Wirral Community Health and Care NHS Foundation Trust

Mortality Report: Learning from Deaths Framework
Quarter 1: 01 April 2019 - 30 June 2019

Meeting	Trust Board of Directors		
Date	4 September 2019	**Agenda item**	**14**
Lead Director	Dr Nick Cross, Executive Medical Director		
Author(s)	Dr Nick Cross, Executive Medical Director		

To Approve	☐	**To Note**	☐	**To Assure**	✔

Link to strategic objectives & goals - 2017-19	
Please mark ✔ against the strategic goal(s) applicable to this paper	
Our Patients and Community - To be an outstanding trust, providing the highest levels of safe and person-centred care	
We will deliver outstanding, safe care every time	✔
We will provide more person-centred care	✔
We will improve services through integration and better coordination	✔
Our People - To value and involve skilled and caring staff, liberated to innovate and improve services	
We will improve staff engagement	
We will advance staff wellbeing	
We will enhance staff development	
Our Performance - To maintain financial sustainability and support our local system	
We will grow community services across Wirral, Cheshire & Merseyside	
We will increase efficiency of corporate and clinical services	
We will deliver against contracts and financial requirements	

Link to the Organisational Risk Register (Datix)
None identified

Has an Equality Impact Assessment been completed?	**Yes** ☐	**No** ✔

Paper history		
Submitted to	**Date**	**Brief Summary of Outcome**
Quality & Safety Committee	24 July 2019	The committee were assured by the contents of the report.

Wirral Community Health and Care NHS Foundation Trust

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Purpose

1. The purpose of this paper is to provide assurance to the Board of Directors in relation to the implementation of the Learning from Deaths framework.

Executive Summary

2. Wirral Community Health and Care NHS Foundation Trust (WCHC) Board recognises that effective implementation of the Learning from deaths framework (National Quality Board, March 2017), is an integral component of the Trusts' learning culture, driving continuous quality improvement to support the delivery of high quality sustainable services to patients and service users.

3. In December 2016, the Care Quality Commission (CQC) published its report: Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England. The recommendations of this report were accepted by the Secretary of State and incorporated into a Learning from Deaths framework by the National Quality Board (NQB) in March 2017.

4. The Learning from Deaths framework aims to address the key findings of the CQC report, ensuring a consistent approach to learning from deaths across the NHS, assuring a transparent culture of learning by delivering a commitment to continuous quality improvement, particularly in relation to the care of vulnerable people.

5. The key findings of the CQC report were as follows:

   - Families and carers are not treated consistently well when someone they care about dies.
   - There is variation and inconsistency in the way that trusts become aware of deaths in their care.
   - Trusts are inconsistent in the approach they use to determine when to investigate deaths.
   - The quality of investigations into deaths is variable and generally poor.
   - There are no consistent frameworks that require boards to keep deaths in their care under review and share learning from these.

6. This quarterly report provides evidence that learning from deaths is firmly embedded as a priority across the Trust, ensuring full adherence to the NQB Learning from deaths framework.

7. WCHC compliance with the NQB framework has been self-assessed by an internal review of the Board Leadership requirements as outlined in the National Guidance on Learning from Deaths (NQB, March 2017). The RAG rating for this process has been included in the inaugural Learning from Deaths report.

WCHC Learning from deaths governance framework

8. All reported deaths are discussed at the weekly Clinical Risk Management Group (CRMG). Further investigations are commissioned on the basis of the events surrounding the death and on the results of the Mortality Screening Tool.

9. Pending investigations are monitored against progress and timelines and expediated where necessary. Any reports (ie Root Cause Analysis - RCA) and associated action plans are quality assured at CRMG.

10. Lessons learnt and learning themes from learning from deaths cases are reviewed at the Trust's quarterly Mortality Review Group which is chaired by the Executive Medical Director who is responsible for the learning from deaths agenda.

11. Minutes from the Mortality Review Group are submitted to the Standards Assurance Framework for Excellence (SAFE) Steering Group, which in turn reports directly to the Quality and Safety Committee and finally to the Board.

12. A report is produced which summarises the details of the deaths which have occurred within the preceding quarter, along with details of any thematic learning. This is ratified by the Quality and Safety Committee prior to being presented to Public Board, again on a quarterly basis.

13. In accordance with the Learning from Deaths framework, the Trust ratified and published a Learning from Deaths Policy during September 2017.

14. The policy provides a framework for how the Trust will evaluate those deaths that from part of our mortality review process, the criteria for review and quarterly and annual reporting mechanisms.

