Kent Surrey Sussex
Academic Health Science
Network

Learning From Deaths and Serious Incidents:
Why are we not sharing the learning across sector within Kent, Surrey and Sussex?

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Kent Surrey Sussex Academic Health Science Network sponsored this project under the Darzi Fellowship in Clinical Leadership programme. The project aims to review, support and spread innovative approaches currently being undertaken across Kent, Surrey and Sussex to learn from serious untoward incidents and learning from deaths.

Context

A conservative estimate of 150 people die from avoidable death in UK hospitals every week (Hogan et al 2015).

While the NHS conducts patient safety investigations into these deaths to learn from mistakes, there is no structure to share learnings across organisations, no standardised, compulsory training in investigation and it is questionable that the right metrics are being measured.

This project seeks to identify the barriers to learning from deaths and serious incident, specifically looking at how learnings are shared.

Stages

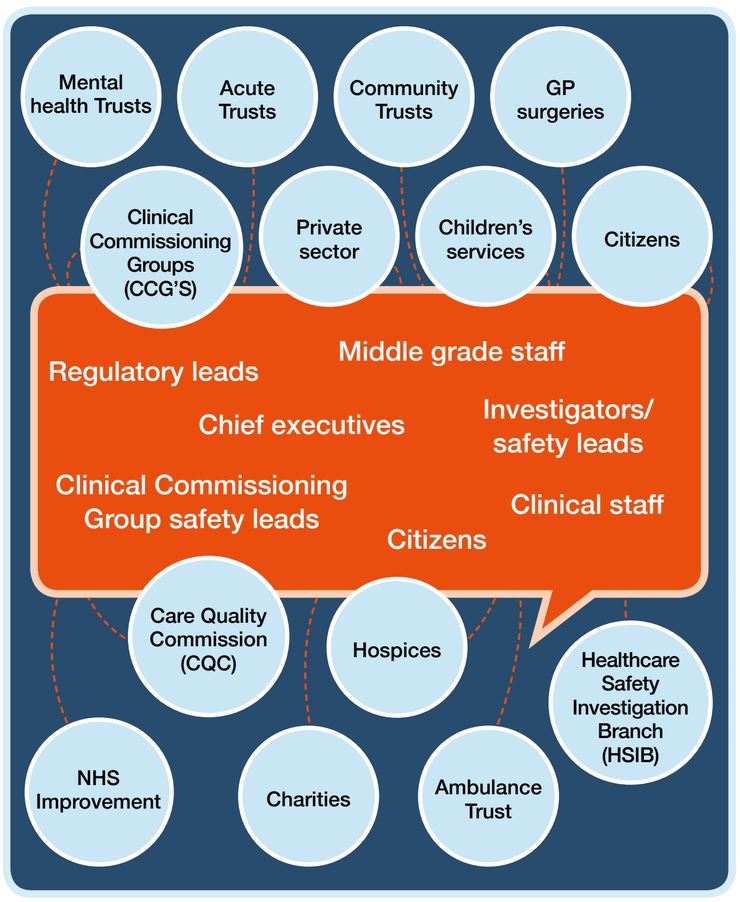
The project had two distinct stages:

1. A four-month scoping period of semi-structured interviews with a range of stakeholders, in order to determine themes for further investigation

