Focus on learning from healthcare mortality

Improvement Academy

Working together across Yorkshire and Humber

The Yorkshire & Humber regional mortality programme is supporting better care in our region and a more open learning culture. Working with all 13 acute trusts and 5 of our 6 mental health trusts, we are supporting healthcare providers in the region to use evidence-based and standardized Structured Judgement Review (SJR) method to identify problems in care, and also to highlight really excellent care. We have now trained more than 800 frontline staff in SJR. Their work is supporting an open safe learning culture across the region and is leading to real and sustainable improvements in care delivery systems. To learn more about the programme click here.

L-R: Professor Allen Hutchinson, Beverley Slater, Dr Michael McCooe, Dr Usha Appalsawmy and Professor John Wright

Royal College of Physicians | PATIENT SAFETY AWARDS | thebmjawards FINALIST 2018

Congratulations to our Mortality programme team for their nominations for three prestigious national awards: HSJ Patient Safety Award for Quality Improvement of the year, BMJ Award for Patient Safety and RCP Excellence Award.

"This has been an amazing opportunity to develop SJR into mental health with the Improvement Academy. The programme has received very positive feedback with identified areas for learning and quality improvement which will make a difference to the lives of people with mental health problems now and into the future."
- Allyson Kent, Head of Nursing and Clinical Quality, Humber NHS Foundation Trust

Mental Health Mortality Case Record Review Programme

This new programme, led by Allyson Kent, uses an adapted Structured Judgement Review method suitable for use for the review of deaths in mental health care. Our training sessions, both within and outside Yorkshire and Humber have received excellent feedback.

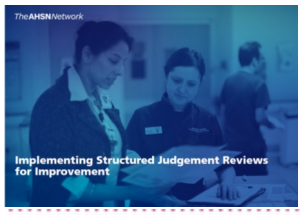
To read a case study on using SJR for Mental Health mortalities click here. For more information, contact Dr Usha Appalsawmy.

Carers and Families—helping to get mortality review processes right

Our mortality programme carers and families involvement group has helped us to develop a framework to guide healthcare organisations to effectively and sensitively embed the voice of the bereaved family into local mortality review processes. In March 2017, the Department of Health published its Learning from Deaths Guidance which included Trusts giving bereaved families and carers the opportunity to raise questions or share concerns in relation to the quality of care received by their loved one.

Our work has focused on effectively capturing the concerns and complaints of families to inform routine Trust level mortality review processes. For more information on the framework please contact Dr Usha Appalsawmy.

Mortality Case Record Review Programme Carers and Families Involvement Group—pictured February 2018



Coming soon: National Launch of Toolkit—7th June 2018

We are delighted to announce the national launch of 'Implementing Structured Judgement Review for Improvement' toolkit will be launched on 7th June 2018. This toolkit forms part of the National Mortality Case Record Review programme and has been developed jointly by the Improvement Academy, the Royal College of Physicians and the West of England AHSN.
For more information on the toolkit contact Dr Usha Appalsawmy.

Click now to stay in touch with the Improvement Academy

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