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Better Tomorrow
learning from deaths, learning for lives

Better Tomorrow - Learning from Deaths Collaborative workshop 21.10.24

@Aqua_NHS #AquaLearningFromDeaths

Welcome and housekeeping

We are just waiting for everyone to join. This event will start shortly

- Keep your **camera on** where possible.
- And your **mic on mute** to avoid feedback.
- Say hello and introduce yourself in the chat
- Please use the chat function to ask questions throughout the session
- Please note that this meeting will be recorded
- All presentations and resources will be shared after the meeting
- If you have any concerns or technical difficulties during the session, please email lismy.cheripelli@aqua.nhs.uk

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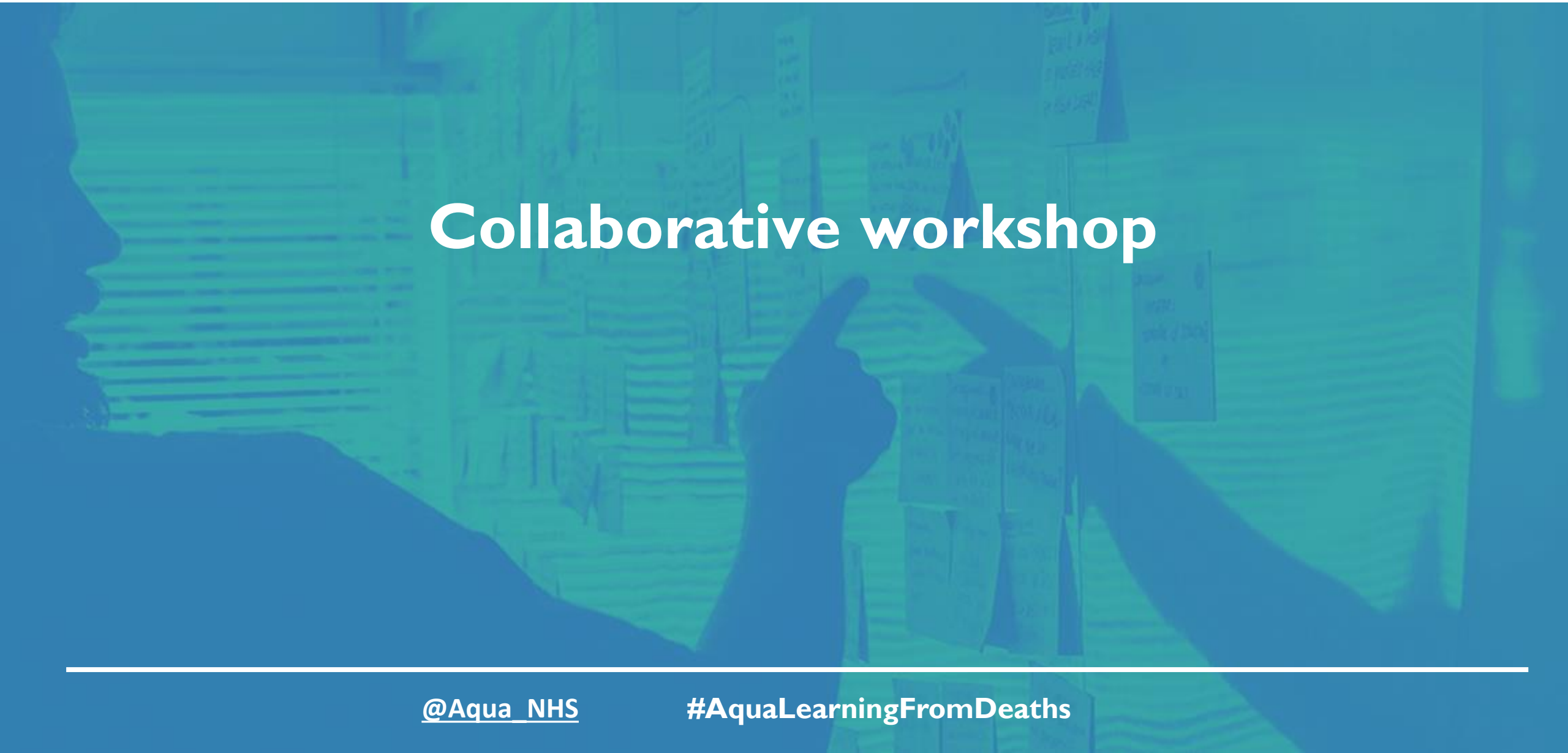

Collaborative workshop

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Collaborative

The ambition

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NHS
Buckinghamshire Healthcare
NHS Trust

NHS
County Durham and Darlington
NHS Foundation Trust

NHS
The Queen Elizabeth Hospital King's Lynn
NHS Foundation Trust

NHS
Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

NHS
North Cumbria Integrated Care
NHS Foundation Trust

NHS
Medway
NHS Foundation Trust

NHS
The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

NHS
The Shrewsbury and Telford Hospital
NHS Trust

NHS
The Rotherham
NHS Foundation Trust

NHS
East and North Hertfordshire
NHS Trust

NHS
James Paget University Hospitals
NHS Foundation Trust

NHS
North Tees and Hartlepool
NHS Foundation Trust

NHS
South Tees Hospitals
NHS Foundation Trust

NHS
University Hospitals of Morecambe Bay
NHS Foundation Trust

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Slido

Who is in the room?

What *role* do you have in Learning from Deaths?

Link:
https://app.sli.do/event/fPR92DYJd3KpGcFWarhBbv

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Slido Results

Which Organisation are you from?

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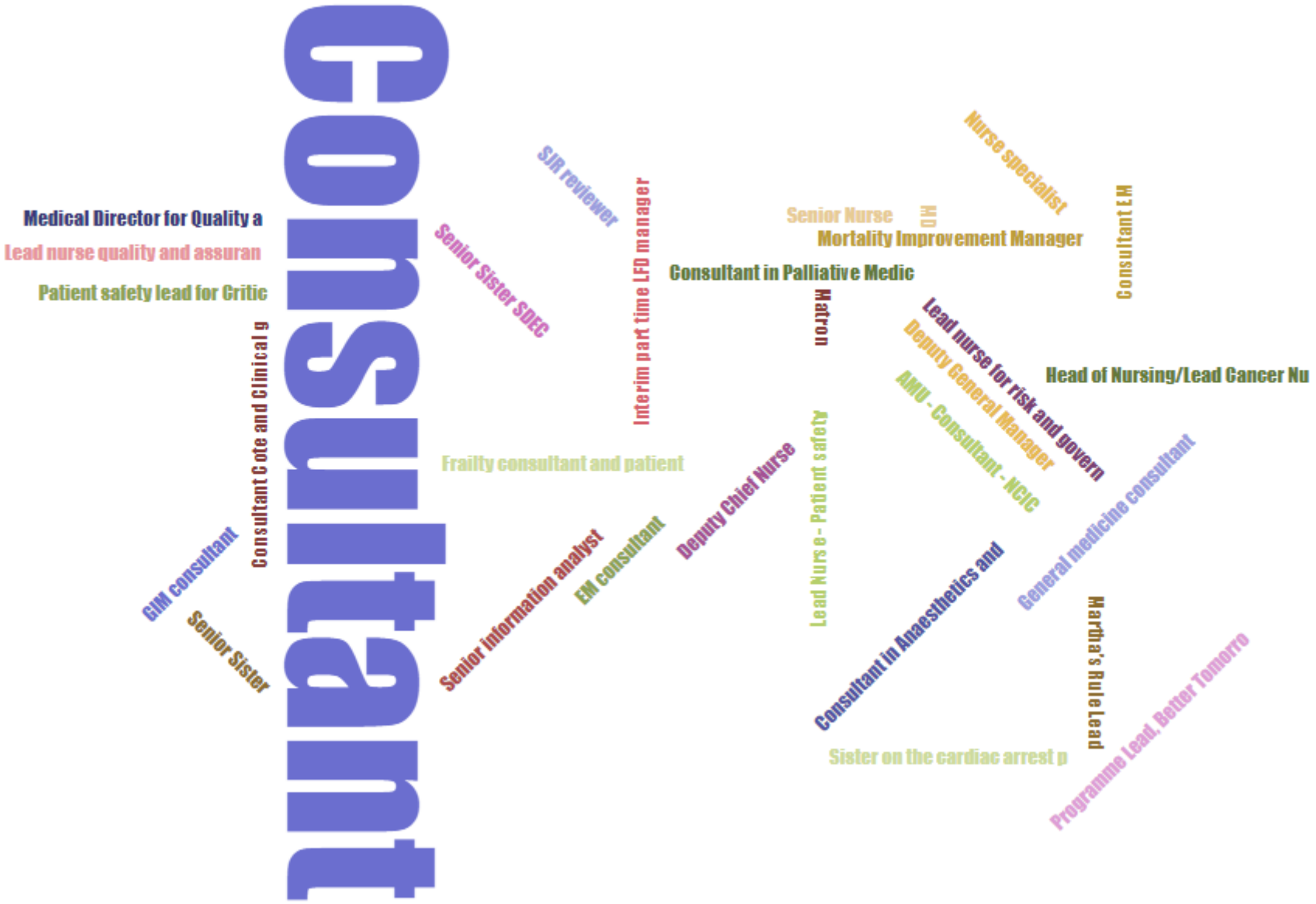
What is your role?

