Scottish Mortality and Morbidity National Survey

Part 1: Quantitative analysis A Scotland wide snapshot of Mortality and Morbidity Meetings

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Preface

Mortality & Morbidity (M&M) meetings or forums are a unique and invaluable resource for education, quality improvement and patient safety. The learning potential from adverse outcome as well as from excellent care, in such forums is immense and there is a definite evolution in its role and mechanisms towards enhancing patient safety and quality improvement. However, there remains significant challenges and variation in the M&M process which restricts its potential.

The Scottish M&M Programme's focus is to develop a structured and where feasible standardised national approach to M&M process that not only serves its purpose but also fits in with current governance structures.
The programme currently seeks to improve this process on three fronts:
1) Education and training on effective M&M process
2) Identifying system(s) that can support a robust M&M process
3) Improving shared learning within and between health boards.

To achieve this, we require a clearer description and understanding of current M&M practice across NHS Scotland. The Scottish Mortality and Morbidity Programs National Survey enable us to characterise M&M meetings or similar practices and gain insight into the value as well as its challenges in learning and improving patient care. The intelligence gathered from responses will be used to help shape the national work and guide future service development on improving the quality and output of Mortality and Morbidity Meetings.

We are very appreciative to the many who took part in this survey. I am also grateful to Dr A Stirling, the SMMP team, those acknowledged and the many others for their contribution to this work. The positive response rate to the survey confirms the wider interest in the development of this process and we look forward to advancing this exciting work.

Mr Manoj Kumar
Scottish Mortality and Morbidity Programme
Steering Group Lead and Consultant Surgeon

Introduction

Mortality and Morbidity (M&M) meetings have been traditionally adopted in medical practice as a mechanism for peer review and medical education (Gore, 2006) but, more recently M&Ms have been evolving into a mechanism for enhancing patient safety and quality improvement. Learning and improving are key personal, team and system attributes that are fundamental for safety and quality. A structured and well organised M&M process provides an excellent opportunity to learn, respond and improve the quality of care provided. It has been advocated that M&M should utilise a standard, consistent approach to case review and adverse event analysis in order to maximise their impact in improving patient safety (Cifra et al, 2014). Healthcare organisations across the globe have attempted to identify current M&M practices within specific sub-specialities such as; paediatrics and surgery (Cifra et al 2014, Freidman et al, 2004 and Gore 2006) and more recently, the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) conducted a survey of mortality review processes in NHS England, albeit this did not exclusively examine the unique forum of M&M meetings (Smith et al, 2015).

What practice currently exists in Scotland?

Currently NHS Scotland does not systematically collate, analyse, interpret and disseminate learning from M&M, to complement other sources of information, to improve quality and safety of healthcare. However, a number of specialty specific programmes are available across Scotland/UK such as: SMART (Scottish Mortality Audit Renal Therapy), EMBRACE (maternal Death) and NCEPOD topic specific mortality audits.

Better ways to capture, curate and disseminate this type of learning and knowledge locally and nationally will support our quality ambitions. Anecdotal intelligence identifies significant variation in the approach to M&M by Health Board, specialty and unit, although there is a paucity of hard data to map the current Scottish picture. There is variation in maturation of existing M&M processes and meetings. It is important to understand the breadth and experience of M&M in Scotland in order to inform the development of the SMMP.

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Acknowledgements

We would like to thank our colleagues for their input into this report.

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Executive Summary

Mortality and Morbidity (M&M) meetings have been traditionally adopted in medical practice as a mechanism for peer review and medical education (Gore, 2006) but, more recently M&Ms have been evolving into a mechanism for enhancing patient safety and quality improvement.

Currently NHS Scotland does not systematically collate, analyse, interpret and disseminate learning from M&M, to complement other sources of information, to improve quality and safety of healthcare. Anecdotal intelligence identifies significant variation in the approach to M&M by Health Board, specialty and unit, although there is a paucity of hard data to map the current Scottish picture.

The purpose of this survey is to describe current M&M activity in acute specialties across NHS Scotland and establish clinician responses to a proposed national M&M programme in order to guide future service development.

Findings

Approximately 20% of the consultant Grade Medical workforce responded to the survey.

Only 9% of M&Ms are conducted within two weeks of death. Most respondents report M&Ms take place at 1-3 months following an event (44%). 9% of respondents reported that the M&M took place over 3 months after the death and 11% were unsure of the timing.

Those working in critical care (53%) and in General Surgery (18.8%) were most likely to hold an M&M within 2 weeks. Haematology, Mental Health and Neurology, had the highest, within specialty proportion of cases reviewed more than three months after the event of 37.1%, 30% and 60% respectively.

Time protected for M&M varied by Board from 30.4% to 85.7% of respondents.

50% of respondents reported that learning from M&Ms is used routinely/most of the time or frequently in NHS. In contrast 31% thought it was used infrequently and a further 9% perceived that it was never used.

The top four recommendations that came from the questionnaire in order of rank were:

1. Provision of an electronic structured M&M system was ranked highest by 19% and second highest by 17%
2. Assistance with quality improvement generated from M&M
3. Analyses, reports and support with data provision
4. A best practice statement

The top 4 recommendations for important characteristics of an electronic structured M&M system

1. learnt and actions to be taken (free text)
2. Background and summary of the case
3. A theme/category for lessons learnt and action (i.e. communication/decision making/technical skill issue)
4. Mechanism to share learning with another sub-speciality or hospital

The main perceived benefits of a national approach were reported as improve shared learning from M&M, improvement in Quality of Care, clearer and more robust governance and minimising variation.

Background

The M&M Programme's focus is on the added value of M&M meetings and related processes, which are unique in their own right and represent established and embedded professional expectation. Learning from deaths and patient harm occurs through a number of mechanisms including adverse event reporting, significant adverse event reviews, complaints, ombudsman reports and fatal accident enquiries.

M&M processes offer a unique opportunity for learning to occur and action to be initiated, close to the patient care episode, by the clinicians directly involved in care delivery. M&M processes can complement other mechanisms for review of deaths or harm such as adverse event report or retrospective case record review, but importantly has ownership and participation of clinical care teams, who are in close proximity to patient care and thereby have direct opportunity to improve quality of care delivery identified through such learning mechanisms.

The aim of the SMMP is to: Improve quality of care by enhancing learning from M&M processes in Scotland.

The primary drivers for this aim are:

1. To generate learning at individual, team and system level to enable improvements in the quality of care.
2. To develop and support the implementation of structured and standardised approaches to mortality and morbidity processes.
3. To improve clinical engagement, staff experience and well being through peer support and team working.
4. To enable generation and use of local intelligence (data and narrative) that supports local learning and improvement.
5. To support national collaboration and generation of a national intelligence (data and narrative) that supports the identification of key themes and common improvement opportunities.

Rationale for survey

Currently, there remains a paucity of intelligence to definitively describe M&M processes across NHS Scotland including sub-specialty variation, frequency and through-put. Hence, at present there are limitations in providing NHS organisations, professionals and the public with reassurance that learning generated from M&M is consistently shared and acted upon in order to enhance patient safety and quality of care across the health care system.

Methods

The purpose of this survey was to describe current M&M processes in acute specialties across NHS Scotland and establish clinician responses to a proposed national M&M programme in order to guide future service development.

A web based cross-sectional survey of consultant grade medical staff was undertaken by NSS utilising Lime Survey. The 24 question survey, co-created by the SMMP operational group, was distributed via the NHS Education for Scotland (NES) Scottish Online Appraisal Resource (SOAR) and/or via Health Board Medical Directors. The survey closed on 31st October 2015 with over 1000 responses.

Prior to sending out the survey, NSS sought internal approval for the work and received confirmation from R&D that ethical approval was not required as the work constituted service evaluation.

The survey results will be reported in two parts.

1. A quantitative- Scotland wide survey to all – snapshot of M&M in Scotland
2. A qualitative – free text.

This paper is a report of Part 1, the quantitative analysis.

Results

There were 1012 responses from individuals based in 14 territorial Health Boards, National Waiting times and special Health Boards (see Table 1). This represents a response rate of approximately 20% of the NHS Scotland consultant population, based on ISD national workforce statistics. The majority of respondents were from NHS GGC (18.7%), followed by 17.9% from NHS Lothian. In addition a further 17.5% did not disclose their Health Board.

Table 1 Proportion of responses by Health board.

NHS Scotland HB	% response
Ayrshire and Arran	6.1
Borders	1.7
Dumfries and Galloway	1.5
Fife	2.5
Forth Valley	4.6
Grampian	11.8
Greater Glasgow and Clyde	18.7
Highland	3.8
Lanarkshire	5.0
Lothian	17.9
Island Boards	1.0
National Waiting Times Centre	2.1
Tayside	5.6
Not recorded	17.5
Other	0.3

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Forth Valley	4.6
Grampian	11.8
Greater Glasgow and Clyde	18.7
Highland	3.8
Lanarkshire	5.0
Lothian	17.9
Island Boards	1.0
National Waiting Times Centre	2.1

Tayside	5.6
Not recorded	17.5
Other	0.3

88.1% of respondents (N=892) said their specialty had an M&M or similar peer review meeting for mortality and morbidity case discussion (See Figure 1 and Figure 2). 74% of those respondents in a specialty with M&Ms work with an adult population (N=746) and 8% worked in paediatric/neonatal disciplines. 187 respondents did not disclose this information.

