AMaT

Audit Management and Tracking

Morecambe Bay use **AMaT** to learn from deaths

AMaT improves the gathering of measurable thematic data from deaths to increase learning.

The Care Quality Commission's (CQC) 2016 report 'Learning Candour and Accountability' requires NHS Trusts to review and investigate patient deaths. Furthermore, in 2017, the National Quality Board issued a set of steps by which Trusts could demonstrate how that learning could be conveyed to the wider organisation.

However, by 2023 and even with the introduction of **AMaT**'s mortality and morbidity module (MaMR), Michelle Andersen, University Hospitals of Morecambe Bay's Quality Assurance Lead for Mortality and Morbidity, saw there was a mounting problem. What Michelle realised was that although there was now a wealth of data going back to 2021 when the module was implemented, the task of extracting measurable learning points from that data was proving to be difficult.

At this time, MaMR was being used to record reviews and learning points but collating those learning points into measurable data was both challenging and resource heavy. In addition, the large amounts of free text they'd gathered was making lessons difficult to theme.

> "I was faced with an ocean of words with no identifying commonality for learning points to focus on and be discussed as a valid learning or improvement"
>
> Michelle Andersen, Quality Assurance Lead for Mortality and Morbidity

Working together to define standards

Although steps had been taken to ensure that MaMR was being properly utilised among Care Groups, a lack of standardised methodology made each review unique – an attribute which didn't lend itself to easy reporting. This meant that learning was not being passed on across the Trust despite there being 308 individual learning points on the MaMR system by January 2023.

To remedy the situation, Michelle set herself two aims. The first was to improve the ability to gather measurable thematic data from deaths. This would help increase learning from manual counts to automated exports by April 2024. Secondly, she wanted to increase the number of the Trust's sub-specialties which were consistently and formally involved in learning from deaths from 0 to 6 by April 2024.

To accomplish this, Michelle worked with the Mortality and Morbidity team to establish common terminology and standardised themes which would help identify commonalities. This meant data would become more measurable and meaningful, exactly as Michelle hoped for.

The ability to enter free text was also removed. Instead, a list was provided for reviewers to choose from. Then, with an eye to the future, the team also established a method to add new learning points which may occur over time, as well as archiving those that were no longer happening. Where data was historic, steps were taken to theme the learning points as best as possible.

Following this was a matter of standardisation, standardisation, standardisation. These new methodologies would prove to be robust and lead to improvement. As Michelle says, "*Learning from deaths in this way means that as a trust we can identify themes of excellence for sharing, or not repeat errors within individual care groups by learning from each other. We will be able to identify themes and collectively improve our practice as a whole Trust system change.*"

Whilst this certainly aided University Hospitals of Morecambe Bay in achieving the first aim, the changes still needed to be widely adopted.

> We will be able to identify themes and collectively improve our practice as a whole Trust system change.
>
> Michelle Andersen

Increasing engagement brings added benefits

The second part of the plan sought to tackle this by involving the Medicine care group and most of its sub-specialties. Six of the eight sub-specialities were chosen to meet the target, and concerted efforts brought in an additional three from other care groups. This was due, in large part, to attendance at audit meetings where consultants were keen to join the project. The sub-specialities were given a list of deaths to be reviewed which were shared Trust-wide through **AMaT**.

In much the same way as the audit meetings had encouraged consultants to engage, so too did the team's training on the MaMR module. Greater understanding of, and proficiency with, the system's capabilities led to wider adoption.

As well as surpassing the set goal of engagement, the project also generated a greater collection of consolidated learning points which were shared in the Mortality Steering Group. This led to targeted conversations around various themes to discuss where changes or improvements could be made. The sub-specialities involved became more aware of their deaths and learning themes, which then became areas for either improvement or celebrations of excellence.

Learning and sharing for the future

The project has been a great success for Michelle and the Mortality and Morbidity team at University Hospitals of Morecambe Bay. They continue to measure and monitor the learning and share improvements and outcomes for the benefit of parents and families in their care, whilst also looking to the future – a future already in progress.

Michelle is refining the reporting around themes so that emerging trends can be identified. To accomplish this, she has been working with **AMaT** as well as Morecambe Bay's Quality and Assurance Systems Manager, John Wilson, on the reports to show how and where any learning from deaths is taking place.

At its core, **AMaT** is a tool used to gather and analyse data for Trusts to demonstrate where improvement has been achieved and where it needs to take place. Michelle's use of the MaMR module, and the steps she took to help refine it, has resulted in new functionality which will benefit the wider community.

AMaT helps:

- Underpin quality improvement programmes from ward to board
- Prepare for and respond to Care Quality Commission inspection
- Provide a searchable, holistic view of organisation's quality activity
- Measure quality progress over time
- Ensure actions are recorded and monitors progress
- System driven prompts
- Empower staff to be a driving force in quality improvement
- Improve and manage compliance with NICE standards
- Support national and local audits, service evaluations, and regular assurance audits across wards and services
- Provide simple access to supporting documentation
- Reduce reliance on paper chasing for audit progress
- Reduce issues arising from version control of emailed word documents
- Save money by providing a flexible platform for improvement activity
- Save time by providing activity reports across multiple departments

AMaT
Audit Management and Tracking

Clinical audit, in your hands

Contact us for a free demonstration

enquiries@amat.co.uk

AMaT
Audit Management and Tracking

ISO 27001 ISOQAR
Cert No.20228

AMaT is developed and managed by Meantime AMaT – ISO27001 certified for information security

meantime
business systems that work

ISO 27001 ISOQAR
Cert No.13607

AMaT is coded, maintained, and hosted by Meantime IT – ISO27001 certified for information security

CYBER ESSENTIALS PLUS

The Old Police Station
62 Chapel Street, Salford
Manchester, M3 7AA

@TrackedByAMaT
enquiries@amat.co.uk
www.amat.co.uk