Slido Results



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Where are you based?

Slido Results

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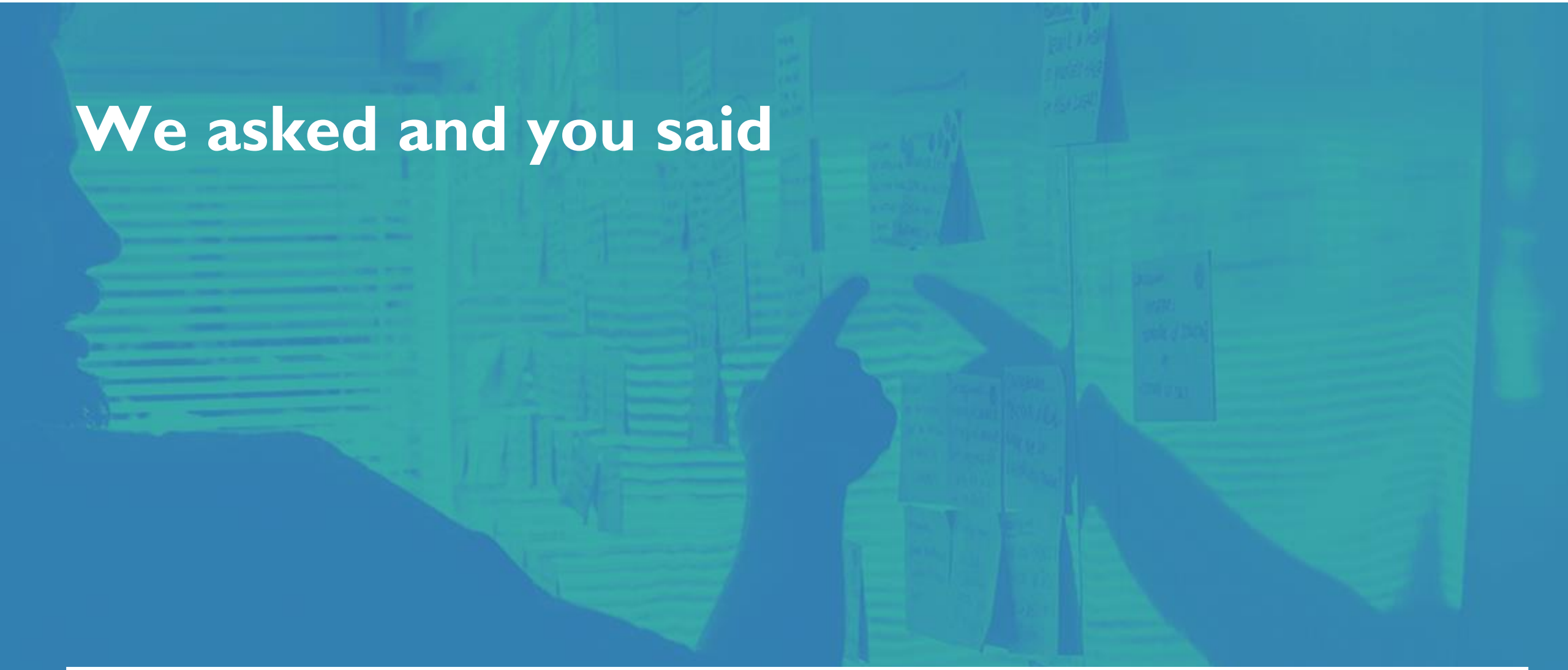
We asked and you said



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Event overview

Interactive workshop

- Current processes and any operational challenges
- Quality of SJRs and potential improvements
- Reporting for impact

Current processes and any operational challenges

SJR among smoke signals and sources

Feedback

Complaints

PSIRF

ME scrutiny

Coroner

Peer review
GIRFT

SJR

Audit

Special reviews
LEDER
MBRRACE
CDOP HSSIB

MH Special reviews eg
NCISH SARs
CDOP HSSIB

Learning from deaths

PLICs

Gathering a full picture of care

Coding & mortality metrics

Thematic analysis

Action, learning and improvement

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Toolkits – PSIRFs and SJR

Link

After action review

Summary

An After Action Review is a method of evaluation that is used when outcomes of an activity or event, have been particularly successful or unsuccessful. It aims to capture learning from these tasks to avoid failure and promote success for the future.

Link

After Action Review - Learning handbook

Document

Multidisciplinary team review

PDF 162 KB 9 pages

Summary

The multidisciplinary team (MDT) review supports health and social care teams to: identify learning from multiple patient safety incidents; agree the key contributory factors and system gaps in patient safety incidents; explore a safety theme, pathway, or process; and gain insight into 'work as done' in a health and social care system.

Document

Patient safety incident investigation overview

PDF 246 KB 6 pages

Summary

A patient safety incident investigation (PSII) is undertaken when an incident or near-miss indicates significant patient safety risks and potential for new learning.

Document

Swarm huddle

PDF 939 KB 9 pages

Summary

Swarm-based huddles are used to identify learning from patient safety incidents. Immediately after an incident, staff 'swarm' to the site to quickly analyse what happened and how it happened and decide what needs to be done to reduce risk.

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Case selection

Is this for an investigation or for structured judgement review?
What should happen beyond the ME scrutiny if concerns are raised?
How do we learn from good practice?

Coroner Inquest

Collate factual statements for Coroner, document accurate chronology of events and investigate through internal process, capturing positive and negative lessons Use Duty of Candour if relevant. Ensure family &/or carers are aware of referral. Coroner will also liaise with family &/or carers for information gathering and let them know processes. Use feedback from Coroner Inquests to gather trends and inform improvement plans.

Coroner
Wants to know facts
Expects and values honesty
Appreciates improvement
Gives judgement

Patient Safety Incident, Complaint or Duty of Candour

Generate incident report to prompt information gathering. Collate factual information: chronology of events and circumstances; contributory factors; and any positive and negative lessons. Different learning approaches can be used depending on the information gathered.
Use Duty of Candour if it is needed. Liaise with family &/or carers to address their concerns, answering complaints directly with available information, involving clinical teams throughout investigation.

Patient Safety Incident Investigation, Multidisciplinary team (MDT) review or After Action Review
Refer to Patient Safety Incident Response Framework

Audit of care bundles or care processes

Review of care processes and care delivery against a standard operating policy or standard of practice, capturing positive and negative lessons. Use improvement methods to complete audit cycle and demonstrate progress. Involve family &/or carers in improvement planning based on audits.
Use an investigation of events and Duty of Candour if any failings influenced the outcome for an individual.

If none of above apply, then consider case for:

Structured Judgement Review

Judgement based holistic review of care with narrative, ratings and grading which captures positive and negative lessons. If SI, Near Miss or DoC identified in case review, then investigate as above. Involve family &/or carers and system partners in discussion of trends and improvement planning.

Include random cases and exemplars for balance.