Figure 1 Response to the question “Does your specialty have a M&M meeting or similar peer review meeting for morbidity and mortality case discussion?” (N=1012)

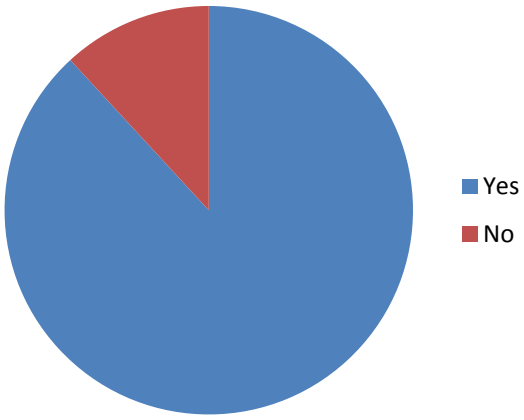
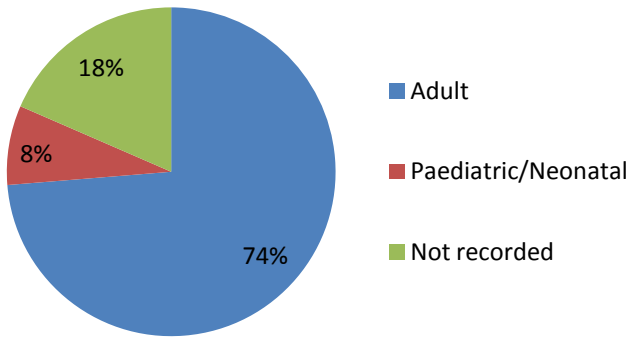


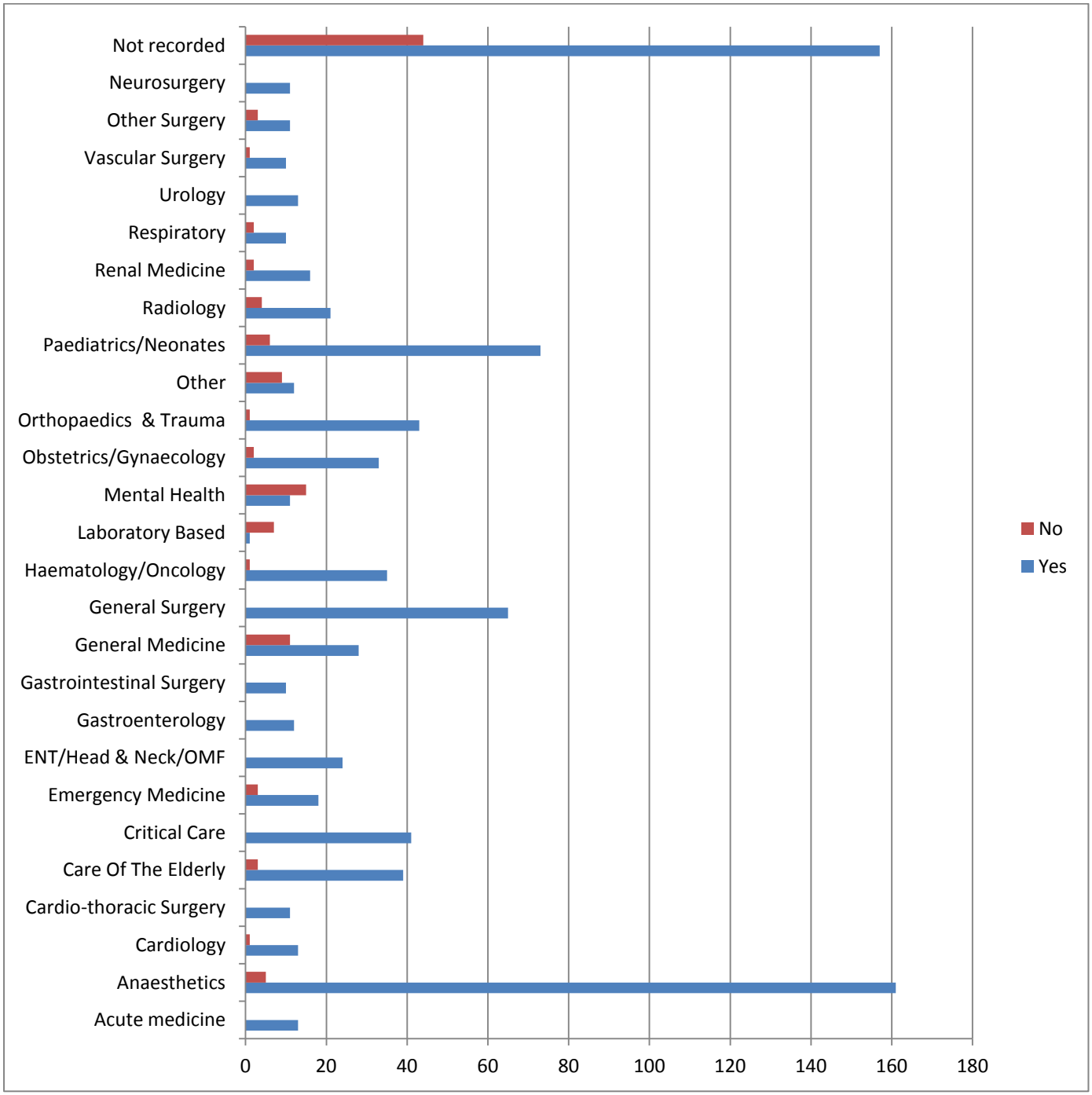
Figure 2 Main patient population (N=892)



Almost a fifth (19.6%) of respondents did not provide their specialty (see Figure 3). A wide range of clinical and non clinical specialties were recorded from the 1012 respondents. Anaesthetics had a significantly higher response compared to any other specialty with 17.5% of the total responses. The next highest response came from Paediatrics and Neonatal, and then General surgery, with

7.8% and 6.8% of responses respectively. 15% of respondents were designated clinical lead for their specialty and 10% of respondents were designated M&M lead.

Figure 3 Principle sub-specialty



Meeting characteristics

The majority of respondents (59%) reported that M&M meetings took place at least monthly. 47 (5%) people reported that meetings took part either twice a year or on an ad hoc basis. The majority of respondents reported that meetings were scheduled for 1-2hrs (52%), just over a quarter for under one hour and 17% for between 2-3 hours (See Figures 5 & 6 for more details).

Within Mental Health, 70% of respondents said meetings were 6 monthly or ad hoc. Critical care was the only specialty where weekly meetings occurred most frequently.

Figure 4 Frequency of M&M meetings (N=892)

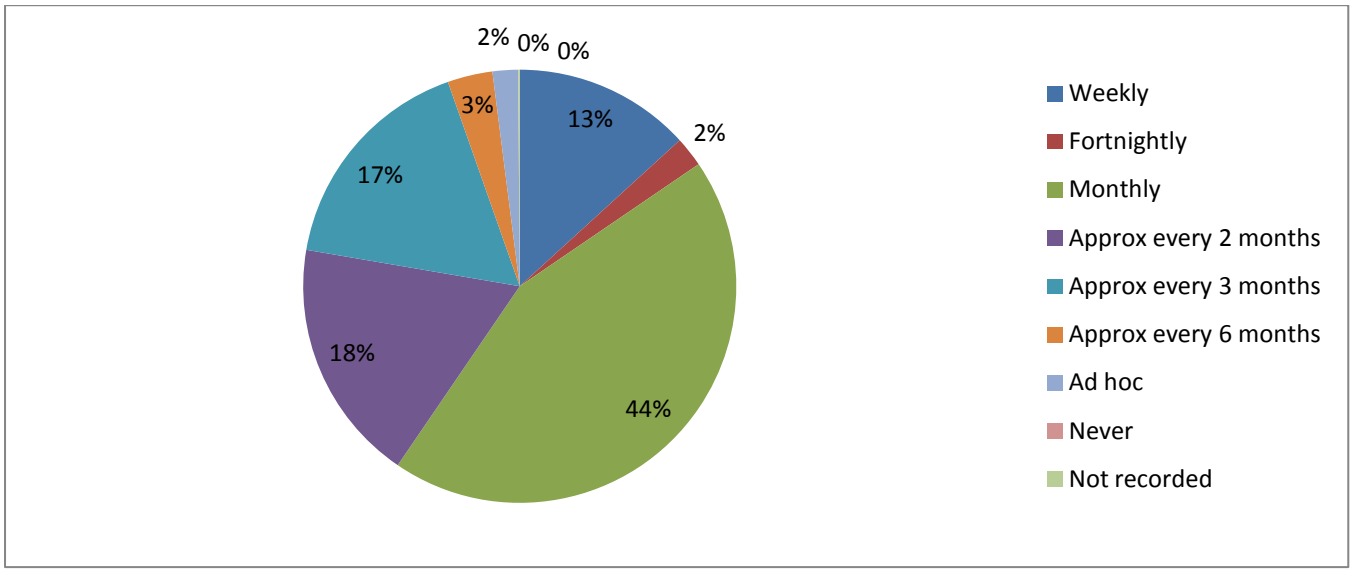
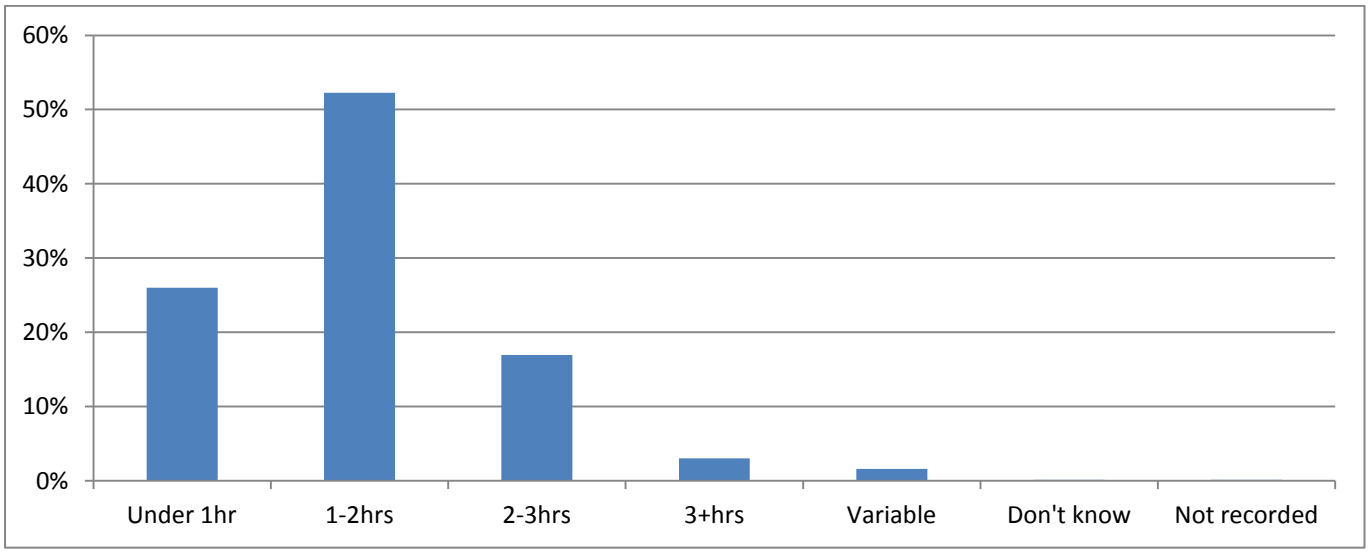


Figure 5 Meeting length (N=892)



Only 9% of M&Ms are conducted within two weeks of death (see Table 2). Most respondents report M&Ms take place at 1-3 months following an event (44%). 9% of respondents reported that the M&M took place over 3 months after the death and 11% were unsure of the timing.