15. The Trust's Datix incident reporting system has been aligned to the Learning from Deaths Policy to ensure prompt communication to the Executive Medical Director, Director and Deputy Director of Nursing for all reported unexpected deaths. This includes integrating the Mortality Screening Tool with Datix.

16. The Incident Management Policy - GP08 has been updated during January 2018 and cross references the newly implemented Learning from Deaths Policy, ensuring a consistent approach to implementation. The revised policy contains arrangements for staff to follow in the event of an unexpected death of an adult and in the event of an unexpected death of a child.

17. The Trust continues to work with our system partners to devise systems whereby Learning from Deaths can take place in a consistent way across all major health and social care providers.

18. The Learning from Deaths report is based on the template devised by the National Quality Board. This report will be published on the Trust's website in keeping with our statutory obligations.

Q1 2019/20 WCHC Reported deaths (Datix incident reporting)

19. During Q1 there were a total of 18 reported deaths within scope.

20. During Q1 no deaths met the criteria for StEIS reporting.

Recording data on Structured Judgement Reviews:		
Total Number of Deaths in scope	18	
Total number of deaths reviewed through Structured Judgement Review methodology	18	W29006 – Child death (expected), no learning W29099 – Child death, SUDIC followed, no learning W29264 – Community nursing, no learning W29237 – Child death, (expected), no learning W29317 – Suicide, no learning W29324 – Community nursing, no learning W29364 – ICCT, RCA, accidental fall, no learning W29420 – Community nursing, RCA, learning for trust W29496 – ICCT, no learning W29528 – Death from sepsis, care appropriate W29671 – Child death, SUDIC followed, no learning W29879 – STAR, 72h, learning external to the trust W30006 – ICCT, cardiac arrest, no learning W30023 – RCR, 72h & safeguarding review, no learning W30051 – ICCT, nursing home death, 72h rev, no learning W30440 – Child death, safeguarding, SUDIC, no learning

		W30537 – STAR, T2A, overdose, RCA in progress W30514 – Community nursing, no learning
Total Number of Deaths considered to have more than 50% chance of being avoidable	0	
Recording data on LeDeR reviews:		
Total Number of Deaths in scope	0	
Total Deaths reviewed through LeDeR methodology	0	
Total Number of deaths considered to have been potentially avoidable	0	
Recording data on SUDIC reviews:		
Total Number of Child Deaths	5	
Total Deaths reviewed through SUDIC methodology	3	

Summary of Thematic Learning

21. Each unexpected death reported during Q1 has been analysed and investigated as appropriate, to identify any relevant learning points for the Trust and the wider health and social care system.

22. Of the 18 cases reported, after investigation, one had lessons which the Trust could learn from.

23. The themes from the learning included:

- The need to follow the Failure to Gain Access policy and procedure.
- In this case, issues have been addressed through dissemination of learning and individual reflection of practice.
- Group supervision raised the awareness of the policy to a wider team and the policy itself was promoted at the Clinical Effectiveness Group.
- A further outcome was the amendment of specific community nursing communications and the creation of a laminated copy of the Failure to Gain access process which could be carried with a health care professional during visits for easy reference.

Update of Outstanding cases from Previous Reports

24. There are no outstanding cases from previous reports.

Board Recommendations

25. The Board of Directors is asked to be assured that quality governance systems are in place to ensure continuous monitoring and learning from deaths in accordance with Trust policy.

26. The Board of Directors is asked to be assured the Trust is actively involved in supporting the system-wide development of processes reporting and learning from deaths.

Dr Nick Cross
Executive Medical Director

18 July 2019

Appendix 1

Learning From Deaths Q1 19/20 Report

The following data represents the high-level reporting of deaths which occurred within our services over the period of Quarter 1 19/20.

A more detailed report has been ratified and approved by the Quality and Safety Committee as per the Learning from Deaths Policy.

There were 18 deaths reported within scope during this period and all have been reviewed in accordance with Trust policy.

18 deaths were not deemed attributable to the care received by our Trust.

The following learning points were recorded:

- The importance of followed appropriate policies and procedures.

There were no deaths which were subject to a LeDeR review.

There were 5 child deaths, all of which were appropriately reported and scrutinised. 3 of these cases followed the SUDIC process and did not reveal any learning specific for the Trust.

We continue to promote shared learning across the health and social care economy.

Dr Nick Cross
Executive Medical Director
Wirral Community Health and Care NHS Foundation Trust

18 July 2019