Wirral Community
NHS Foundation Trust

Mortality Report: Learning from Deaths Framework
Quarter 2: 01 July 2018 - 30 September 2018

Purpose

1. The purpose of this paper is to provide assurance to the Quality and Safety Committee in relation to

Executive Summary

2. Wirral Community NHS Foundation Trust (WCT) 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 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. WCT 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.

WCT Learning from deaths governance framework

8. Learning from deaths is 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.

9. Minutes from the quarterly mortality review group are submitted to the Quality and Safety Committee, which reports directly to Trust board.

10. In accordance with the Learning from deaths framework, the Trust ratified and published a Learning from deaths policy during September 2017.

11. 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.

12. 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.

13. 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.

Development of a learning from deaths dashboard

14. The mortality review group have been working on the development of a Learning from Deaths Dashboard within the Datix patient safety reporting system. This will be finalised during the Quarter 3 period.

15. The Trust continue 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.

16. The Learning for 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.

Q2 2018/19 WCT Reported deaths (Datix incident reporting)

17. During Q2 there were a total of six reported unexpected deaths. Three of these incidents involved the deaths of people under the age of 18 and have being reported by the safeguarding service, following receipt of reporting notifications.

18. The three incidents reported by the safeguarding service have been progressed via the appropriate safeguarding pathway.

Recording data on Structured Judgment Reviews:		
Total Number of Deaths in scope	6	Three cases of people under the age of 18 years old. Of these cases all had evidence of following the appropriate notification and safeguarding procedures and pathways.
Total number of deaths reviewed through Structured Judgement Review methodology	3	In progress in accordance with Trust policy. Learning will be reported during Q3.
Total Number of Deaths considered to have more than 50%	0	

chance of being avoidable		
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	

Recommendations

19. It is recommended that:

- The learning from deaths Q2 2018/2019 report is approved for inclusion within the Board papers and for publication on the Trust website.

Committee action

20. The committee 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.

21. The committee 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

Contributor:
Claire Wedge, Deputy Director of Nursing

11 October 2018