Table 2 Approximate time period between a patient's death/discharge/morbidity and review at M&M (N=892)

Time period	N	%
Within 2 weeks	81	9%
Approximately within 1 month	240	27%
Between 1-3 months	391	44%
Over 3 months	78	9%
Unsure	101	11%
Not recorded	1	0%

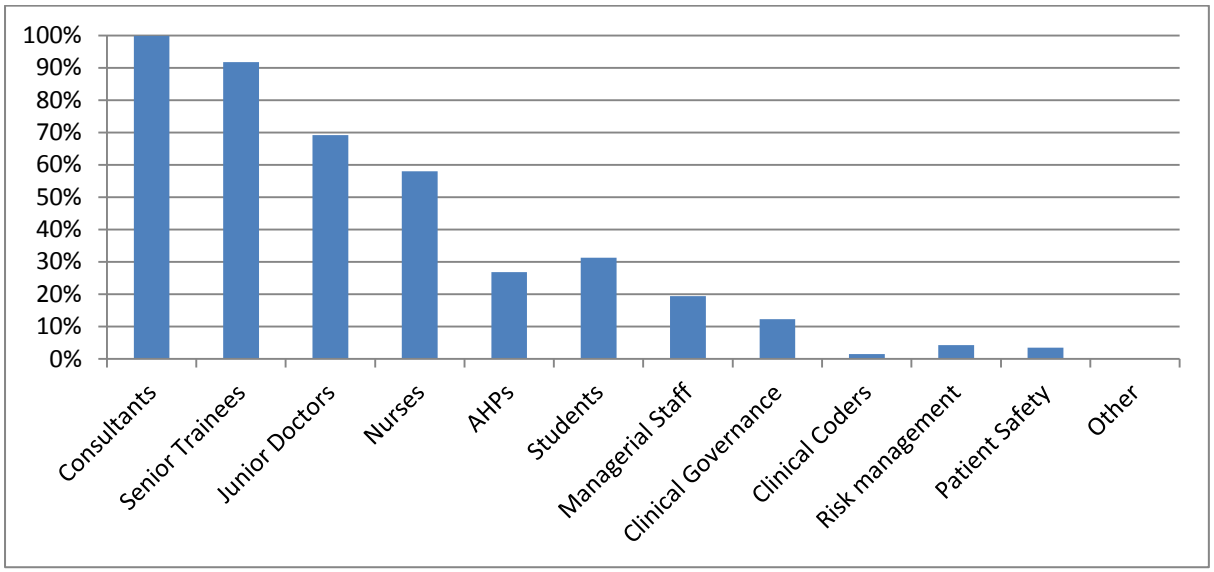
53% of respondents working in critical care and 18.8% in General Surgery reported reviewing cases within 2 weeks. Haematology, Mental Health and Neurology, had the highest, within specialty proportion of cases reviewed more than three months after the event of 37.1%, 30% and 60% respectively. Of those respondents who stated that their specialty held M&M meetings (N=892), the range of meetings attended can be summarised in Table 3 below.

Table 3 Proportion people attending meetings

	Critical Incident/Adverse Event Meeting	**Audit/Research Meetings**	**Clinical Governance/SPSP Meeting**	Do not know
N	649	636	536	11
%	73	71	60	

All respondents reported that M&M meetings were regularly attended by Consultants, closely followed by senior trainees (92% of respondents) (see Figure 6)

Figure 6 Proportion of people, reporting the following members as regular attendees to M&M meetings.



69% and 58% of respondents said that junior doctors and nurses attended meetings respectively. Only 3-4% of respondents reported that either patient safety or risk management were regular attendees at their M&M.

58.4% of respondents said that their time to attend M&M was protected i.e. part of the job plan (Figure 7). Whilst the majority of respondents reported they had protected time for M&M, there was evidence of variation between specialties and Boards (see Figure 8 and Figure 9).

Figure 7 Proportion of respondents reporting M&M as a job planned activity (N=891)

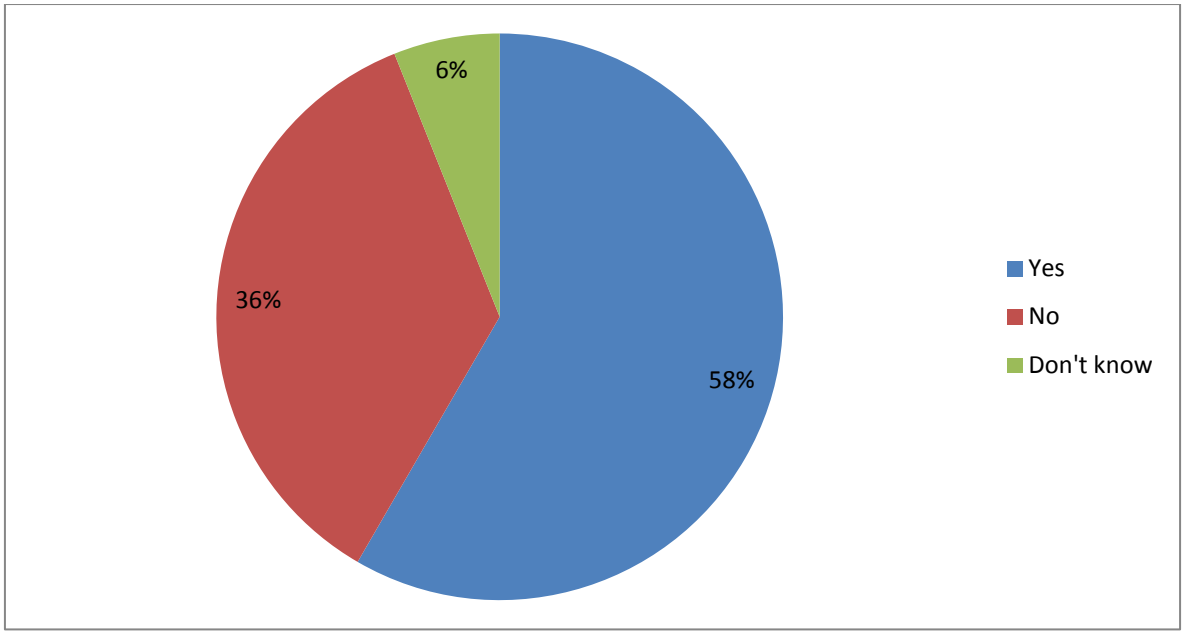


Figure 8 Proportion of within specialty respondents with protected M&M time

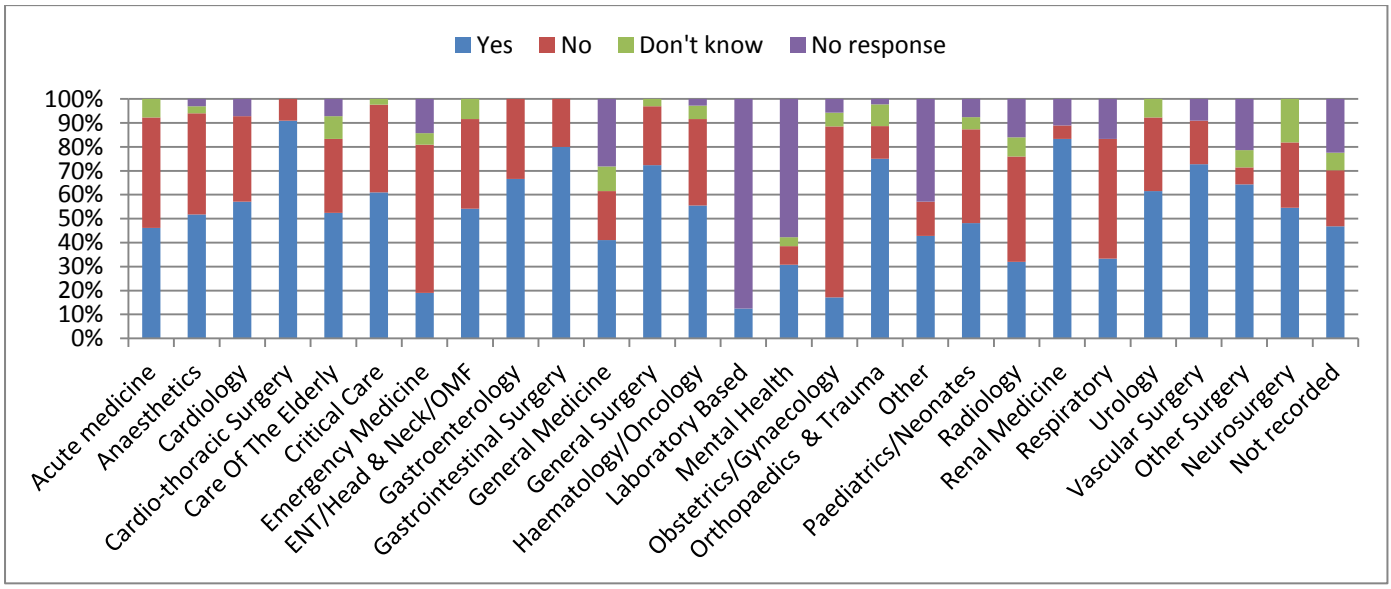
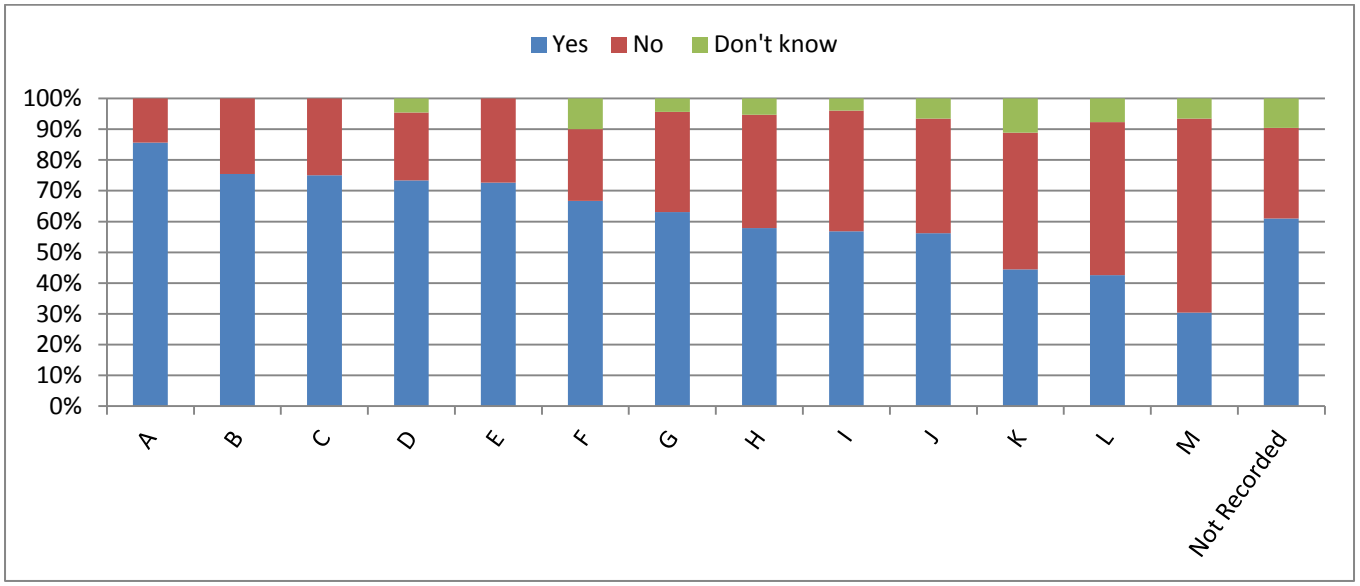


