will be fed back to the directorate whose care the patient was under. It is expected that the directorate will discuss individual cases at their local M&M meetings. The specialty may be required to undertake local investigations or provide context to the care and develop any action plans resulting from the SJR.

6.3 SJR cases deemed as ‘possibly’ or ‘probably’ preventable will be presented to the weekly medical director’s incident review panel, where it will be decided if further investigation is required. The Death Review Panel will triangulate outcomes from all required investigations.

6.4 The findings of any other investigations will be triangulated with the SJR to understand whether any organisational factors contributed to the death.

6.5 A weekly review meeting, chaired by the associate medical director will take place to review any complex cases and triangulate all associated reviews and investigations. These cases will also be scrutinised to ascertain whether the death was avoidable, or if there are any themes which have led to poor patient care, or experience in relation to the care and treatment provided and the quality of end of life care. Any learning from this process will be disseminated across the divisions via the learning from deaths forum and the EMB quality group.

7. Implementation and dissemination of learning

7.1 The Trust Learning from death quarterly report will aggregate outcome data from all learning from death review processes to identify Trustwide trends, themes and learning. This will be disseminated through the Learning from Death forum to clinical divisions.

7.2 Divisional quality and safety meetings have a standing agenda item to discuss key themes from learning from death reports.

7.3 Learning and outcomes from all SJRs will be disseminated to divisional and directorate leads so that learning can be shared with clinical teams.

7.4 Specialty M&M meetings will identify themes, trends and learning at a specialty level. This will be recorded and disseminated to specialty clinical teams and will also feed into wider Trust learning from death programme.

7.5 Learning will include examples of good practice and areas for improvement. All elements of these will be reviewed by the learning from deaths forum and fed back through divisional/directorate governance processes in a uniform format, which explicitly states issues identified, expected changes in practice and monitoring after implementation of changes.

7.6 Data from reviews will be aggregated to provide Trust level data on deaths, particularly focusing on the number of avoidable deaths in the Trust and the quality of end of life care. These data will be reported upwards to the Board via the EMB Quality Group, EMB and the Quality Committee.

8. References

- CQC (2016) Learning, candour and accountability: A review of the way NHS Trusts review and investigate the deaths of patients in England
- RCP Mortality Case Record Review Programme
- NHSE (2018) National guidance for NHS Trusts engaging with bereaved families
- Learning Disability Mortality (death) Review programme (2021)
- MoJ (2009) Coroner's and Justice Act

9. Monitoring Arrangements

Lead	Policy Objective	Method	Frequency	Responsible Committee / Group
Head of quality compliance and assurance	That SJRs are conducted in accordance with the National Guidance on Learning from Deaths	Quality assurance audit Reporting of completion data through the LfD dashboard	TBC Monthly	Weekly learning from deaths meeting
Divisional governance directors / AMD	That learning is shared and actions taken in response to the findings of the processes outlined in this policy	LfD communications plan Divisional/directorate action plans	Monthly	Learning from deaths forum Divisional quality and safety committees
AMD / Head of quality compliance	That data and learning is provided quarterly to the	Quarterly learning from deaths report	Quarterly	EMB Quality Group

and assurance	board and shared with NHSE			
AMD / Head of quality compliance and assurance	That bereaved relatives and carers are fully involved in the SJR process, and any subsequent investigations	Monitoring of complaints and concerns	TBC	Learning from deaths forum

10. Definitions & Abbreviations

10.1 Definitions

10.1.1 **Notification of Death Form**: Receipt of this form by the clinical directorate triggers a mortality review.

10.1.2 **Structured Judgement Review:** is an independent review, conducted by an independent individual, trained in SJR.

10.1.3 **SI:** serious incident requiring investigation.

