Wirral Community
NHS Foundation Trust

Mortality Report: Learning from Deaths Framework
Quarter 4: 01 January 2018 - 31 March 2018

Purpose

1. The purpose of this paper is to provide assurance to the Quality and Safety Committee in relation to the implementation of the Learning from Deaths framework.

Executive Summary

2. Wirral Community NHS Foundation Trust 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 Interim Medical Director – Executive Director 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. A non-executive director has been identified to take responsibility for oversight of progress in accordance with the Learning from deaths framework.

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

12. 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.

13. The trust's Datix incident reporting system has been aligned to the Learning from deaths policy to ensure prompt communication to the Interim Medical Director, Director and Deputy Director of Nursing for all reported unexpected deaths.

14. 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

15. The mortality review group are currently working with the trusts' Business Intelligence and Incident Reporting teams to develop a learning from deaths dashboard to support open, transparent reporting to trust board.

16. Use of the National Learning from Deaths Dashboard (Appendix 1) is being utilised by the mortality review group. This will continue to be the case until a dashboard is created which reflects the case mix of a community trust.

17. WCT 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.

18. 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.

Q4 2017/18 WCT Reported deaths (Datix incident reporting)

19. During Q4 there were a total of eight reported unexpected deaths. Four 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.

20. The four 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	8	Four 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.

		Of the remaining four adult cases, three cases did not lead to in-depth review.
Total number of deaths reviewed through Structured Judgement Review methodology	1	One case is currently in the process of being investigated (reference W23031)
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	

Recommendations

21. It is recommended that:

- The learning from deaths Q4 17/18 report is approved for inclusion within the Board papers and for publication on the trust website.

Committee action

22. 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.

23. 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.

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10 July 2018

Wirral Community NHS Foundation Trust

Appendix 1
National Learning from Deaths Dashboard

Learning from Deaths Dashboard

Purpose of the dashboard

This suggested dashboard is a tool to aid the systematic recording of deaths and learning from the care provided by NHS Trusts. Trusts may use this to record relevant incidents of mortality, deaths reviewed and lessons learnt to encourage future learning and the improvement of care.

Guidance on what should be recorded in individual fields is provided below, alongside instructions for completing and updating the dashboard. This guidance on individual fields complements the wider guidance provided in the National Framework on Learning From Deaths and separate methodology guidance on the Structured Judgement Review (SJR) as developed by the Royal College of Physicians (RCP). The dashboard is not prescriptive and Trusts may set their own definitions according to local goals and data availability, although minimum requirements are set out in the framework.

To update this dashboard - enter your data on the "Data" worksheet. The dashboard sheet is automatically updated.

Guidance on individual fields

Field No.	Field	Description of Field
Recording data on structured judgement reviews:		
1	**Total Number of Deaths in scope**	This must as a minimum include all adult inpatient deaths excluding maternity services. Where additional deaths are included (for example maternal deaths, deaths post-discharge or deaths of outpatients etc) the inclusion criteria should be made clear in this field, which can vary by trust. The total number of deaths in scope defined in this field must be used in all subsequent relevant fields in this work book. If a post-discharge period is being included in scope, (eg deaths within 30 days of discharge) then the death should be counted in the month where the death actually occurred rather than time of admittance or discharge. Note that where it has been identified that a patient has a learning disability the death should be recorded separately (see Data item 6, below).
2	**Total Number of Deaths Reviewed under the SJR methodology**	This is the total number of deaths for which the care provided to the patient has been reviewed by your Trust. This may be a combination of deaths reviewed under national and local minimum requirements and random sampling of all other deaths in scope.
3	**Total number of deaths considered to have more than a 50% chance of having been avoidable**	The Structured Judgement Review methodology, for use in relation to adult acute inpatient deaths, allows for reviewers to score a death as having a more than 50% chance of having been avoidable when this judgement is made in relation to the care provided by the trust conducting the review. This is the equivalent of a score of 3 or less. If using the RCP SJR then the number of such deaths scored in this way is equivalent to this field If not using RCP SJR, then the method used to judge whether a death was more likely than not to have been avoidable in relation to the care provided by the trust conducting the review (or another provider if appropriate) should be stated here including any definitions used. Note that if you are applying other methodologies to specific groups, such as learning disabilities patients, those methodologies may require a degree of judgement to determine whether the death was more likely than not to be avoidable. It may be appropriate to cross-reference those outputs with the processes for assessing structured judgement reviews, and if appropriate to include those outputs here. If the RCP SJR methodology is being used for structured judgement reviews Trusts are able to include monthly totals of reviewed deaths that were in each category 1 to 6. If the Trust is not using this methodology these fields can be either left blank or edited as appropriate.
Recording data on LeDeR reviews:		
4	**Total Number of Deaths in scope**	This must include all adult inpatient deaths for patients with identified learning disabilities. The total number of deaths in scope defined in this field must be used in all subsequent relevant fields. If a post-discharge period is being included in scope, (eg deaths within 30 days of discharge) then the death should be counted in the month where the death actually occurred rather than time of admittance or discharge.
5	**Total Deaths Reviewed Through the LeDeR Methodology**	Formally, the LeDeR review methodology should be applied to all of the deaths shown as 'in scope'. You should record the total number of deaths reviewed here.
6	**Total Number of deaths considered to have been potentially avoidable**	Record the total number of deaths for which review evidence leads to a conclusion that it is more likely than not that the death was potentially avoidable. This will require that a degree of judgement is applied to the outputs of the LeDeR review, and it may be appropriate to cross-reference these outputs with the processes for assessing structured judgement reviews