Figure 9 Proportion of within Health Board respondents with protected M&M time

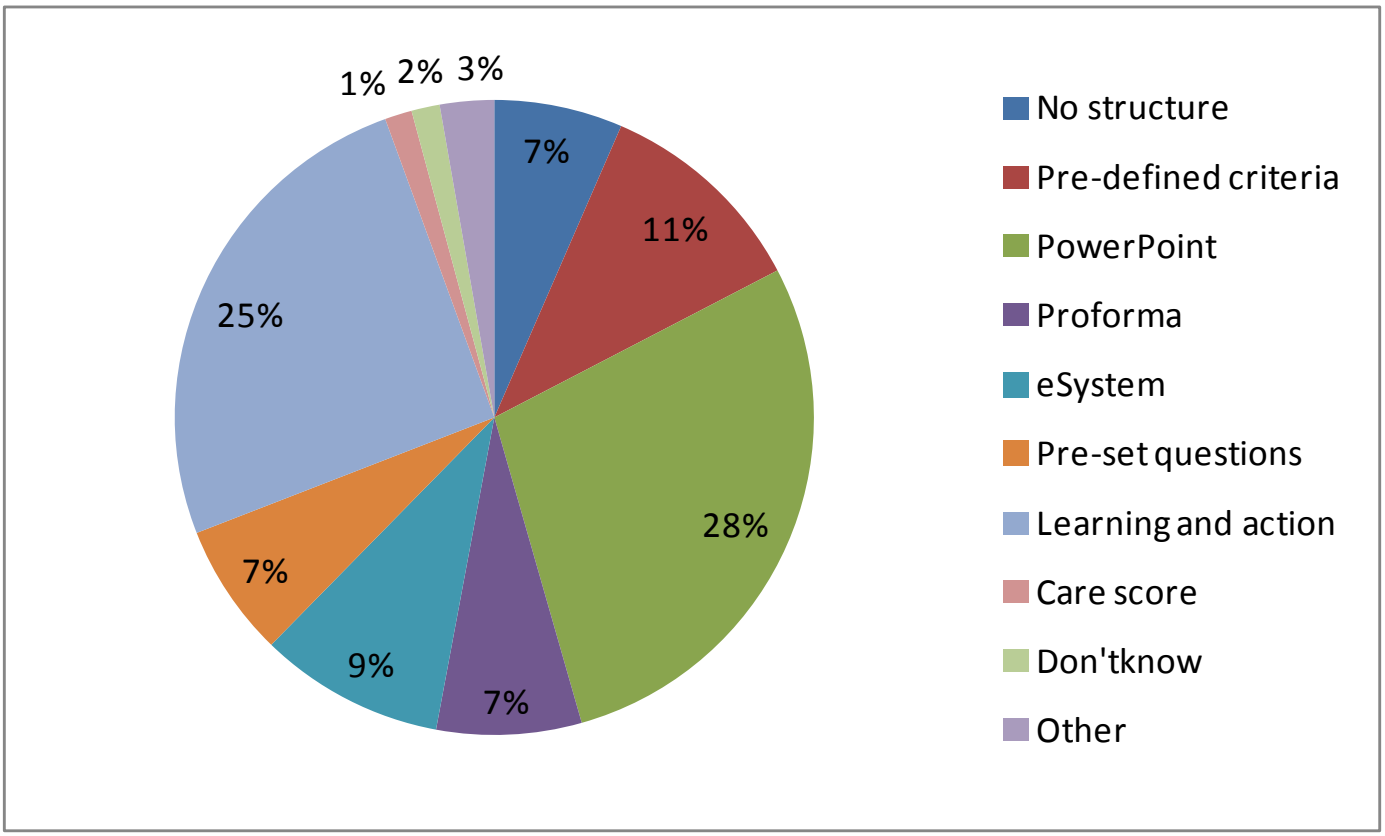


In General, respondents working in NHS M were least likely to report that time was protected for M&M work (30.4%). NHS L and NHS K reported protected time in 42.6% and 44.4% of their Boards respondents respectively. The Board with the highest proportion of respondents reporting protected time was NHS A 85.7%. In the remaining Boards between 56.2% and 75.4% of respondents reported that time was protected for M&M activity (Figure 9).

M&M structure

The most commonly reported meeting structure was power point (28%), and learning and action (25%). 7% of respondents reported that M&M had no structure and 35% reported using either predefined criteria, a proforma or preset questions (Figure 10). Only 10% of respondents are currently using an e system.

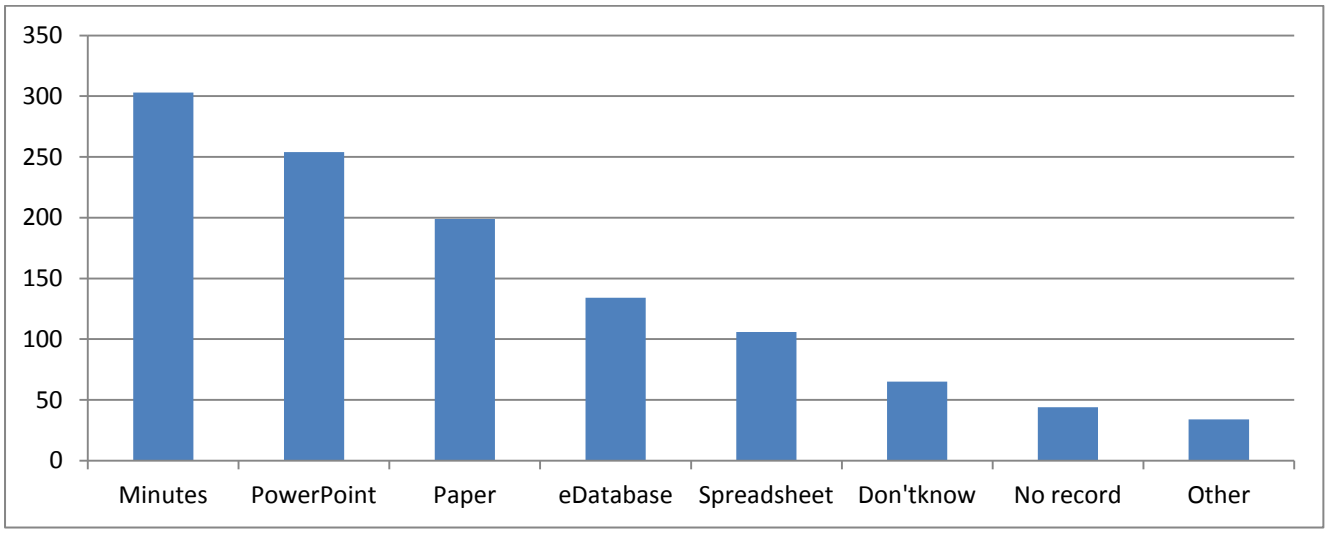
Figure 10 Reponses to the ways M&M is structured



Methods of reporting

Minutes, PowerPoint and paper based reporting was most frequently used by respondents. All Boards used a variety of tools. NHS D, NHS L and NHS J used e-databases more than other Boards. Of the Boards with no reported method of recording M&M meetings, NHS F had the highest proportion of within Board responses (Figure 12).