Insight and learning comes from sharing all of these

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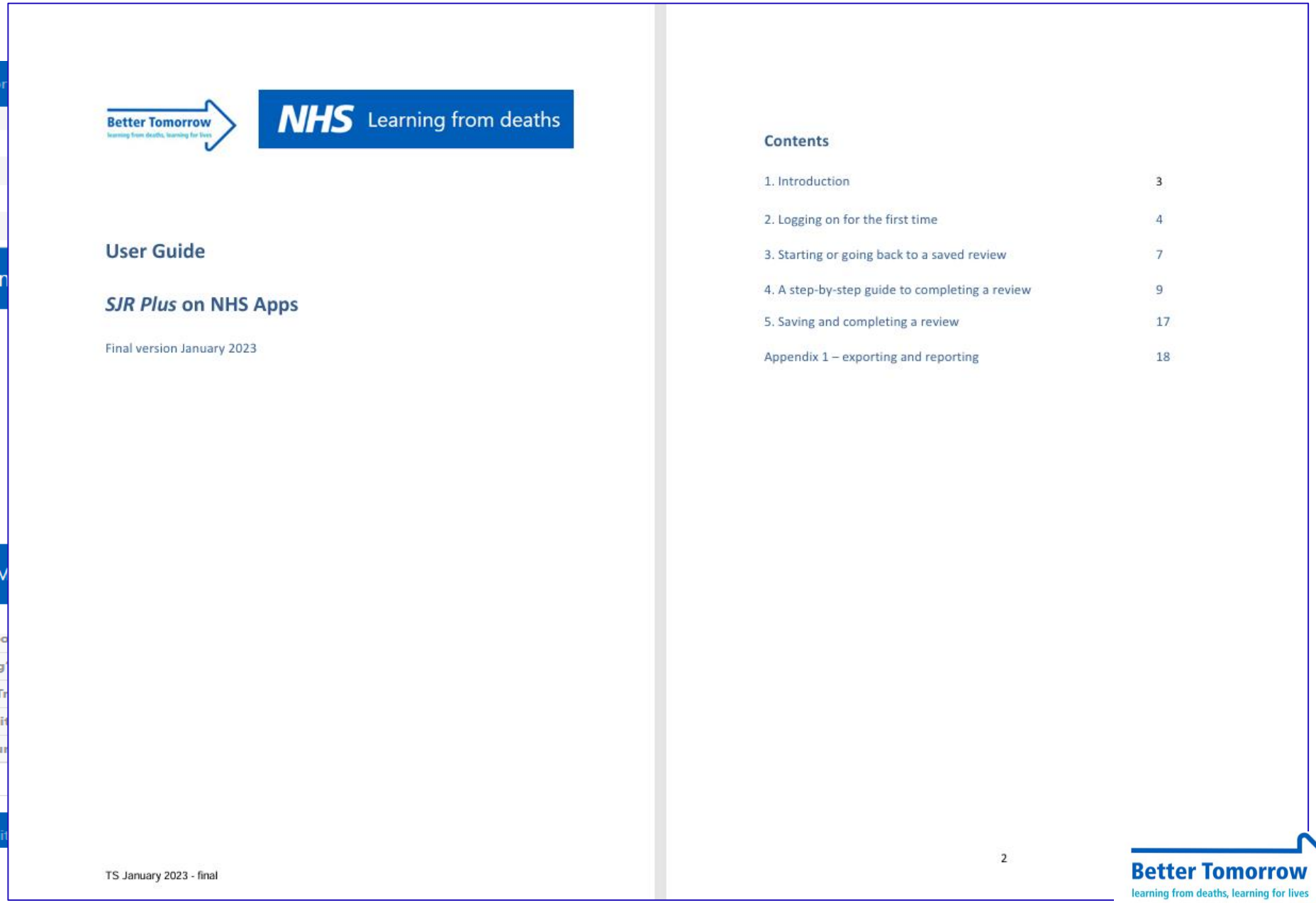
Accessing User Guide



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Current processes and any operational challenges

Anything else to cover?

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Quality of SJRs – are they good enough for learning and assurance?

Tracey Sparkes
Programme Lead for Better Tomorrow

PRINCIPLES OF SJR

- Combines traditional, clinical-judgement based, review methods in a standardised format
- Usable across services, multiprofessional teams and specialties

- Relies upon trained reviewers looking at the patient record in a critical and holistic manner and commenting on specific phases of clinical care

- Requires safety and quality judgements and a score for phases of care
- Uses free text and categorical variables to capture the quality of care delivered

Ongoing Care

29. Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice (for example, your professional standards or your professional perspective). If there is any other information that you think is important or relevant that you wish to comment on, then please do so.

How much to write?
What to say?
How do I justify my rating?

Please do not enter any personal information

487 words remaining.

30. Ongoing Care Rating

○ Very Poor Care ○ Poor Care ○ Adequate Care ○ Good Care ○ Excellent Care ○ N/A

Care during a procedure (if applicable)

31. Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice (for example, your professional standards or your professional perspective). If there is any other information that you think is important or relevant that you wish to comment on, then please do so.

What is a procedure?
How do I rate this if I'm not a surgeon?

Please do not enter any personal information

486 words remaining.

32. Care during a procedure rating

○ Very Poor Care ○ Poor Care ○ Adequate Care ○ Good Care ○ Excellent Care ○ N/A

Types of Problems

36. Problems leading to admission or readmission *(including transfer decision, admission avoidance, escalation planning and/or potential for admission avoidance)*

◉ Yes ○ No

37. Did this lead to harm?

○ Yes ○ No ○ Maybe

38. Problems in initial assessment, investigation or diagnosis *(including assessment of pressure ulcer risk, VTE risk, history of falls)*

○ Yes ○ No

40. Problem related to initial or ongoing treatment and management plan including preventative strategies? *(including pressure damage, falls, VTE)*

○ Yes ○ No

42. Problem in clinical monitoring? *(including failure to plan, to undertake, or to recognise and respond to change)*

○ Yes ○ No

44. Problem related to any invasive procedure, including surgical operation in theatre setting or intervention requiring anaesthetic? *(other than infection control)*

○ Yes ○ No

46. Problem in resuscitation following a cardiac arrest or respiratory arrest, including Do Not Resuscitate decisions?

○ Yes ○ No

48. Problem with medication?

○ Yes ○ No

50. Problems with IV fluids/Electrolytes/oxygen?

○ Yes ○ No

52. Problem with nutrition?

○ Yes ○ No

54. Problem with infection control? *(Including nosocomial infection)*

○ Yes ○ No

71. Are there any lessons to be learned from this review?

(•) Yes ( ) No ( ) Maybe

72. Are there any positive lessons to be learned from this case?

(•) Yes ( ) No

73. Please describe the positive lessons learned.

This happened which meant that
Exceeded standards
Addressed individual needs
Exemplary behaviours or practice
Wow why doesn't this happen every time

Please do not enter any personal information. 479 words remaining.

74. Are there any negative lessons to be learned from this case?

(•) Yes ( ) No

75. Please describe the negative lessons learned

This happened which meant that
This didn't happen which meant that
This behaviour has this potential impact
We should try to change this because...
if only we had done...

Please do not enter any personal information. 471 words remaining.

76. Where do you suggest this learning should be shared?

Person team organisation system

496 words remaining.

Quality of SJRs and potential improvements

Anything else to cover?

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Reporting for impact

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SJR Plus dataset – there's a lot in it!

Patient
Demographics
Unique Patient Identifier
Gender
Age at death (years)
Casenote number
Ethnicity
Postcode
Hospital stay
Hospital site if required
Date of this admission
Time of this admission
Was this a readmission
Source of admission
Existing Conditions on Admission
Reason for this admission
Main speciality at death
Date of death
Calculated length of stay
Cause of death recorded
MCCD 1a
MCCD 1b
MCCD 1c
MCCD 2
Risk Factors
Learning Disability?
Confusion/Memory Problems?
Mental Illness?
Asylum seeker?

Problems in healthc
Were there any prob
Types of problems
Problems leading to avoidance, escalatio
Problems in initial as pressure ulcer risk, V
Problem related to i strategies (including
Problem in clinical m and respond to char
Problem related to a setting or interventi
Problem in resuscita Resuscitate decision
Problem with medic
Problem with IV flui
Problem with nutriti
Problem with infecti
Problems in commu
Problems in commu
Problems in commu
Problem of any othe

Yes No

Overall Assessment			
Additional Quality Questions			
Review Outcome	Expected death Unexpected death Unable to grade		
Preventability	Definitely not preventable Slight evidence for preventability Possibly preventable, less than 50-50 Possibly preventable, greater than 50-50 Strong evidence for preventability Definitely preventable Unable to grade		
Clinical and organisational scores (NCEPOD grading system)	Good practice Room for improvement in clinical care Room for improvement in organisational care Room for improvement in clinical and organisational care Less than satisfactory Unable to grade		
Overall Assessment			
Please record your explicit judgement about the quality of care the patient received	Text		
Overall Assessment Rating	Very poor care Poor care Adequate care Good care Excellent care		
Lessons Learnt			
Are there any lessons to be learned from this review	Yes No Maybe (if yes or maybe lessons opens)		
Are there any positive lessons to be learned from this case?	Yes No	If Yes:	Please describe the positive lessons learned
Are there any negative lessons to be learned from this case?			Please describe the negative lessons learned
Where do you suggest this learning should be shared?	Text		

