Wirral Community Health and Care NHS Foundation Trust

# Mortality Report: Learning from Deaths Framework
# Quarter 4: 01 January 2019 - 31 March 2019

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| **Meeting** | Board of Directors | | |
| **Date** | 3 July 2019 | **Agenda item** | **19** |
| **Lead Director** | Dr Nick Cross, Executive Medical Director | | |
| **Author(s)** | Dr Nick Cross, Executive Medical Director | | |

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|---|---|---|---|---|---|
| **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 | 22 May 2019 | The committee was assured by the report. |

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## Purpose

1. The purpose of this paper is to provide assurance to the Board 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. Learning from deaths is reviewed at the Trust's monthly Mortality Review Group which is chaired by the Executive Medical Director who is responsible for the learning from deaths agenda.

9. 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.

10. A report is produced which summarises the details of the deaths which have occurred within the preceding three months, 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.

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 Executive 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.

15. 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.

16. 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.

**Q4 2018/19 WCHC Reported deaths (Datix incident reporting)**

17. During Q4 there were a total of five reported deaths within scope.

18. During Q4 one death was StEIS reported

| **Recording data on Structured Judgement Reviews:** | | |
|---|---|---|
| Total Number of Deaths in scope | 5 | |
| Total number of deaths reviewed through Structured Judgement Review methodology | 5 | W29467 - 72 hr rev, no organisational learning<br>W27988 - 72 hr rev, death in care home falling fall<br>W28003 - 72 hr rev, natural causes<br>W27988/9 - SBAR complete<br>W29059 - SBAR complete, suicide out of area |
| 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 | |

**Summary of Thematic Learning**

19. Each unexpected death reported during Q4 has been analysed and investigated as appropriate, to identify any relevant learning points for the Trust and the wider health and social care system.

20. Of the five cases reported, after investigation, three had lessons which the Trust could learn from.

21. The themes from the learning included:

- Two cases of communication issues between care providers and the importance of robust information gathering from all stakeholders involved in the care of our service users.
- One case reflected the importance of accurate documentation and completion of templates.
- In each case, issues have been addressed through dissemination of learning and individual reflection of practice.

**Update of Outstanding cases from Previous Reports**

22. Quarter 1 18/19 - The one 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.

23. Quarter 2 18/19 - update:

| **Progress following Outstanding Q2 Report Reviews** | | |
|---|---|---|
| W26037 | STEIS & RCA complete | Learning from RCA - communication between team. Recognition that mental capacity can be affected by physical health problems. CHC referral need centralisation - Action plan in place. |
| W25988 | Review was confirmed as natural causes | Safeguarding learning review shared with the CCG for system-wide dissemination. |
| W26032 | STEIS & RCA complete | Learning from RCA - Recommendations to feed in to amendments within Failure to Gain Access Policy - draft due to be submitted to May 2019. Also introduction of group supervision for all members of team irrespective of skill mix. |

24. Quarter 3 18/19 - update:

| **Progress following Outstanding Q3 Report Reviews** | | |
|---|---|---|
| W27094 | Coroners report now available | Action plan in place led by Adult Social Care. |
| W27695 | RCA complete | Action plan in place focussing on improvement of documentation of leg ulcers, the use of photography and also increased training in NEWS2. |

**Board Recommendations**

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

27. The Board is asked to note the contents within the above report**.**

28. The Board is asked to approve the high level report, as detailed in **Appendix 1**, for publication on the Trust's public website.

**Dr Nick Cross**
**Executive Medical Director**

25 June 2019

**Appendix 1**

## Learning From Deaths Q4 18/19 Report

The following data represents the high-level reporting of deaths which occurred within our services over the period of Quarter 4 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 five deaths reported within scope during this period and all have been reviewed in accordance with Trust policy.

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

The following learning points were recorded:

- Importance of robust information gathering from other stakeholder involved in the care of our service users
- Importance of accurate and complete record keeping

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