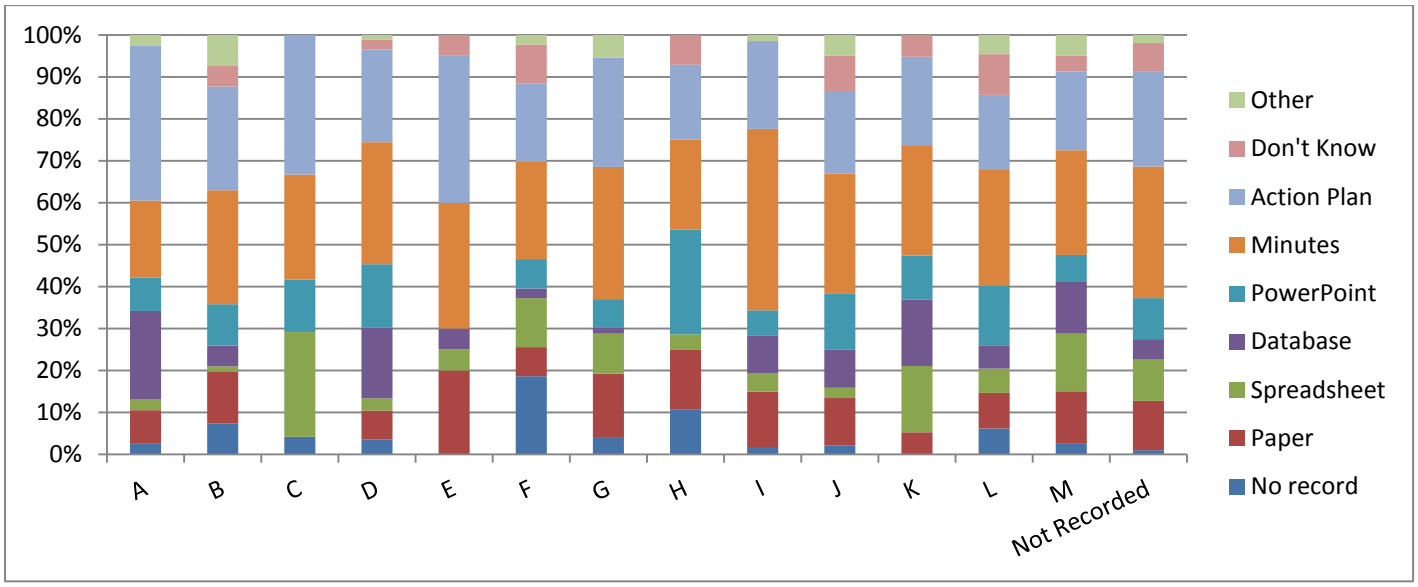
Figure 11 Methods of recording M&M details discussed



Disseminating findings and shared learning

When individuals were asked about how they disseminated their findings, once again there were a range of media used. Minutes were commonly used as well as action plans.

Figure 12 Methods of disseminating findings, within Board proportions.

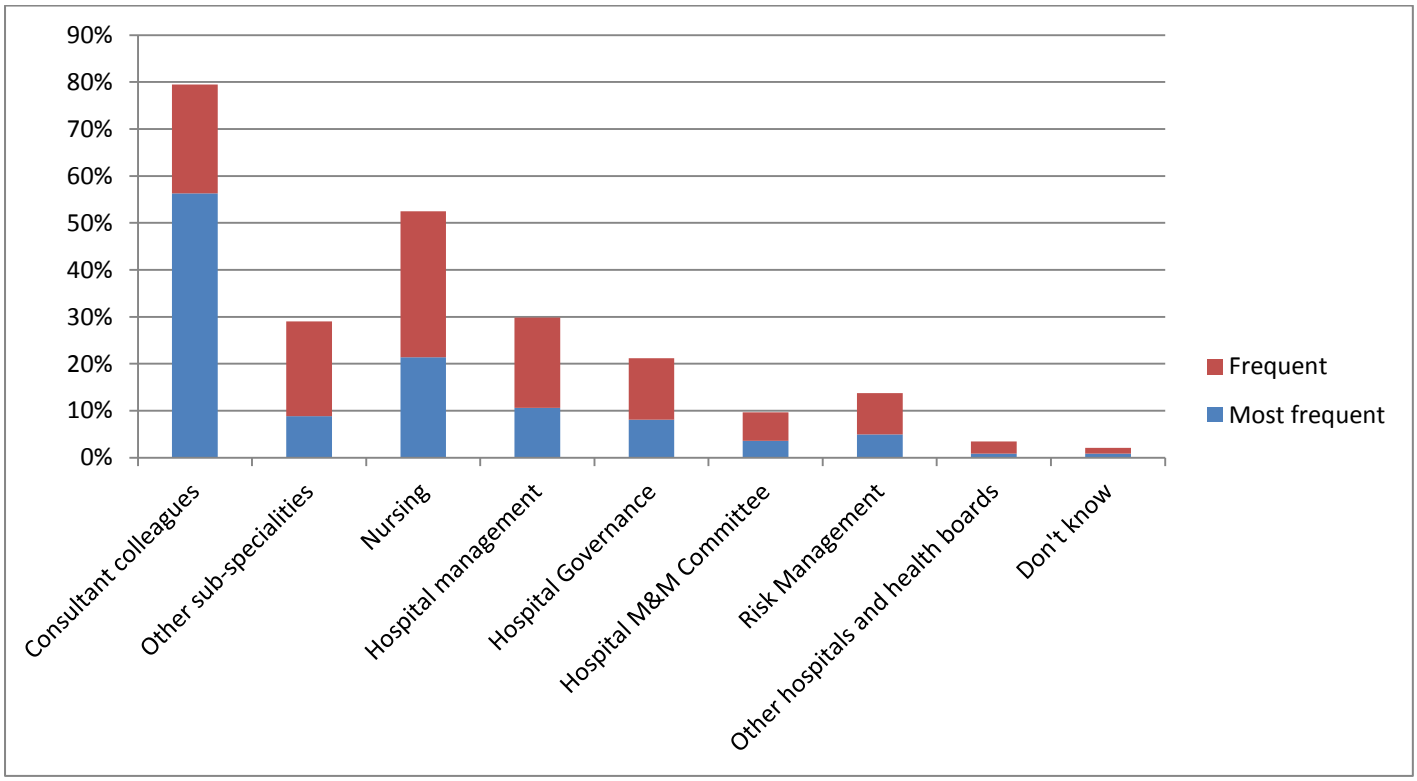


Clinical Audit and Quality Improvement work is generated following M&Ms either most frequently or frequently according to only 4.0% and 24.9% of respondents respectively. 3.9% of respondents said it was never carried out and 21.2% did not answer the question.

Table 4 Methods of sharing learning by frequency with which each is shared.

	Informal conversations	Formal teaching /education session	Posters /notice board updates	Email Updates	Newsletters	Safety briefs	Circulation of minutes	Circulation of action plan	National Audit
Most Frequent	192	79	14	103	6	47	239	123	29
Frequent	396	248	57	187	38	122	159	144	44
Infrequent	41	108	179	133	118	155	60	123	154
Less Frequent	79	244	173	174	82	147	73	134	83
Never	8	42	223	99	370	169	148	136	233
Not Recorded	296	291	366	316	398	372	333	352	469

Figure 13 Learning points from M&M most frequently or frequently shared by professional grouping



Where learning points are shared they are done so frequently amongst consultant colleagues (79%) and nurses (52%).Learning is rarely shared with other hospitals or Health Boards (4%). 77.7% of respondents reported the main aim of M&M was quality improvement.

This was followed by education (69.2%), peer review (40.7%) and performance monitoring (36.4%). Only 12.1% reported that benchmarking was a main aim (Figure 14).

Figure 14 Perceived main aim of M&M meetings (N=821)

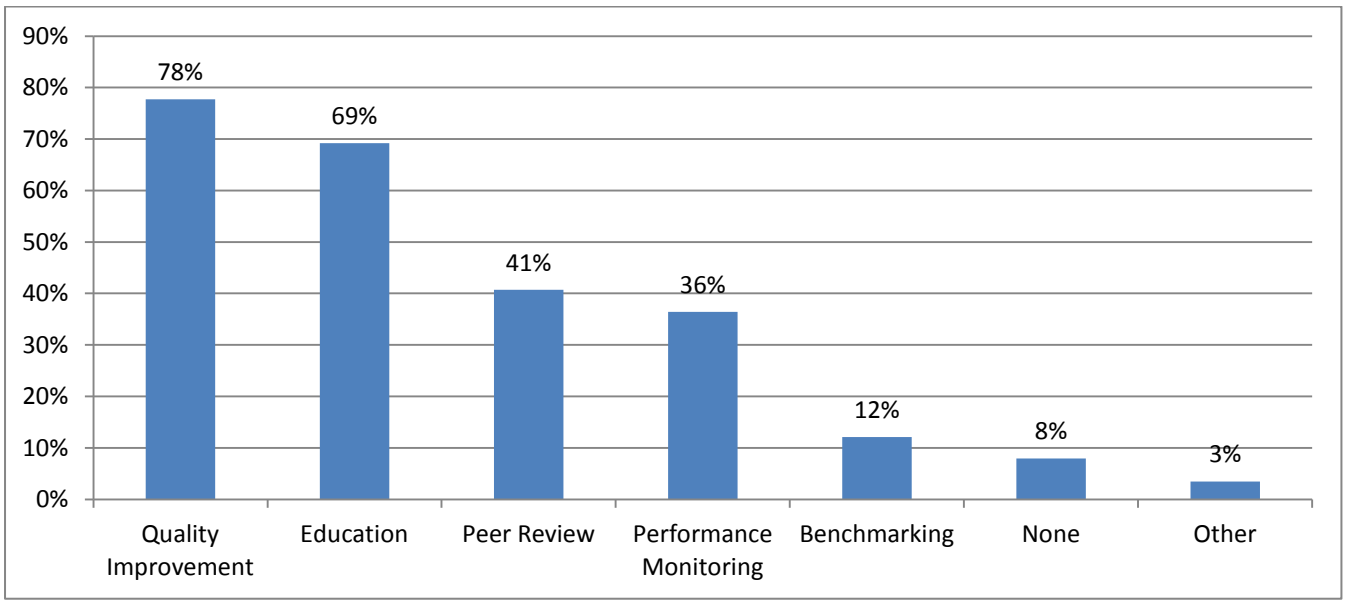
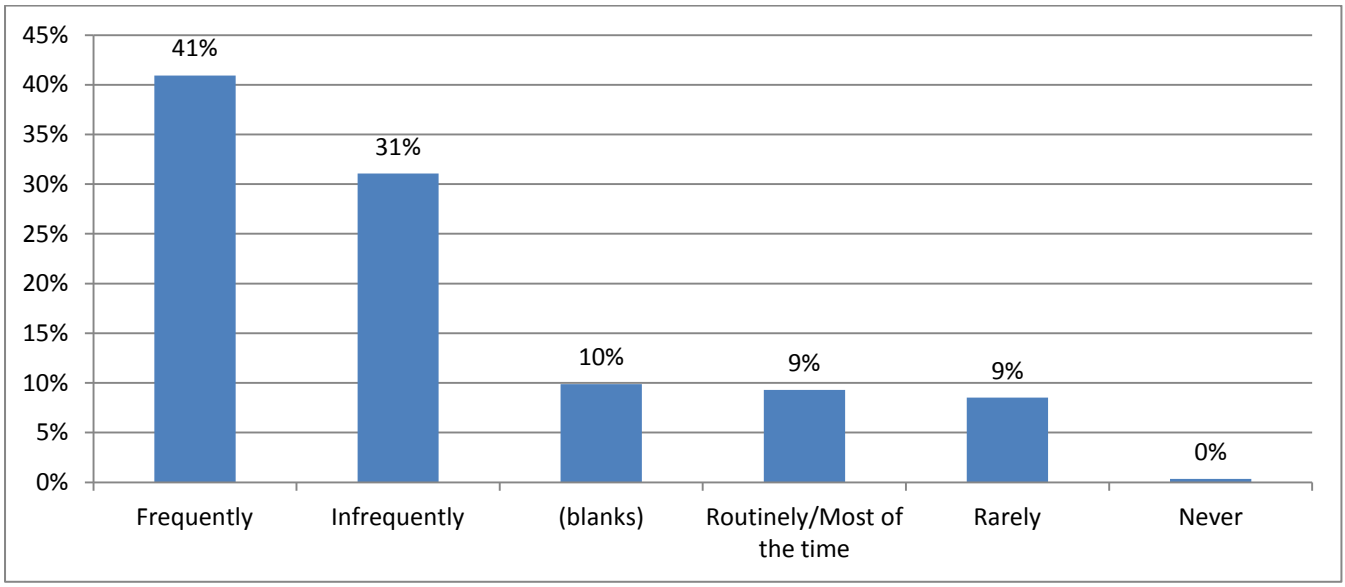


