Learning from Deaths – Hindsight to Foresight

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The Aim

Increase the ability to gather measurable thematic data from deaths to increase learning from manual counts to automated exports by April 2024.

Increase the number of UHMBT subspecialties who are consistently and formally involved in learning from deaths from 0 to 6 by April 2024.

Background

In 2016 the CQC published its report "Learning Candour and Accountability" which is a review in which NHS Trusts are required to review and Investigate deaths of patients.

In 2017 the National Quality Board published guidance on learning from deaths, which set out a series of steps that NHS Trusts need to demonstrate how learning from deaths is an integral part of mortality and how that learning is conveyed to the wider organisation.

Learning from the deaths of those in our care can help us as an organisation to improve the quality of care the organisation provides to the patients and their families.

The Problem

Central Mortality and Morbidity (M&M) team reviewed trigger target deaths (outlined in Learning from Deaths Policy) for the Trust utilising AMaT's MaMR module (introduced Summer 2021) recording all the reviews and learning points, which was excellent practice. However, collating the learning points into a measurable data, that could be easily reported back to teams and trust meetings was challenging and resource heavy. Lessons learned were in free text, very wordy, and difficult to theme as individual to each review. At January 2023 there were 308 individual learning points on the MaMR system.

Prior to January 2023 Care Groups in UHMBT also reviewed deaths within their own meetings. AMaT MaMR was not well utilised within Care Groups. So much learning was not shared across the Trust.

I was faced with an ocean of words, with no identifying commonality for learning points to focus and discussed as a valid learning or improvement.
Michelle Andersen

The Plan

1. For agreeing a common language to be used within the MaMR system:

- Standardised themes to identify commonalities, with short descriptors in collaboration with the M&M team
- Remove the function of free text, ensuring the reviewer is restricted to a standardised list
- Establish a process for adding new learning points that may occur over time
- Archive learning points that were no longer occurring
- Theme the historic learning points already on the system

2. For increasing the number of colleagues involved in learning from deaths:

- Target a single care group (Medicine) and 6 of the 8 sub specialties
- Provide a list of deaths by subspecialty for 25% of their own deaths to be reviewed within subspecialty and shared Trust wide via MaMR
- Support subspecialties with MaMR Training

"Learning from deaths in this way means that as a trust we can identify themes of excellence for sharing, or not repeat errors within individual care groups by learning from each other. We will be able to identify themes and collectively improve our practice as a whole UHMBT system change"
Michelle Andersen

Impact

The number of UHMBT subspecialties who are consistently and formally involved in learning from deaths is at 9, the additional increase was as a result of attendance at audit meetings and consultants keen to be on board – this has exceeded the ambition of the aim and beyond a single care group.

A greater collection of consolidated learning points to be shared via the Mortality Steering Group and discussed for the Trust. Enabling targeted conversations around a theme to an individual care group/specialty and change/improvements can be made.

The M&M team can measure and monitor the learning identified and shared, whether trust wide or specialty driven, and share the improvements and outcomes - striving for excellence for the benefit of the patients and families in our care.

Targeted subspecialties are more aware of their deaths and learning themes, acting on areas for improvement, recognising and celebrating areas of excellence.

Next Steps

- Work with AMaT to develop thematic reporting to identify trends to target improvement
- Ensuring and evidencing that improvement linked to learning from deaths is taking place with care groups and across the Trust
- Greater celebration of areas of excellence

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