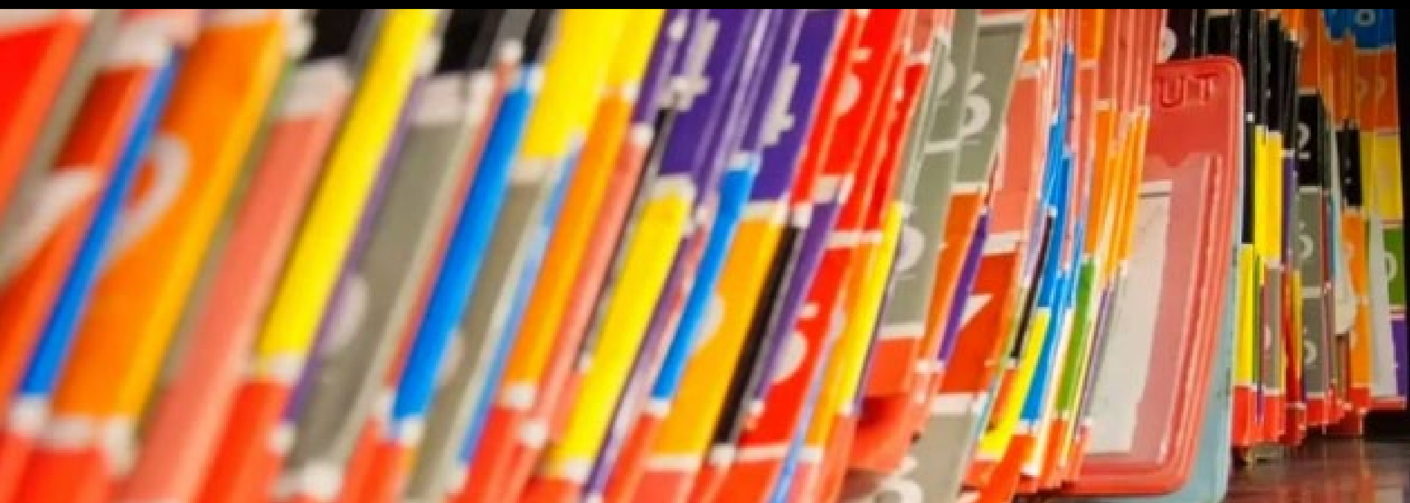
Learning From Deaths – time to reflect?



We support our clients to learn from deaths by a better understanding and helping them improve all aspects of mortality governance from reporting through to practice improvement.

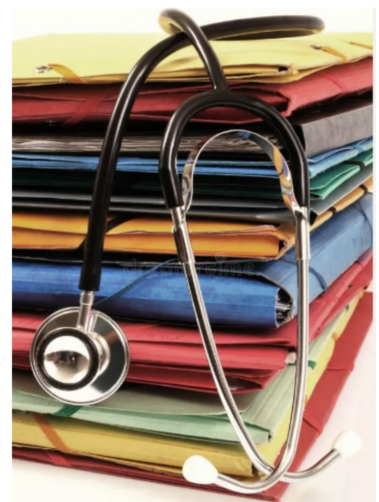
About Mortality Governance Review

Mortality governance is a statutory process undertaken throughout the NHS. Many trusts already have a process for reviewing serious incidents and inpatient or mental health deaths through existing national and local audits or through the newly established Patient Safety Incident Response Framework (PSIRF) which emphasises the importance of thematically reviewing relevant evidence. However, the focus on learning has changed significantly since the Learning from Deaths Guidance was issued in March 2017 and recent very high-profile incidents in the NHS brings into stark relief requirements around:

- **knowing which of your patients have died and when;**
- **Analysing this data at a trust, specialty and procedure level to identify and understand possible trends, and**
- **implementing a process that facilitates the identification of which of those deaths should be subject to case review or further investigation.**

Alongside the widely publicised changes to Learning from Deaths comes an increase in public expectation that families are appropriately involved, Duty of Candour applied and that any subsequent learning is implemented.

Different types of mortality governance review packages:



- **System-wide mortality review (ICS)** – We can work across systems, between partners to identify key issues arising from learning from deaths across agencies and to support the development of collaborative solutions.
- **Process review** – We can assess your mortality governance processes to ensure they are robust as you shift towards the PSIRF and thematic review learning
- **Mortality governance / assurance review** – We can undertake reviews at a Board level or more directly at the level of clinical governance within services. Reviews can be targeted or wide-ranging.
- **Mortality data review** – We can look in detail at incident reporting, data flows, reporting between divisions, data validation processes, data segmentation categories, the role of the medical examiner and thematic analysis.
- **Learning from Deaths Policy review** – We can evaluate your policy implementation and test out areas for improvement, supporting the development of your updated policy.
- **Investigation assurance** – We are the leading supplier of investigations under the NHS England Framework. Using our extensive knowledge we can assess the quality of your own investigations and make recommendations for improvement.