Figure 15 Frequency with which learning from M&M is perceived to impact on clinical practice and NHS systems (N=892)



50% of respondents reported that learning from M&Ms is used routinely/most of the time or frequently in NHS. In contrast 31% thought it was used infrequently and a further 9% perceived that it was never used (Figure 15).

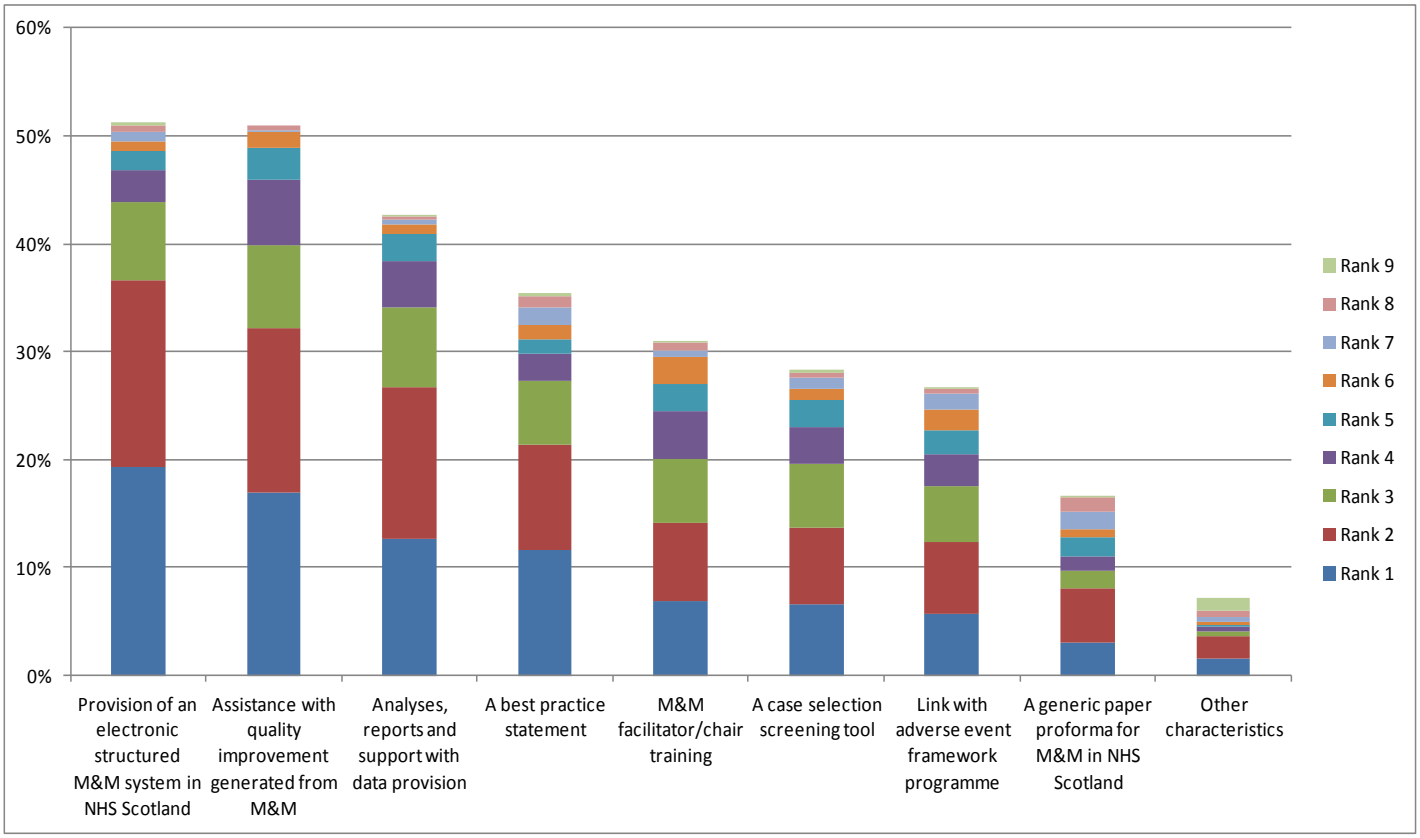
Recommendations for the M &M Programme

The top four recommendations that came from the questionnaire in order of rank:

1. Provision of an electronic structured M&M system was ranked highest by 19% and second highest by 17%
2. Assistance with quality improvement generated from M&M
3. Analyses, reports and support with data provision
4. A best practice statement

(See Figure 20 for further details)

Figure 16 Recommendations by type and rank



Other recommendations with over 25% support included:

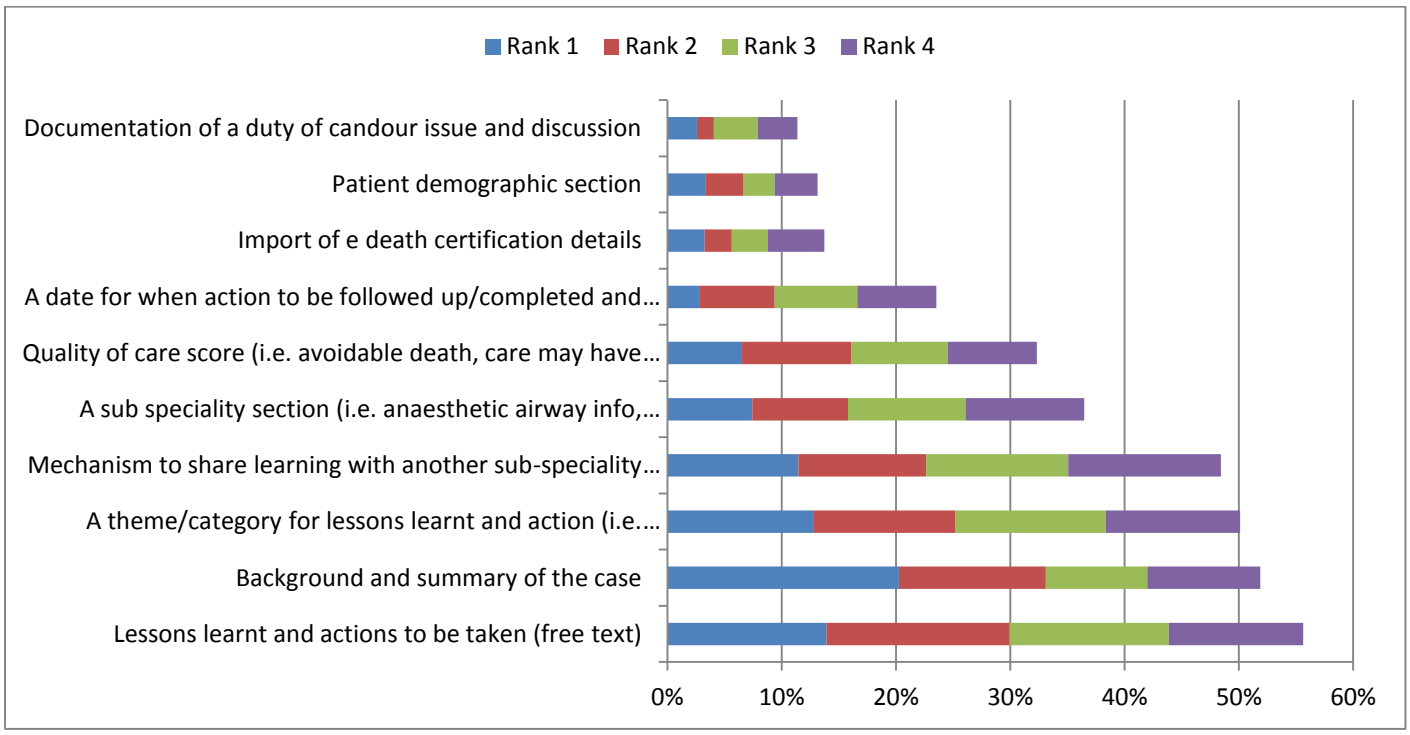
- M&M facilitator/chair training,
- A case selection screening tool
- Link with adverse event framework programme

Top recommendations of important characteristics of an electronic structured M&M system.