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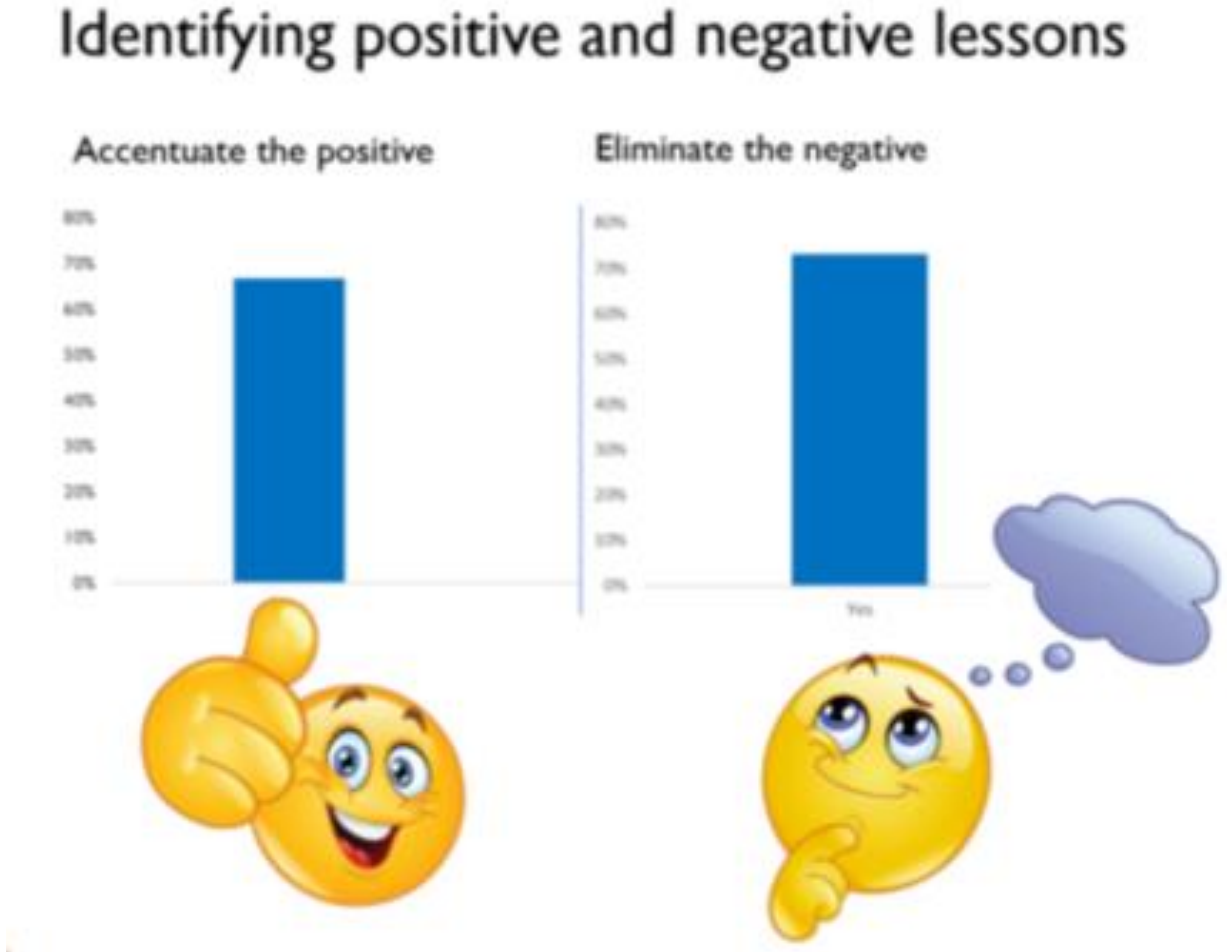
Seeing the wood for the trees

What data do we need?

Is this cohort representative?

No blame culture in the NHS?

Or affirmative learning for change?



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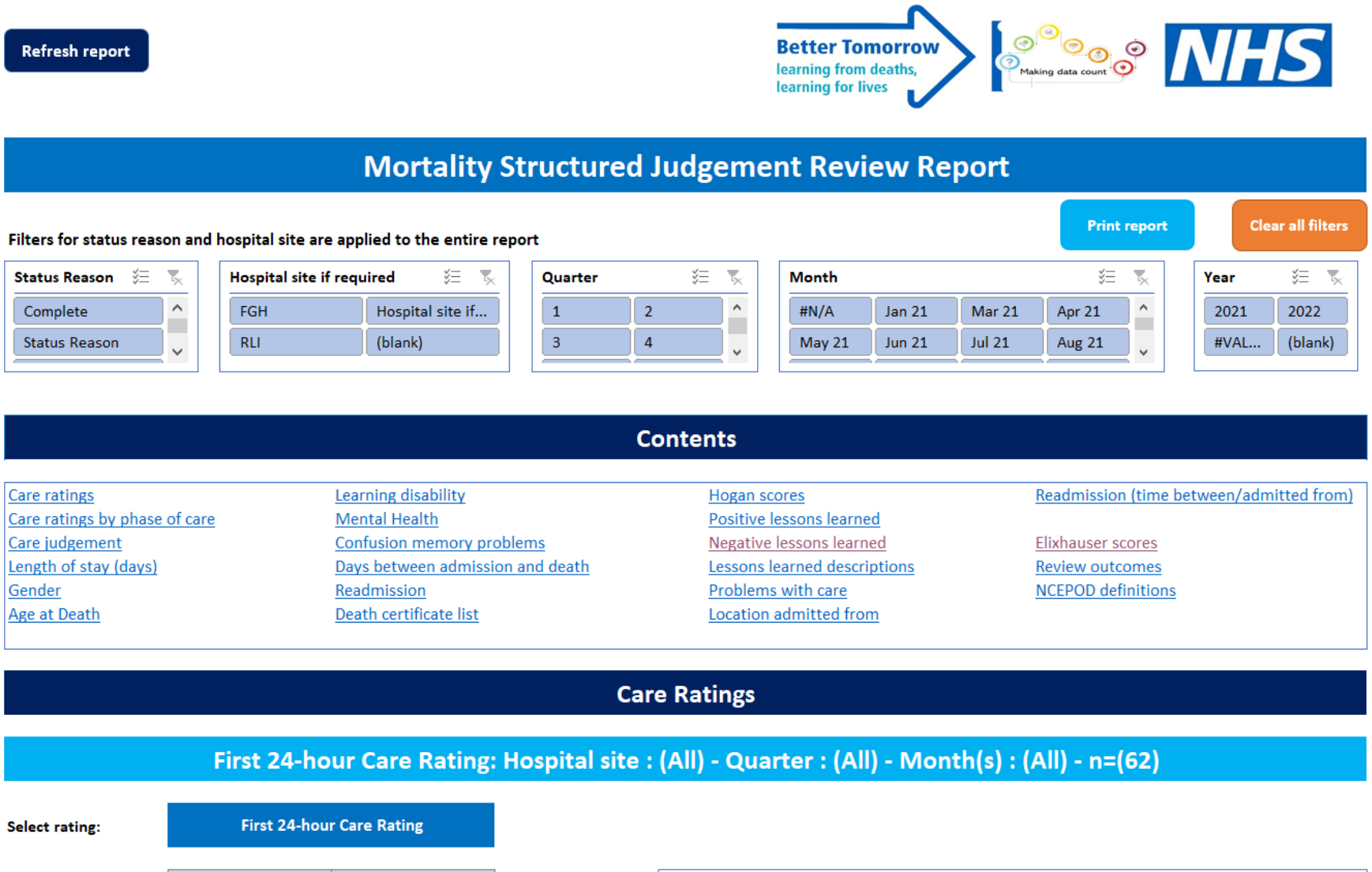
Cohort reporting



