Wessex

Patient Safety Collaborative

Learning From Deaths

Following the publication of the National Quality Board guidance issued in March 2017 last year - endorsed by Dr Kathy McLean NHSI, Professor Sir Mike Richards CQC and Professor Sir Bruce Keogh NHS England, regarding the importance of 'Learning from Deaths' and working with carers and families / respecting the duty of candour the NHS has been working to develop more robust processes to review deaths and identify essential learning.

Across Wessex all local provider organisations have reviewed their policies, processes and reporting since this time. On the 22nd of January 2018 representatives from across Wessex attended a learning event to share their journeys to date and to explore how as a professional community we can share learning and good practice. During the session we heard from representatives from acute, mental health, learning disability and community trusts how local processes have and are being further developed to facilitate more robust reviews of deaths within organisations. The West of England AHSN shared their experience as a regional pilot site for the RCP structured judgment review process. The themes from all speakers were similar. For most cases there was a great deal of good care with few avoidable deaths but many avoidable admissions. Early identification of patients nearing the end of their life to avoid unnecessary intervention or investigation and the recognition and escalation of deteriorating patients were also common. There was also a common theme about the need to strengthen the rigour and discipline of Mortality and Morbidity Reviews, assuring such reviews are multi professional, properly documented and that evidence and learning is fed through internal quality and governance processes to ensure Boards are sighted so that they can direct necessary improvement actions.

Many families will have questions when a loved one dies. We heard how important this is for those with learning difficulties and how this is being explored via the LeDeR process. Starting from a point of positivity and the methodology of Appreciative Inquiry (AI) participants also benefitted from a valuable perspective on how we can genuinely drive improvement by being proactive not reactive and by actively Listening - really listening to patients, families and staff who often struggle to navigate our systems.

Meaningful engagement with families and answering their concerns is not only the right and humane thing to do but is also likely to ensure that families will not feel that they need to either complain or claim to have their issues properly addressed. This was evidenced by colleagues who joined us from NHS Resolution (formerly entitled the NHS Litigation Authority)

There was an appetite in the room to more actively share our learning and experiences across the region and to develop better ways to hear the voices of families and carers. The PSC has a mandate to work and support Wessex organisations and primary care to make improvements in three nationally determined domains - culture/ maternity and neonatal care / deterioration and sepsis.

We recognise that sharing and developing a pan Wessex approach of learning from deaths will be hugely beneficial. Increasingly so, due STP developments, pathway reform and reconfiguration of services - so many professionals and provider organisations touch the lives of the patients we serve and we need to share our learning for the benefit of improvement on where we have been.

We will update in a future CSIP newsletter our plans and ambitions to achieve this.

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