10.1.4 **Death certification:** The process of certifying, recording and registering death, the causes of death and any concerns about the care provided. The process includes identifying cases for referral to the Coroner

10.1.5 **Investigation:** The act or process of investigating; a systematic analysis of what happened, how it happened and why. This draws on evidence, including physical evidence, witness accounts, policies, procedures, guidance, good practice and observation - in order to identify the problems in care or service delivery that preceded an incident to understand how and why it occurred. The process aims to identify what may need to change in service provision in order to reduce the risk of future occurrence of similar events. The Serious Incident Policy details the process of investigation, including the different levels of investigations required in specific circumstances

10.1.6 **Duty of Candour:** Health and Social Care Act 2008 Regulation 20. The intention of this regulation is to ensure that providers are open and transparent with people who use services and other 'relevant persons' (people acting lawfully on their behalf) in general in relation to care and treatment. It also sets out some specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong.

11. Abbreviations

11.1 **ICHT:** Imperial College Healthcare NHS Trust

11.2 **CQC:** Care Quality Commission

11.3 **SJR:** Structured Judgement Review

11.4 **PALS:** Patient Advice Liaison Service

11.5 **M&M:** Morbidity & Mortality

11.6 **MD:** Medical Director

11.7 **SI:** Serious Incident

11.8 **LfDF:** Learning from Deaths Forum

11.9 **EMBQ:** EMB Quality Group

11.10 **ToR:** Terms of Reference

11.11 **MCCD:** Medical Certificate of Cause of Death

11.12 **SBAR:** Situation Background Analysis Recommendation

11.13 **LeDeR:** learning from deaths of people with a learning disability

11.14 **CDOPs:** Child Death Overview Panel

11.15 **HQIP:** Healthcare Quality Improvement Programme

11.16 **MBRRACE-UK:** Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK

11.17 **PMRT:** Perinatal Mortality Review Tool

12. Supporting Information

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Document Lead:	Darren Nelson, Head of quality compliance and assurance
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Committees / Groups	Learning from deaths forum

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Appendix 1: Learning from Deaths Forum terms of reference

May 2021

Duties

This group has been established to provide assurance to the Trust Board that there is a strategic approach to reviewing all mortality at the Trust, which ensures that there is a consistent and effective process for learning from deaths at an organisational level and across all clinical areas.

By benchmarking outcomes of death reviews the committee supports the Trust to examine, monitor and improve the quality of patient care and experience.

The Committee's main responsibilities are as follows:-

- To provide assurance to the Trust Board that the Trust is meeting all statutory duties for the national learning from deaths programme.
- That the Trust's learning from deaths governance processes are effective and include the participation of all appropriate staff groups.
- Ensure learning from death themes are discussed and shared with stakeholder groups.
- Oversee the Trust Learning from Death processes and their outcomes.
- To ensure that there is dissemination of learning outcomes, sharing of good practice and integration of common themes to improve quality and safety.
- To engage with the evolving national strategy for learning from deaths.
- To lead and promote effective governance of mortality within divisions through sharing best practice and implementing Trust-wide protocols.
- Inform and advise the Executive of any areas of concern and the progress of any necessary investigations.

Performance

- To monitor and report learning from deaths metrics via the Trust level dashboard.
- Identification of themes for learning and improvement.
- To benchmark mortality at a procedure and diagnostic level and to provide oversight of investigations where outcomes appear to be statistically significantly different to the national average or appropriate peer groups.

Ratification of Procedural Documents

- To ratify procedural documents related to the learning from deaths programme.

Reporting

- Executive Management Board
- Quality Committee (quarterly)
- Trust Board (quarterly)

Membership

The core membership of the committee will comprise of the following:

- Associate Medical Director (Chair)
- Chief of Staff
- Structured Judgement Reviewers (6)
- Head of Quality Compliance and Assurance
- Divisional Director for Clinical Governance – SCCS
- Divisional Director for Clinical Governance – MIC
- Divisional Director for Clinical Governance – WCCS

- Quality Compliance and Assurance Lead
- Lead Medical Examiner (quarterly)
- Clinical lead for end of life care
- Corporate Nursing Representative
- Trainee Representative

Other Trust officers may be asked to attend the committee as appropriate.
The committee will be chaired by the Associate Medical Director Audit & Effectiveness, who can request any member of the group to act as Vice-chair.
Administrative support for the committee will be provided by the Quality and Safety team.

