Wirral Community NHS Foundation Trust

Mortality Report: Learning from Deaths Framework
Quarter 3: 01 October 2018 - 31 December 2018

Meeting	Board of Directors		
Date	6 March 2019	**Agenda item**	**13**
Lead Director	Dr Nick Cross, Executive Medical Director		
Author(s)	Claire Wedge, Deputy Director of Nursing		

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 Principal Risks in the Board Assurance Framework - *please mark ✔ against the principal risk(s) - does this paper constitute a mitigating control?*	
Failure of organisations across the system to delegate appropriate authority to support the integrated care system (Healthy Wirral)	
Failure to engage staff to secure ownership of the Trust's vision and strategy	
Increasing fragility of the social care market	
The impact of the outcome of the Urgent Care Review compromising financial stability and the future model of care	
Services fail to remain compliant with the CQC fundamentals of care leading to patient safety incidents and regulatory enforcement action and a loss of public and system confidence	✔
Inability to implement the Trust's clinical transformation strategy and preferred model of care - Neighbourhood care	
Commissioning decisions do not promote integrated working across the health and care system	

Failure to build the workforce skills and infrastructure to transform services to meet the demographic needs of the workforce and population	
Security of public health funding and subsequent contractual decisions impacting on the range of services provided to Wirral & Cheshire East	
Failure to foster, establish and manage the right partnerships that enable a response to commissioning intentions	
Development of place-based care outside of Wirral, limits the Trust's ability to expand/retain services in these areas	
Failure to deliver the efficiency programme	
Failure to achieve all the relevant financial statutory duties	
The impact of the outcome of the Carter Review on community services benchmarking on commissioning decisions	
Impact of supporting the delivery of the 3-year financial plan and future sustainability of the Wirral system	

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	23 January 2019	The committee were assured by the contents of the report.

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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 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 safe 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's national 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 has been 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. A review of the frequency of these meeting has resulted in them occurring on a monthly basis with effect from January 2019.

9. Minutes from the Mortality Review Group are submitted to the Standard Assurance Framework for Excellence (SAFE) meeting and 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 (via a bespoke dashboard) 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.

14. 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.

15. 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.

Q3 2018/19 WCT Reported deaths (Datix incident reporting)

16. During Q3 there were a total of eight reported in scope deaths.

17. During Q3 one death was reported on the StEIS reporting portal.

Recording data on Structured Judgment Reviews:		
Total No. of Deaths in scope	8	
Total number of deaths reviewed through Structured Judgement Review methodology	8	W27695 - Sepsis, complaint from family. 72 hour review and proceeding to RCA W27562 - Parent died in A&E not in receipt of WCT services W27531 - Child death on family holiday no action for WCT W27287 - 72 hour review - clarified died from natural causes W27201 - 72 hour review - no further action required W27142 - Neonatal death. Not in receipt of WCT services W27094 - StEIS reported. RCA in progress. Case remains open to the Coroner. W26605 - Out of area death of a child. No involvement from the Trust
Total No. 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	

Summary of Thematic Learning

18. Each unexpected death reported during quarter 3 has been analysed and investigated as appropriate, to identify any relevant learning points for the Trust and the wider health and social care system.

19. Of the 8 cases reported, after investigation, 3 provided organisational learning.

20. The themes from the learning included:

- 2 cases of communication issues between care providers. 1 case has created a working group to create a solution to the problem.
- 1 case relates to IT issues linked to the mobile working solution.
- In each case, action plans are in place to address to ensure continuous improvement.

Update of Outstanding cases from Previous Reports

21. Q1 2018 - The outstanding RCA has now been completed and revealed areas of learning that has resulted in changes to communication pathways and an update to the Failure to Gain Access policy.

22. Q2 2018 - update:

Progress following Q2 Report Reviews Adult Deaths: Quarter Two		
W26037	RCA in progress	Final report will be shared at SAFE meeting February 2019
W25988	Review was confirmed as natural causes	Safeguarding undertaking a post incident learning review
W26032	RCA in progress	Final report will be shared at SAFE meeting February 2019

Recommendations

23. It is recommended that:

- The learning from deaths Q3 2018/2019 report is approved for inclusion within the Board papers and Appendix 1 is published on the Trust's public website.

Board action

24. 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.

25. 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

Contributors:
Claire Wedge, Deputy Director of Nursing
Cindy Freeman, Quality and Safety Matron

28 February 2019

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NHS Foundation Trust

Appendix One

Learning From Deaths Q3 18/19 Report

The following data represents the high level reporting of deaths which occurred within our services over the period of Q3 18/19.

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

There were 8 deaths reported within scope during this period and all have been reviewed in accordance with Trust policy.

1 death remains open to the coroner.

7 deaths were not deemed attributable to the care received by our trust.
The following learning points were recorded:

- Importance of reporting deaths in a timely manner
- Importance of record keeping

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