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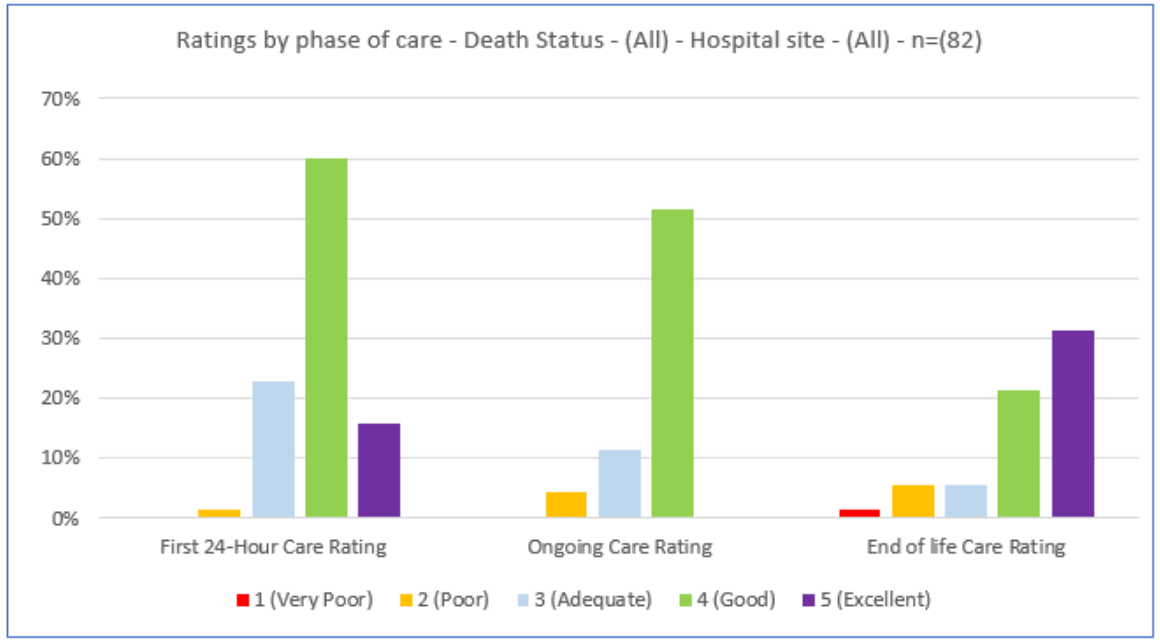
High level – phases of care

Ratings by phase of care: Hospital site : (All) - Quarter : (All) - Month(s) : (All) - n=(70)

Ratings by phase of care: Hospital site : (All) - Quarter : (All) - Month(s) : (All) - n=(70)			
	First 24-Hour Care Rating	Ongoing Care Rating	End of life Care Rating
1 (Very Poor)	0.0%	0.0%	1.4%
2 (Poor)	1.4%	4.3%	5.7%
3 (Adequate)	22.9%	11.4%	5.7%
4 (Good)	60.0%	51.4%	21.4%
5 (Excellent)	15.7%	0.0%	31.4%
Grand total	**100.0%**	**67.1%**	**65.7%**

Ratings by phase of care: Hospital site : (All) - Quarter : (All) - Month(s) : (All) - n=(70)			
	First 24 hour care	Ongoing care	End of life care
1 (Very Poor)	0	0	1
2 (Poor)	1	3	4
3 (Adequate)	16	8	4
4 (Good)	42	36	15
5 (Excellent)	11	0	22
Grand total	**70**	**47**	**46**

**number of not applicable records 0*



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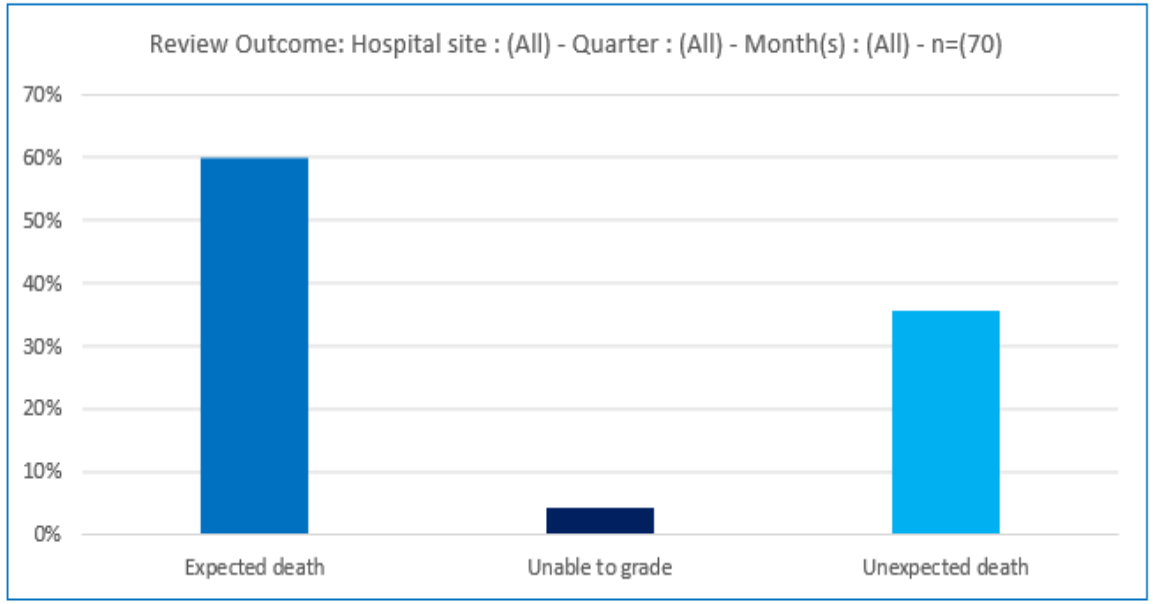
Review outcomes

Review Outcome: Hospital site : (All) - Quarter : (All) - Month(s) : (All) - n=(70)

Review outcome	n.	%
Expected death	42	60.0%
Unable to grade	3	4.3%
Unexpected death	25	35.7%
Grand total	**70**	**100.0%**

**number of incomplete records 0*



Capturing problems in care

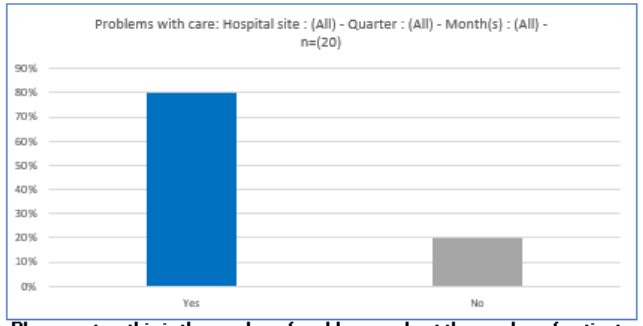
Problems with care: Hospital site : (All) - Quarter : (All) - Month(s) : (All) - n=(20)

	n.	%
Yes	16	80.0%
No	4	20.0%
Grand Total	**20**	**20.0%**

**number of incomplete records 6*

Problem area	
Problem in Clinical Monitoring	
Problems in Assessment	
Problems in Communication	
Problem related to Treatment	
Problem with Medication	
Problems leading to readmission	
Problem of any other type	
Problem with Infection Control	
Problems leading to readmission harm	5
Problem with Nutrition	5
Problem related to Operation	1
Problem in Resuscitation	0

Pareto chart ranks all the problems with care categories

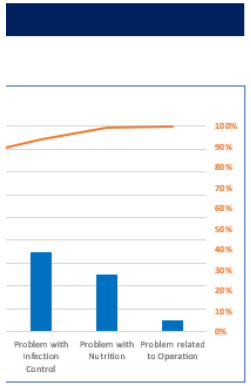


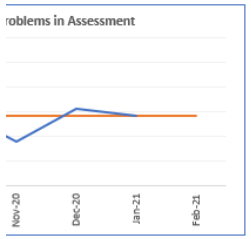
Please note – this is the number of problems and not the number of patients. Some cases had problems in more than one phase of care

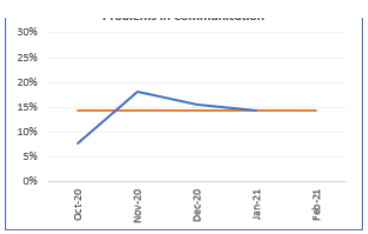
Click here to view detailed charts on problems with care

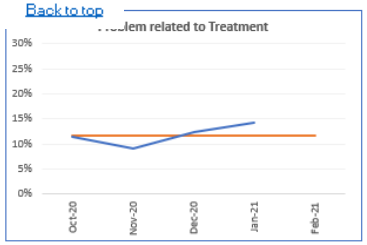
Problem area		
Problem in Clinical Monitoring Harm?		
Problems in Assessment Harm?		
Problem with Infection Control Harm?		
Problem related to Treatment Harm?		
Problem with Medication Harm?		
Problems in Communication Harm?		
Problem of any other type Harm?		
Problem in Resuscitation Harm?		
Problem related to Operation Harm?	0	0
Problem with Nutrition Harm?	0	1

Four charts underneath displays the top four categories as ranked on the pareto chart







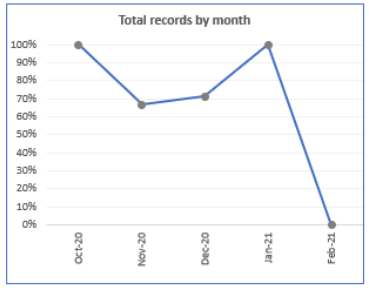


Run charts, will change to SPC charts when it reaches 15 data points

Back to top

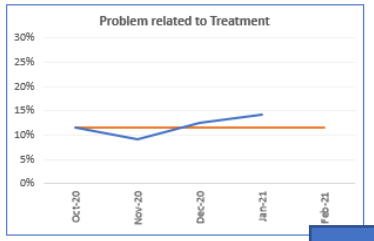
Back to contents

Back to problems with care



Top chart details how many records out of the total recorded Yes (problem with care)