Expected Attendance

Members of the committee will be expected to attend each of scheduled meetings throughout the year.

Quorum

A quorum will consist of no less than 50% of the committee membership

Frequency of Meetings

The Committee will meet monthly.
An extraordinary meeting may be called at the request of the Chairman of the Committee.

Declaration of interests

All committee members must declare any conflict of interests, should they arise, and exclude themselves from the meeting for the duration of that specific item.

Authority

The Committee is authorised to investigate any activity within its terms of reference. It is authorised to seek and may secure any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

Reporting (to Board/High Level Committees)

The Committee will report to the Executive Management Board that in turn reports to the Trust Board.
The annual Quality Accounts will incorporate a summary of the outputs from the Committee.

Procedures

The Committee shall appoint the a member of the Quality & Safety Team as secretary to prepare agendas, keep minutes and deal with any other matters concerning the administration of the Committee.

Review of Terms of Reference

The Terms of Reference (TOR) will be primarily reviewed six months after the first meeting. Thereafter, the TORs will be reviewed and amended accordingly at regular intervals, as a minimum this Terms of Reference will be reviewed annually.

Monitoring Effectiveness of the Committee

Present regular reports to the Board and committee from which the committee derives its delegated authority.
Review the terms of reference for the committee, reaffirming the purpose and objectives of the committee.

Appendix 2 - Specialty Mortality and Morbidity reviews – best practice guide

The Learning from Deaths policy sets out how we scrutinise the manner in which all deaths in our care occur, identify any learning and implement actions in response. It seeks to ensure the Trust engages meaningfully and compassionately with bereaved families and carers and supports staff to find all opportunities to improve the care the NHS offers by learning from deaths.

Specialty Mortality and Morbidity (M&M) reviews play a key role in the Trust's learning from deaths processes. Effective reviews are opportunities to locally identify improvement opportunities and share learning across the Trust so that other specialties and directorates benefit.

This guide sets out M&M review best practice that has been evidenced in the Trust and is to used by specialties to plan and carry out effective reviews and disseminate information and learning after.

Identifying cases for discussion

- All deaths within the specialty should be reviewed at an M&M meeting.
- All cases where Medical Examiner review has identified issues of concern must have a detailed review at specialty M&M meetings.
- All cases case that demonstrate an opportunity for reflection or learning must have a detailed review at specialty M&M meetings.
- In addition, clinical teams should consider setting local quality indicators and thresholds as M&M review triggers so that all cases in certain scenarios are reviewed.

Identifying themes, trends and learning

- Mortality rates should be reviewed in M&M reviews as well as individual cases. This will support identifying trends and themes.
- Mortality rates and trend data is available on the Mortality Dashboard on QlikSense.
- Meetings should be scheduled so there is enough time to consider the detail of each case and identify common themes, trends and learning.

Coordination and administrative support

- Specialty M&M reviews should have a dedicated person to coordinate meetings and take actions and minutes in each meeting.
- Actions and minutes should be recorded locally and shared quarterly with quality and safety meetings.
- A record of the Specialty M&M review must be documented in the relevant section of the mortality module in Datix so that learning and outcomes are included in Trust-wide learning from death processes.

Sharing learning

- Actions should be circulated to meeting attendees and relevant accountable and responsible owners.
- Progress should be monitored locally and through quarterly quality and safety meetings.
- Learning and improvements should be circulated to all doctors and lead nurses through local communication cascades after each meeting. An example of a local safety briefing produced after M&M review meetings is for on next page.

Example of local safety briefing circulated after M&M review meeting

1	Day surgery cases: **check patients' social status** (ie. chaperone) to allow them to go home prior to GA
2	Check the **Cerner prescription chart** prior to administering drugs (esp. analgesia & antibiotics). If on PCA or Fentanyl epidural **– stop other Opioids**.
3	Ensure **traceability tags** are completed and **donor unit number** recorded on the anaesthetic chart
4	Minimise distraction bias/ errors. **Prep Stop Block** is a **mandatory 2 person process**. 'Stop Before You Block' **pause immediately prior to injection**.

Making our care safer