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HEALTH & SOCIAL CARE CONSULTING

Our Mortality Governance Assurance Framework (MGAF)

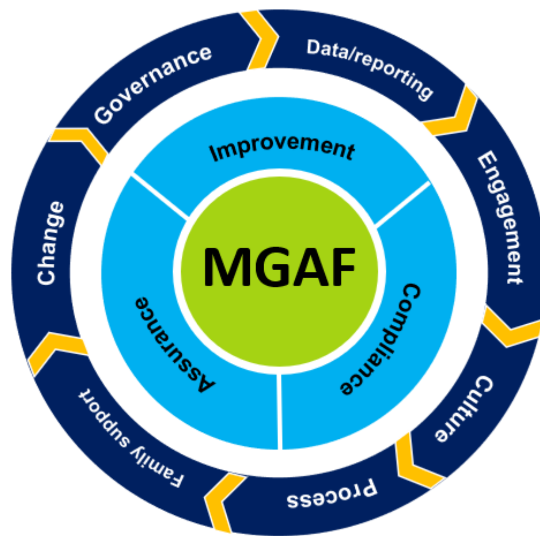
The importance of learning from deaths:

Having effective systems and processes for learning from deaths does carry at least some resource requirement. However, most clinicians, managers and quality teams express the unequivocal view that the learning arising from deaths is worth it. Many indicate it is a ‘no brainer’; others say that the investment in the review process has impacted on staff and families positively – for example, the funding and introduction of Family Liaison Officers (FLOs) and along with it a culture that has improved communication and transparency with families.

Structured Judgement Reviews

The introduction of case note reviews – notably the Structured Judgement Review (SJR) process - supports the learning and development of care processes. Our practitioners were the first to use SJR Methodology across a health system.

Seeing first-hand the developing story of a patient’s care in the months before they die is an opportunity for learning in so many ways – record keeping; communication; timeliness; compassion; team working; good practice and of course, the identification of good and poor practice.



About the Framework

Our **Mortality Governance Assurance Framework** (MGAF) has been developed as the result of our work with a number of different organisations. The Framework can work if applied in a holistic way, i.e. if undertaking a whole-scale mortality governance review, or, aspects of the framework can be applied within services. The MGAF can also be applied across systems to enable broader learning and shared improvement to take place.

We understand how accountable healthcare organisations work

Our practitioners have worked extensively with, and within the NHS. We have a good mix of clinical, investigative and governance experience which underpins our unique methodology in this field.

We also have a dedicated team of NHS trained data scientists that bring sophisticated tools and techniques to analysing your data

We understand the challenges you face in applying limited resources to best effect, particularly in the vital sphere of learning from deaths.

About the work we do

Our way of working is collaborative and flexible. We will work in a supportive manner whilst providing appropriate levels of challenge and use our experience to provide external perspectives, insight and honest appraisal of the current state.

We develop good collaborative working relationships with our clients and their stakeholders at all levels. We have a reputation for honest advice whilst developing mutually supportive partnerships, enabling joint learning and relationship building. Our co-production approach means working alongside clients to capitalise on respective skills, facilitate knowledge transfer and secure buy-in. We have demonstrated this way of working repeatedly on all of our large scale, system-wide projects involving data collection and analysis, investigations and case reviews.

Our work often involves running engaging and inclusive workshops/focus groups for cross-sector audiences on specific topics and programmes of work. We have held numerous, regional collaborative workshops on mortality governance and a wide number of local/bespoke workshops with NHS and local authority partnership forums and other professional groups.

No other consultancy approaches the quality agenda in the same way as Niche

Best of all we are almost always the most cost-efficient option for organisations who are trying to access consultancy support whilst also offering even deeper expertise than some of the larger professional services firms. Niche is and Employee Owned Trust and are proud to be a **values driven consultancy and a Bcorp** and we always connect our work and outcomes to service-user experience.

insight
integrity
impact

Mary-Ann Bruce- Partner
Mary-Ann Bruce was commissioned by NHS England to review the deaths at Southern Health NHS Foundation Trust. She was a key member of the CQC Expert Advisory Group for the subsequent CQC report commissioned by the Secretary of State – Learning, Candour and Accountability. Mary-Ann led the first system-wide Clinical Quality Audit using Structured Judgement Review methodology.

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