Select option for cha Problem related to Treatment



Key

- Problem with care metric
- Mean
- UPL
- LPL
- Concern
- Improvement

*note charts will appear as run charts until 15 data points are reached, SPC charts will then be displayed

View how the number of each problems with care category change overtime

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Positive lessons learned with qualitative illustrations

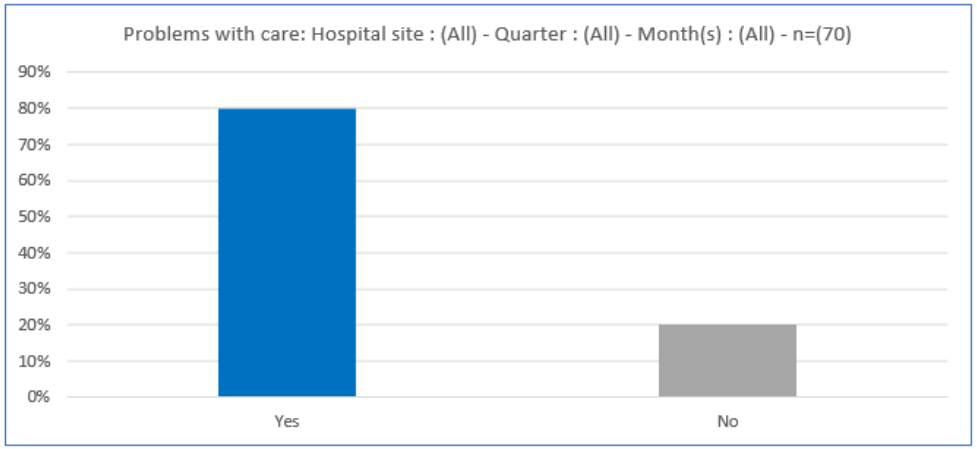
Category and number of times featured		Representative comment from notes or reviewer
Good involvement of specialist teams	18	*Regular reviews recorded including advice from specialist teams* *Evidence Trust has a hospital alcohol team who provide support and care to patients* *Evidence of lovely caring notes from physio team who saw people on ward 7. Taking time to explain what has happened to patient*
Clear and responsive treatment plans	18	*Involvement of ITU and move to level 3 age agnostic* *Recognition of O2 issue (high flow and hypercapnia in COPD)* *CT Scan reported quickly, and patient taken to surgery timely* *Good initial clinical assessment and treatment for sepsis in ED* *Responsive and flexible care as she rallied and exceeded her ceiling of care, treatment recommenced.*

Negative lessons – thematic analysis

Problems with care: Hospital site : (All) - Quarter : (All) - Month(s) : (All) - n=(70)

	n.	%
Yes	56	80.0%
No	14	20.0%
Grand Total	**70**	**20.0%**

**number of incomplete records 0*



Please note – this is the number of problems and not the number of patients.
Some cases had problems in more than one phase of care

Ranked order

Problem area	Yes
Problem in Clinical Monitoring	56
Problems in Assessment	54
Problems in Communication	53
Problem related to Treatment	41
Problem with Medication	40
Problems leading to readmission	29
Problem of any other type	28
Problem with Infection Control	27
Problems leading to readmission harm	15
Problem with Nutrition	15
Problem related to Operation	1
Problem in Resuscitation	0

Click here to view detailed charts on problems with care

Ranked order

Problem area	Yes	Probably
Problem in Clinical Monitoring Harm?	40	15
Problems in Assessment Harm?	27	25
Problem with Infection Control Harm?	26	1
Problem related to Treatment Harm?	15	26
Problem with Medication Harm?	13	27
Problems in Communication Harm?	13	27
Problem of any other type Harm?	12	15
Problem in Resuscitation Harm?	0	0
Problem related to Operation Harm?	0	0
Problem with Nutrition Harm?	0	1

Case studies

Case 2 – excellent first 24-hour care

35-year-old male in 24-hour care Mobilises in wheelchair and non-verbal.

Evidence of lower limb contractures on admission.

Emergency care was prompt and thorough; presentation was with severe acute hypoxic respiratory failure, this was recognised by ED and immediately escalated to ICU. Intervention was swift with well documented and reasoned decisions to provide invasive mechanical ventilation. The process of initiation of mechanical ventilation was well managed as was the cardiovascular and ventilatory strategy selected.

Communication with family was done appropriately as was the recognition of potential legal / safeguarding issues.

The investigative strategy was comprehensive recognising the atypical presentation of covid pneumonitis (raised neutrophil count) and appropriately covered and investigated for community acquired pneumonia.

Challenges and ideas in reporting?

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Reporting for impact with dashboards

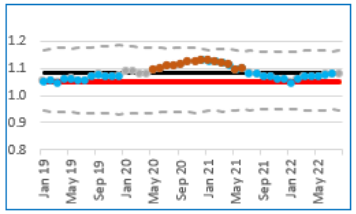
Acute trust dashboard: information sharing from bed to board

Trust A

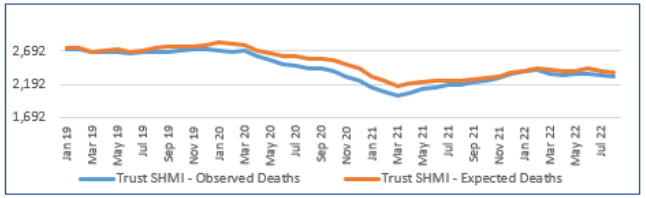
Context — Detail

SHMI

Latest month	Aug 22
SHMI	1.03
SHMI in expected range	
Observed deaths	2315
Expected deaths	2380



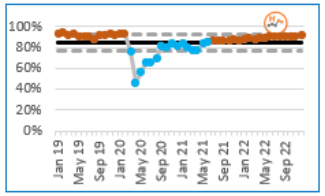
SHMI - Expected Vs. Observed



Hospital Occupancy

Latest month	Dec 22
%	91.9%

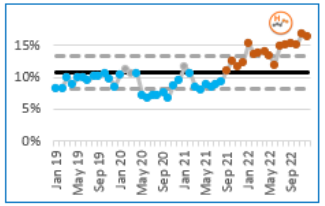
Significant deterioration



% Patients with LoS > 7 days

Latest month	Dec 22
%	16.3%

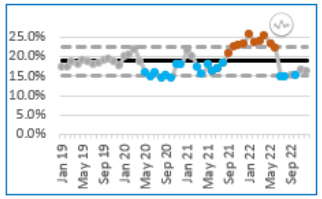
Significant deterioration



% Patients with LoS > 21 days

Latest month	Dec 22
%	16.3%

No significant change

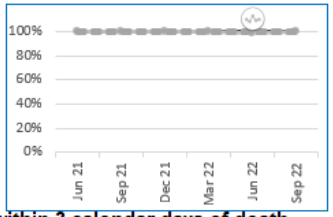


Scrutiny to SJR — Detail

No. deaths scrutinised by ME - Q5h

Latest month	Sep 22
%	100.0%
Number	503

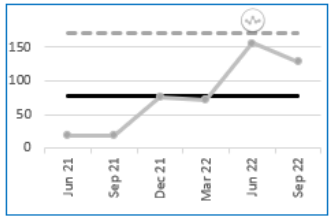
No significant change



No. MCCDs not completed within 3 calendar days of death - Q16

Latest month	Sep 22
Number	129

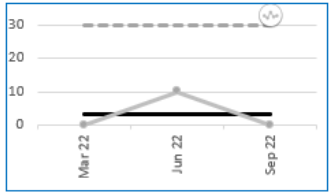
No significant change



No. Patient Safety Incidents notified by medical examiner office as a result of scrutiny - Q23

Latest month	Sep 22
Number	0

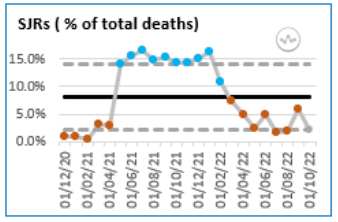
No significant change



SJRs (% of total deaths)