1. Lessons learnt and actions to be taken (free text)
2. Background and summary of the case
3. A theme/category for lessons learnt and action (i.e. communication/decision making/technical skill issue)
4. Mechanism to share learning with another sub-speciality or hospital

In addition there was an expression of need for a sub specialty section (i.e. anaesthetic airway info, surgical technical issues etc) and quality of care score (i.e. avoidable death, care may have contributed to death etc) (see Figure 17 for further details).

Figure 17 Characteristics of a National electronic system by type and rank



The main perceived benefits of a national approach were reported as improve shared learning from M&M, improvement in quality of care, clearer and more robust governance and minimising variation.

Table 5 Benefits of National approach (n=856)

	N	%
Improve shared learning from M&M	679	67.1%
Improvement in quality of care	597	59.0%
Clearer and more robust governance	567	56.0%
Minimising variation	507	50.1%
Reassurance to patients	418	41.3%
Improved staff engagement	374	37.0%
Reassurance	367	36.3%
No benefit	40	4.0%
Don't know	24	2.4%
Other	20	2.0%
Not recorded	156	15.4%

Appendix 1 Letter of Invitation to Medical Directors

Public Health and Intelligence

Scottish Healthcare Audits
Public Health and Intelligence
National Services Scotland
2nd Floor
Meridian Court
5 Cadogan Street
Glasgow, G2 6QE
0141 282 2280

Date: 2nd September 2015

Enquiries to: Isobel Macleod (Clinical Coordinator)
Direct Line: 0141 282 2280
Ref: National Survey Medical Director Letter 1.3
Email: NSS.SMMG@nhs.net

Dear Medical Directors,

Scottish Mortality and Morbidity National Survey

I write to advise you of the planned distribution of a national survey to NHS Consultants in all territorial Health Boards and the National Waiting Times Centre.

The purpose of this survey is to better understand the practice of Mortality and Morbidity (M&M) meetings or similar processes, in acute specialities across NHS Scotland. Anonymised responses will be used to help shape a proposed structured M&M programme for NHS Scotland.

The web based cross-sectional survey undertaken using Lime Survey will be conducted by National Services Scotland. It will be issued by the Scottish Online Appraisal Resource (SOAR), which is administered by NHS Education Scotland (NES). We are also kindly inviting each Medical Director to cascade the enclosed invitation letter to your consultant medical staff and encourage participation.

Please be reassured that although NHS Board level reports can be generated, if requested by Medical Directors, for the purposes of national reporting only aggregated data will be displayed; by anonymised NHS Board and/or sub-speciality groups. These results may also be presented externally and published in a peer-reviewed journal and will once again be done so using anonymised aggregated data.

I would like to take this opportunity to thank you for your support and interest with the ongoing work of the Scottish M&M Programme. If you would like to discuss this further please don't hesitate to get in touch. We anticipate the distribution of the National Survey by SOAR will commence week beginning 21st September 2015.

Yours sincerely,

Mr Manoj Kumar
Scottish Mortality and Morbidity Programme Steering Group Chair
Consultant Surgeon, NHS Grampian

Cc. NHS Health Board Clinical Effectiveness Department

Appendix 2: Letter of Invitation-Scottish Mortality and Morbidity National Survey

Public Health and Intelligence

Scottish Healthcare Audits
Public Health and Intelligence
National Services Scotland
2nd Floor
Meridian Court
5 Cadogan Street
Glasgow, G2 6QE
0141 282 2280

Date: 15th September 2015

Enquiries to: Isobel Macleod (Clinical Coordinator)
Direct Line: 0141 282 2280
Ref: National Survey Invitation Letter 1.4
Email: NSS.SMMG@nhs.net

Dear Consultant Colleague,

Letter of Invitation: Scottish Mortality and Morbidity National Survey

As a Consultant working in NHS Scotland, you are kindly invited to participate in a national survey which is being conducted by National Services Scotland (NSS), on behalf of the Scottish Mortality and Morbidity (M&M) Programme (a joint partnership between Healthcare Improvement Scotland and Information Services Division (ISD) at NSS). The aim of the programme is to improve quality of care by enhancing Mortality and Morbidity meetings or similar processes, across all acute specialities in NHS Scotland.

The purpose of the survey is to identify current M&Ms or similar practice and gain insight into its value as well as challenges, in learning and improving patient care. This intelligence will be used to help shape the national work in improving the quality and output of M&Ms.

We are also keen to get your views on any proposed national approach to learning from patient mortality and morbidity.

Presentation of results at a national level will not identify individual units, but will group results to represent NHS Board and/or sub-speciality across NHS Scotland. All results will be anonymised and stored securely; you will never be individually identified.

We would greatly appreciate your involvement in this exercise. The survey can be accessed and completed by following the link
http://www.nsssurvey2.scot.nhs.uk/index.php?r=survey/index/sid/995848/lang/en.
It should take about 5-10minutes to complete this survey.

If you would like any further information please email NSS.SMMG@nhs.net.

Many thanks,

Yours sincerely,

Mr Manoj Kumar
Scottish Mortality and Morbidity Programme Steering Group Chair
Consultant Surgeon, NHS Grampian

Appendix 3: Scottish Mortality and Morbidity National Survey Questionnaire

Scottish Mortality and Morbidity National Survey

As an NHS Consultant we would be very grateful if you could complete this short questionnaire about mortality and morbidity meetings. All responses will be treated anonymously and presented in such a way that individual clinicians and units will not be identified. The results of the survey will be used to guide the potential development of M&Ms in Scotland.

This survey is being conducted by the Scottish Mortality and Morbidity Programme, supported by National Services Scotland. If you would like to contact a member of the team please email: NSS.SMMG@nhs.net

Thank you

This questionnaire will take approximately 5-10mins to complete.

There are 32 questions in this survey

Mortality and Morbidity Details

[]Does your speciality have an M&M meeting or a similar peer review meeting for mortality and morbidity case discussion? *

Please choose **only one** of the following:

- ○ Yes
- ○ No

[]Does your department/unit regularly hold any of the following meetings? *

Only answer this question if the following conditions are met:
Answer was 'Yes' at question '1 [Q1]' (Does your speciality have an M&M meeting or a similar peer review meeting for mortality and morbidity case discussion?)

Please choose **all** that apply:

- ☐ Critical Incident/Adverse Event Meeting
- ☐ Audit/Research Meetings
- ☐ Clinical Governance/SPSP Meeting
- ☐ None
- ☐ Don't know
- ☐ Other meeting with a focus on 'quality':

[]Who regularly attends your Mortality & Morbidity meetings? *

Only answer this question if the following conditions are met:
Answer was 'Yes' at question '1 [Q1]' (Does your speciality have an M&M meeting or a similar peer review meeting for mortality and morbidity case discussion?)

Please choose **all** that apply:

- ☐ Consultants
- ☐ Senior Trainees
- ☐ Junior Doctors (FY)
- ☐ Nurses
- ☐ AHPs
- ☐ Students
- ☐ Managerial Staff
- ☐ Clinical Governance/Audit Staff
- ☐ Clinical Coders
- ☐ Risk Management
- ☐ Patient Safety Staff
- ☐ Other:

[]What topics are routinely included in your M&M? *

Only answer this question if the following conditions are met:
Answer was 'Yes' at question '1 [Q1]' (Does your speciality have an M&M meeting or a similar peer review meeting for mortality and morbidity case discussion?)

Please choose **all** that apply:

- ☐ Mortality cases
- ☐ Morbidity cases
- ☐ Unit/department workload i.e. admission figures
- ☐ Adverse event/critical incident discussion (i.e. drug errors, needle stick injuries, falls etc)
- ☐ Safety alerts
- ☐ Summary of relevant literature/evidence
- ☐ Presentation of audit/research/quality improvement projects being conducted
- ☐ Other:

[]

How are cases for discussion at your M&M selected?

Only answer this question if the following conditions are met:
Answer was 'Yes' at question '1 [Q1]' (Does your speciality have an M&M meeting or a similar peer review meeting for mortality and morbidity case discussion?)

Please choose the appropriate response for each item:

	Mortality	Morbidity
All cases reviewed	○	○
Random selection	○	○
Consultant nomination	○	○

Unexpected cases	○	○
Screening Tool/ trigger list used	○	○
Don't know	○	○
Not applicable	○	○

[]If you answered at Q6 "Screening Tool/ trigger list used" please can you give details:

Only answer this question if the following conditions are met:
Answer was 'Yes' at question '1 [Q1]' (Does your speciality have an M&M meeting or a similar peer review meeting for mortality and morbidity case discussion?)

Please write your answer here:

[]

How frequently does your M&M meet?

*

Only answer this question if the following conditions are met:
Answer was 'Yes' at question '1 [Q1]' (Does your speciality have an M&M meeting or a similar peer review meeting for mortality and morbidity case discussion?)

Please choose **only one** of the following:

- ○ Weekly,
- ○ Fortnightly
- ○ Monthly
- ○ Approximately once every 2 months
- ○ Approximately once every 3 months
- ○ Approximately once every 6 months
- ○ Ad hoc
- ○ Never

[]

How long are your M&M meetings scheduled for?

*

Only answer this question if the following conditions are met:
Answer was 'Yes' at question '1 [Q1]' (Does your speciality have an M&M meeting or a similar peer review meeting for mortality and morbidity case discussion?)

Please choose **only one** of the following:

- ○ Under 1hr
- ○ 1-2hrs
- ○ 2-3hrs
- ○ 3+hrs
- ○ Variable
- ○ Don't know

[]

How quickly following the patient's death/discharge/morbidity are cases reviewed at your M&M?

*

Only answer this question if the following conditions are met:
Answer was 'Yes' at question '1 [Q1]' (Does your speciality have an M&M meeting or a similar peer review meeting for mortality and morbidity case discussion?)

Please choose **only one** of the following:

- ○ Within 2 weeks
- ○ Approximately within 1 month
- ○ Between 1-3 months
- ○ Over 3 months
- ○ Unsure
- ○

[]Is the time to attend M&M protected i.e. part of your job plan? *

Only answer this question if the following conditions are met:
Answer was 'Yes' at question '1 [Q1]' (Does your speciality have an M&M meeting or a similar peer review meeting for mortality and morbidity case discussion?)