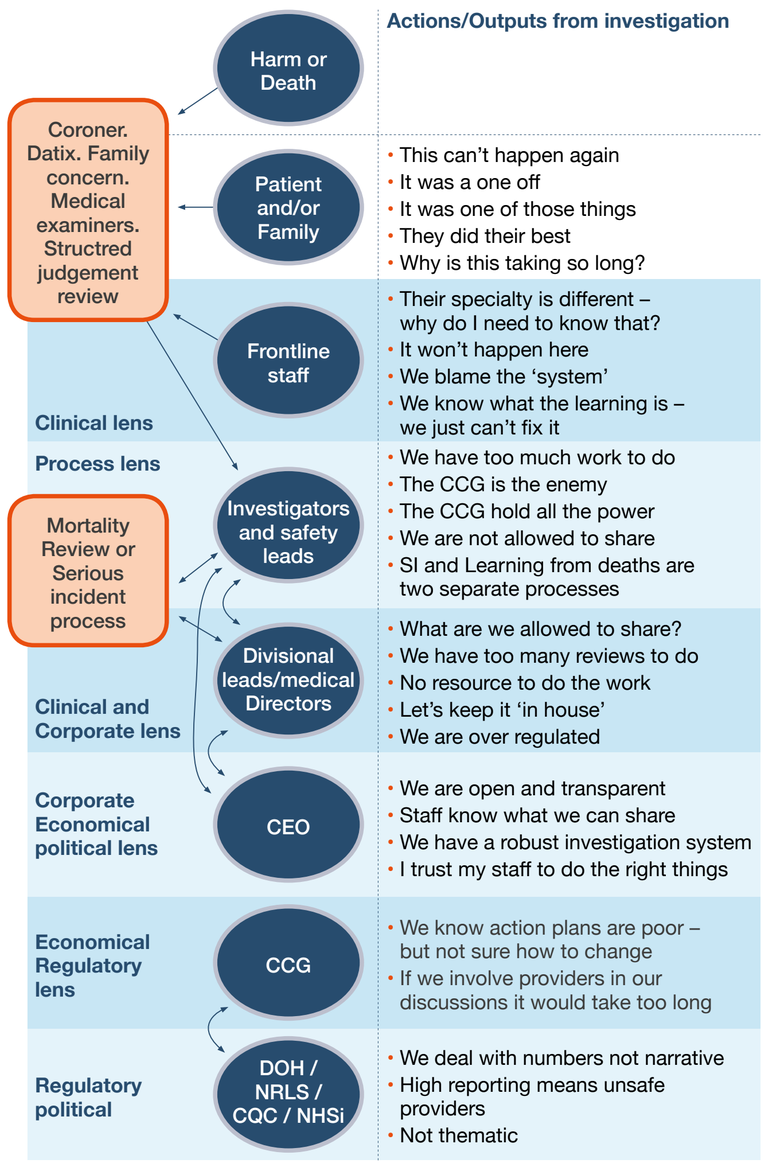
2. An event where themes were discussed and projects set up to challenge problems

Stage 1 - Scoping period

Semi structured interviews were carried out to gather data on role, processes used, understanding of guidance, barriers to learning across sector and barriers to learning within an organisation. An inductive approach was used to understand the problem. Interviews took place with representatives from these groups below at organisations outlined in the circles.



From these discussions, a process map was created to show how each group interacted with the other, and the particular lens they saw the issue through.



Stage 2 – Dare to Share event

More than 100 people attended the event, with a good representation from across disciplines as shown below:

• 40 Clinicians (35%) • 26 Senior staff (23%) • 8 Citizens (7%)
• 28 Investigators (25%) • 12 CCGs/Regulators (10%)

Delegates were asked to undertake four activities, designed to help them better understand the barriers to learning, as identified in the scoping period.

They then formed small project groups to identify pragmatic, practical solutions to local barriers/issues.

Their anecdotal feedback pointed to a range of local issues, including:

- no standardised approach to how investigation are carried out
- lack of robust training in conducting investigations
- an absence of feed-back, good and bad, to frontline staff
- a clear appetite for citizens and staff to work together, but no mechanism to do so.

Following the event we were able to group these local issues together, creating a set of national recommendations that may increase learning from deaths.

Recommendations

- Involve clinicians to work with the investigation team to uncover good and poor practices and find innovative solutions to reduce risk
- Involve patients, families and citizens, not only with the investigation process, but finding innovative solutions to reduce the risk of it recurring.
- Ensure standardised, competency-based training to anyone conducting a clinical investigation
- Involve the investigation team on the 'shop floor'
- Improve the relationship between citizens and families and the Trust
- Improve the relationships between CCGs and regulators with the Trust
- Reconsider the way we measure safety, are we measuring the right things?
- Use a standard approach to investigations, nationally
- Consider a new model of care to allow governance of large hospital Trusts to be shared to allow improved access to information.

Next steps

The project groups from the 'Dare to Share' event will attend one further meeting to report on their progress and, more importantly, learnings from their work.

This feedback will be used to strengthen and consolidate existing recommendations, and will appear in the final project write up.

Conclusion

There was a sense of wanting to improve the way we share learning from deaths and serious incidents across Kent Surrey and Sussex from people who attended the day. Fantastic change ideas will be implemented as a result of the Dare to Share event. However, to ensure that our health system is among the safest in the world a dynamic shift in the way reporting, investigation and regulation are conducted is required. Clinicians are the care givers, citizens are central, but not involving them with the investigation, as part of the solution, is short-sighted.

There is an assumption made by clinicians and citizens that investigators are trained experts in investigation, ensuring changes are made to reduce the risk of future harm. However, this is not the case.

Assumptions held by each tribe are part of the barrier for not sharing information or giving up power. However the current processes and system we have for embedding and sharing learning from deaths and serious incidents are not robust. There are pockets of good practice but getting these ideas/ solutions shared will only compound unwarranted variation. At present, there are no current standardised mechanisms for closed loop feedback to front line staff thus leading repeated serious incidents and avoidable deaths.

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