Latest month	Oct 22
%	2.1%

No significant change

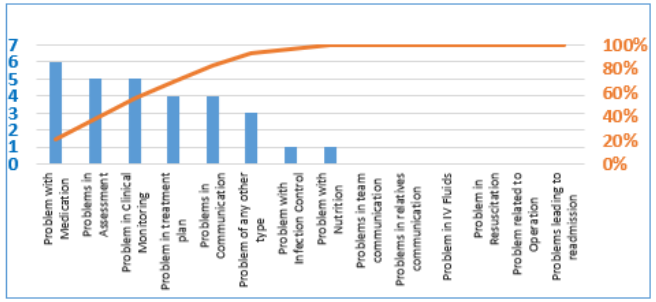


Care — Detail

Good care identified

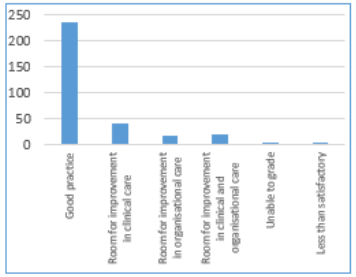
In 238 out of 327 cases (73%) good care was identified

Problems with care Apr-22 to Aug-22



NCEPOD definitions Nov-19 to Oct-22

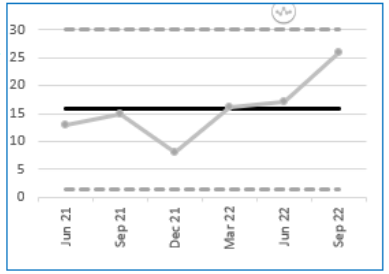
Good practice	238
Room for improvement in clinical care	41
Room for improvement in organisational care	18
Room for improvement in clinical and	22
Unable to grade	4
Less than satisfactory	4



Deaths where a significant concern about the quality of care provided is raised by bereaved families and carers - Q20a

Latest month	Sep 22
Number	26

No significant change



Making data count

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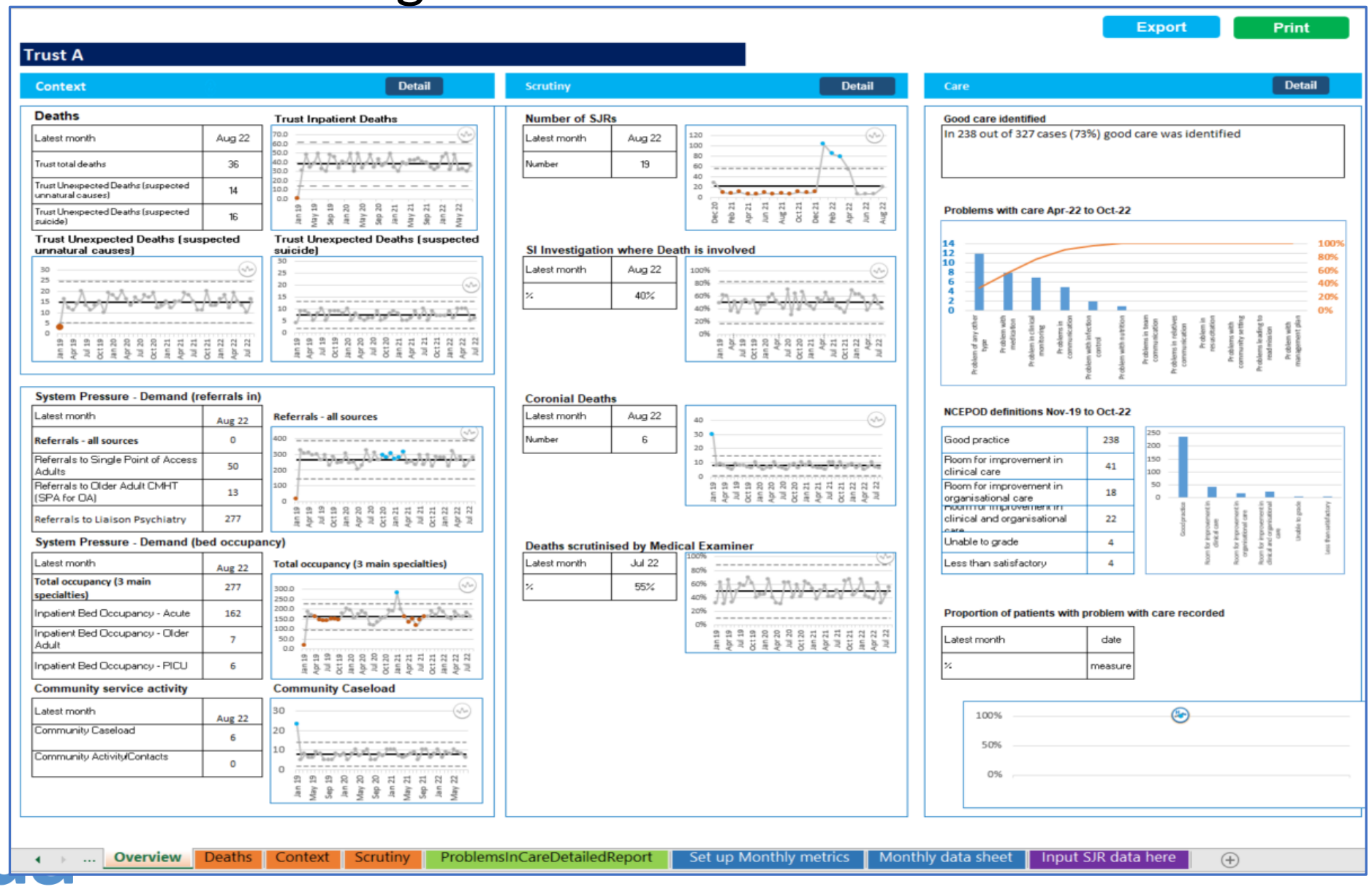
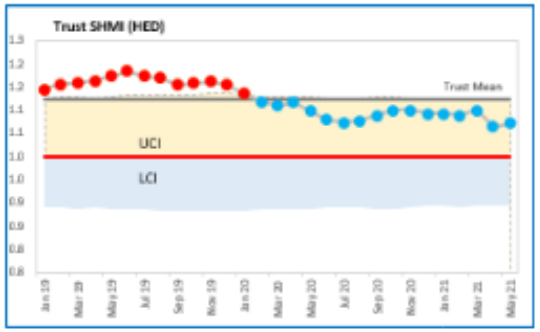
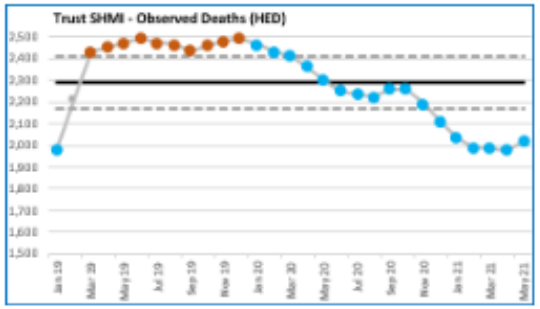
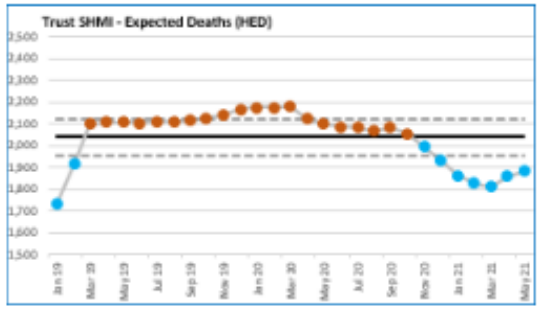
Mental health mortality dashboard: information sharing from bed to board