Please choose **only one** of the following:

- ○ Yes
- ○ No
- ○ Don't know

[]How is your M&M structured?

Only answer this question if the following conditions are met:
Answer was 'Yes' at question '1 [Q1]' (Does your speciality have an M&M meeting or a similar peer review meeting for mortality and morbidity case discussion?)

Please choose **all** that apply:

- ☐ No structure
- ☐ Cases selected using a defined set of criteria rather than clinician nomination
- ☐ Case presented using template PowerPoint slides
- ☐ Case presented using a paper proforma
- ☐ Case presented using an electronic system
- ☐ Pre set questions used to guide discussion
- ☐ Learning and action points summarised and recorded
- ☐ 'Care score' used
- ☐ Don't know/Not applicable
- ☐ Other: _____

Outputs

[]What is the medium used to record details of the cases discussed?

Only answer this question if the following conditions are met:
Answer was 'Yes' at question '1 [Q1]' (Does your speciality have an M&M meeting or a similar peer review meeting for mortality and morbidity case discussion?)

Please choose **all** that apply:

- ☐ No record kept
- ☐ Paper proforma
- ☐ Excel spreadsheet
- ☐ Powerpoint presentation saved
- ☐ Standardised electronic database (redcap/datix/other)
- ☐ Minutes
- ☐ Don't know
- ☐ Other: _____

[]How are lessons learnt and actions to be taken documented?

Only answer this question if the following conditions are met:
Answer was 'Yes' at question '1 [Q1]' (Does your speciality have an M&M meeting or a similar peer review meeting for mortality and morbidity case discussion?)

Please choose **all** that apply:

- ☐ No documentation
- ☐ Paper proforma
- ☐ Excel sreadsheet
- ☐ Database i.e. datix, redcap, other
- ☐ Powerpoint presentation saved
- ☐ Minutes
- ☐ Action plan
- ☐ Don't know
- ☐ Other:

[]What local outputs are generated from your M&Ms?

Only answer this question if the following conditions are met:
Answer was 'Yes' at question '1 [Q1]' (Does your speciality have an M&M meeting or a similar peer review meeting for mortality and morbidity case discussion?)

Please choose the appropriate response for each item:

	Most frequent	Frequent	Less frequent	Infrequent	Never
Guideline initiation/review	○	○	○	○	○
Clinical Audit/Quality Improvement work	○	○	○	○	○
Review of research and adoption of evidence based medicine	○	○	○	○	○
Team learning	○	○	○	○	○
Incident reporting	○	○	○	○	○
Incident investigation	○	○	○	○	○
Immediate changes/improvement	○	○	○	○	○
New educational developments	○	○	○	○	○
Identification of resource issues	○	○	○	○	○
Identification of proposed research topics	○	○	○	○	○
Escalation of concerns to management etc	○	○	○	○	○

[]The learning from your M&M is shared by the following

Only answer this question if the following conditions are met:
Answer was 'Yes' at question '1 [Q1]' (Does your speciality have an M&M meeting or a similar peer review meeting for mortality and morbidity case discussion?)

Please choose the appropriate response for each item:

	Most frequent	Frequent	Less frequent	Infrequent	Never
Informal conversations	○	○	○	○	○
Formal teaching/education session	○	○	○	○	○
Posters/Notice board updates	○	○	○	○	○
Email Updates	○	○	○	○	○
Newsletters	○	○	○	○	○
Safety briefs	○	○	○	○	○
Circulation of minutes	○	○	○	○	○
Circulation of action plan	○	○	○	○	○
National Audit i.e. SALG	○	○	○	○	○
Not shared	○	○	○	○	○

[]The learning points from M&M are shared with the following groups of people:

Only answer this question if the following conditions are met:
Answer was 'Yes' at question '1 [Q1]' (Does your speciality have an M&M meeting or a similar peer review meeting for mortality and morbidity case discussion?)

Please choose the appropriate response for each item:

	Most frequent	Frequent	Less frequent	Infrequent	Never
Consultant colleagues within sub-speciality	○	○	○	○	○
Other sub-specialities	○	○	○	○	○
Nursing	○	○	○	○	○
Hospital management	○	○	○	○	○
Hospital Governance	○	○	○	○	○
Hospital M&M Committee	○	○	○	○	○
Risk Management, Patient Safety personnel	○	○	○	○	○
Other hospitals and health boards	○	○	○	○	○
Don't know	○	○	○	○	○

[]In your opinion what is the main aim of M&M meetings? *

Only answer this question if the following conditions are met:
Answer was 'Yes' at question '1 [Q1]' (Does your speciality have an M&M meeting or a similar peer review meeting for mortality and morbidity case discussion?)

Please choose **all** that apply:

- ☐ Benchmarking
- ☐ Performance Monitoring

- ☐ Quality Improvement
- ☐ Education
- ☐ Peer Review
- ☐ Other: [ ]

[]How frequently does learning from your M&M impact on clinical practice and NHS systems?

Only answer this question if the following conditions are met:
Answer was 'Yes' at question '1 [Q1]' (Does your speciality have an M&M meeting or a similar peer review meeting for mortality and morbidity case discussion?)

Please choose **only one** of the following:

- ○ Routinely/Most of the time
- ○ Frequently
- ○ Infrequently
- ○ Rarely
- ○ Never

Mortality and Morbidity National Programme

[]What characteristics would you like to see in a national M&M programme?

All your answers must be different.
Please select at least 2 answers

Please number each box in order of preference from 1 to 9

Please choose at least 2 items.

- [ ] Provision of an electronic structured M&M system in NHS Scotland
- [ ] A generic paper proforma for M&M in NHS Scotland
- [ ] A best practice statement
- [ ] A case selection screening tool
- [ ] M&M facilitator/chair training
- [ ] Analyses, reports and support with data provision
- [ ] Assistance with quality improvement generated from M&M
- [ ] Link with adverse event framework programme
- [ ] Other characteristics

Please drag and drop at least 2 options to the right hand side and shuffle them into order of importance

[]

If you answered "Other characteristics" at question 1, please enter details

Please write your answer here:

[]If a national electronic system was to be available for M&M in NHS Scotland what sections would be most important?

All your answers must be different.
Please select 4 answers

Please number each box in order of preference from 1 to 10

Please choose at least 4 items.

Please choose no more than 4 items.

- [ ] Patient demographic section
- [ ] Background and summary of the case
- [ ] Lessons learnt and actions to be taken – free text
- [ ] A theme/category for lessons learnt and action (i.e. communication/decision making/technical skill issue)
- [ ] A date for when action to be followed up/completed and then closed
- [ ] Mechanism to share learning with another sub-speciality or hospital
- [ ] Import of e death certification details
- [ ] Documentation of a duty of candour issue and discussion
- [ ] Quality of care score (i.e. avoidable death, care may have contributed to death etc)
- [ ] A sub speciality section (i.e. anaesthetic airway info, surgical technical issues etc)

Please drag and drop up to 4 options to the right hand side and shuffle them into order of importance

[]If you answered "Other sections" at question 1, please enter details

Please write your answer here:

[]

What do you think are the benefits of a nationally adopted approach to structured M&Ms?

Please choose **all** that apply:

- ☐ Improve shared learning from M&M
- ☐ Improvement in Quality of Care
- ☐ Clearer and more robust governance regarding learning from deaths/morbidity
- ☐ Minimising variation and promoting equality in review of M&M cases
- ☐ Improved staff engagement
- ☐ Reassurance to patients
- ☐ Reassurance to organisations and professionals
- ☐ Don't know
- ☐ No benefit
- ☐ Other:

[]Please use the space below to make any comments regarding M&M in your speciality or the national M&M programme.

Please write your answer here:

Demographics

[]

The information provided in this section will only be used to group responses and results will be presented in such a way that individuals and specific units cannot be identified i.e. results will be grouped as a collated NHS Boards or as a speciality across Scotland.

[]

What NHS Board do you work in?

Please choose **only one** of the following:

- ○ Ayrshire and Arran
- ○ Borders

- ○ Dumfries and Galloway
- ○ Fife
- ○ Forth Valley
- ○ Grampian
- ○ Greater Glasgow and Clyde
- ○ Highland
- ○ Lanarkshire
- ○ Lothian
- ○ Orkney
- ○ Shetland
- ○ Tayside
- ○ Western Isles
- ○ National Waiting Times Centre
- ○ Other area

[]

What is your main patient population?

Please choose **only one** of the following:

- ○ Adult
- ○ Paediatric
- ○ Neonatal

[]

What is your principle sub-speciality?

Please choose **only one** of the following:

- ○ Acute medicine
- ○ Anaesthetics
- ○ Burns/Plastics
- ○ Cardio-thoracic Surgery
- ○ Cardiology
- ○ Care of the Elderly
- ○ Critical Care
- ○ Emergency Medicine
- ○ ENT/Head & Neck/OMF
- ○ Gastroenterology

- ○ Gastrointestinal Surgery
- ○ General medicine
- ○ General Surgery
- ○ Haematology/Oncology
- ○ Hepatology
- ○ Interventional Radiology
- ○ Mental Health
- ○ Neurosurgery
- ○ Neurology
- ○ Obstetrics/Gynaecology
- ○ Ophthalmology
- ○ Palliative Care
- ○ Renal Medicine
- ○ Respiratory
- ○ Rheumatology
- ○ Orthopaedics & Trauma
- ○ Vascular Surgery
- ○ Other

[]Are you the clinical lead for your speciality? *

Please choose **only one** of the following:

- ○ Yes
- ○ No

[]

Are you a designated lead for M&M?

*

Please choose **only one** of the following:

- ○ Yes
- ○ No

Participation

[]

If you would like to receive information in the future about a national M&M programme and the results of this survey please enter your email below:

Please write your answer here:

Your responses to this section will not be attached to the survey results to maintain anonymity.

[]

Please can you again enter your email below:

Please write your answer here:

Thank you for completing this survey.

If you would like any further information about the Scottish M&M or wish to contact a member of the project team by emailing: NSS.SMMG@nhs.net

Submit your survey.
Thank you for completing this survey.