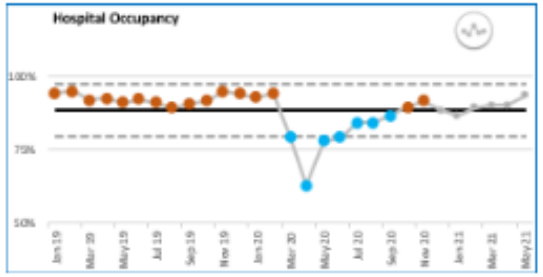


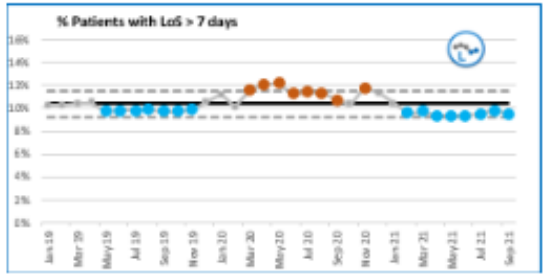
Behind the dashboard

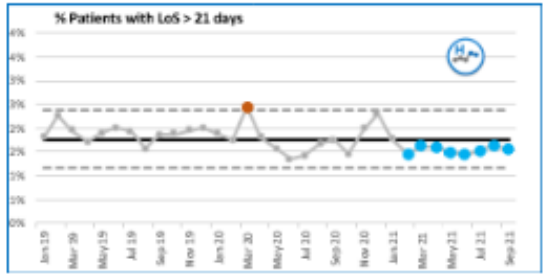


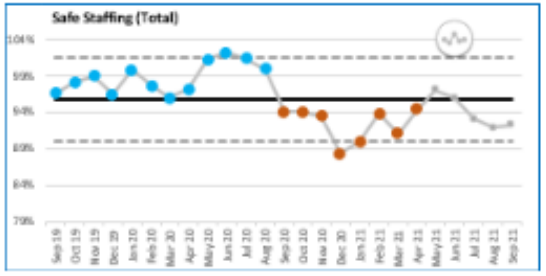


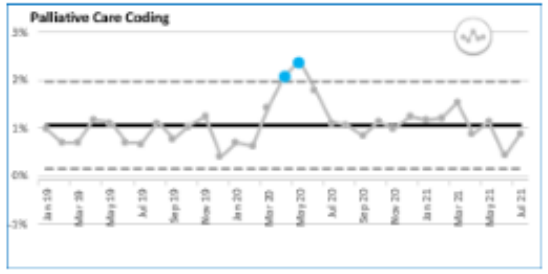


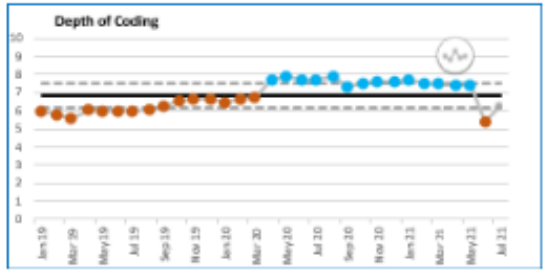












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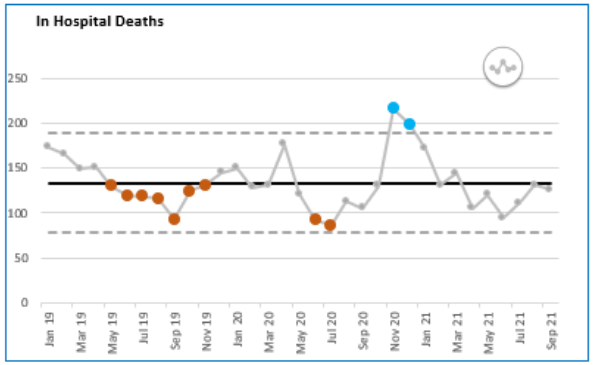
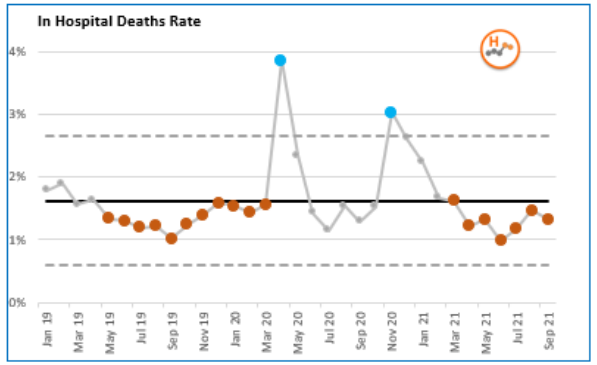
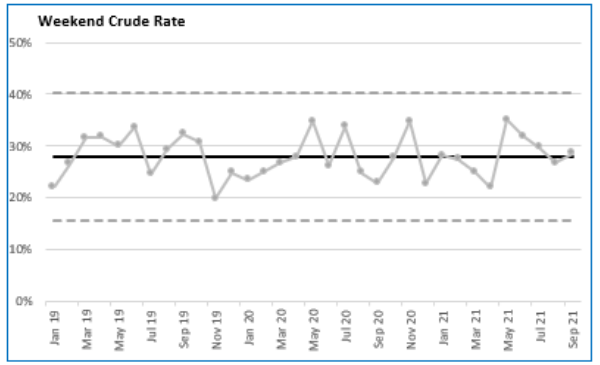
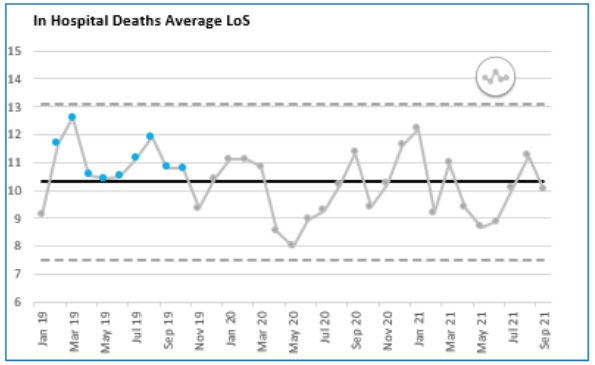
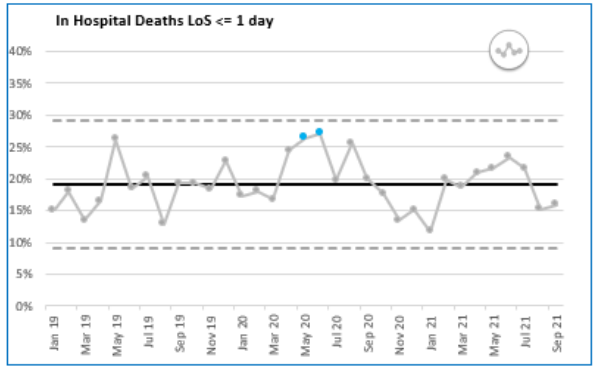
Behind the dashboard

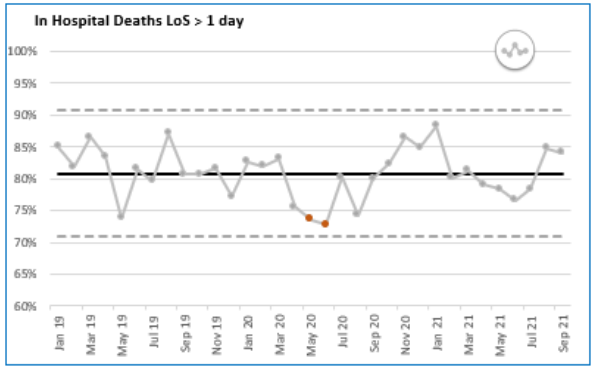


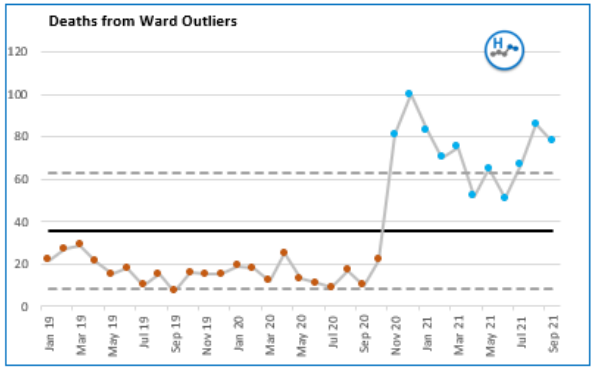


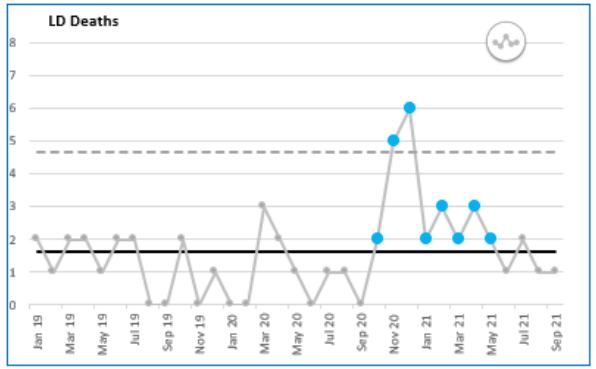












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Join in the community discussion

[Better Tomorrow - FutureNHS Collaboration Platform]

https://future.nhs.uk/BetterTomorrow

Future collaborative April 2025

What have you done, what could you share, what do you need?

Send us queries ideas and successes

Evaluation

How can we do better next time?

Link:
https://www.surveyhero.com/s/LfD211024

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NHS Better Tomorrow is a programme dedicated to Learning from Deaths, and focusses on how that learning can influence future patient care. It originated from a passion for improving care, and a respect for Learning from Deaths.

Aqua is proud to be working closely with the Better Tomorrow team to enable organisations to access the SJRApps.

Get in touch

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Contact for more specific info

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