Wirral Community Health and Care NHS Foundation Trust

# Mortality Report: Learning from Deaths Framework
# Quarter 1: 01 April 2021 - 30 June 2021

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|---|---|---|---|
| **Meeting** | Board of Directors | | |
| **Date** | 04/08/2021 | **Agenda item** | **19** |
| **Lead Director** | Nick Cross, Medical Director | | |
| **Author(s)** | Nick Cross, Medical Director | | |

**Action required** (please tick the appropriate box)

| | | |
|---|---|---|
| **To Approve** ☐ | **To Discuss** ☐ | **To Assure** ☑ |

**Purpose**

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

**Executive Summary**

This quarterly report provides evidence that learning from deaths is firmly embedded as a priority across the Trust, ensuring full adherence to the National Quality Board Learning from deaths framework. It provides anonymised details of the numbers of unexpected deaths which have been reported by Trust staff throughout Q1 2021/22, along with a summary of thematic learning identified during investigation into these cases. Attached as an appendix is a report detailing this information for purposes of publication on the Trust website.

**Risks and opportunities:**
None identified

**Quality/inclusion considerations:**
Quality Impact Assessment completed and attached No
Equality Impact Assessment completed and attached No
A QIA and EIA is not applicable in this particular case

**Financial/resource implications:**
Not applicable

**Trust Strategic Objectives**
*Please select the top three Trust Strategic Objectives that this report relates to, from the drop down boxes below.*

| | | |
|---|---|---|
| Our Populations - outstanding, safe care every time | Our Populations – provide more person-centred care | Our Populations - improving services through integration and better coordination |

**Board action**

The Board is asked to be assured that 1: processes are in place to meet our statutory obligations surrounding Learning from Deaths, 2: that processes are in place to engage with families and meet our Duty of Candour obligations

**Report history**

| Submitted to | Date | Brief summary of outcome |
|---|---|---|
| Quality and Safety Committee | 28/07/21 | Committee assured |

Wirral Community Health and Care NHS Foundation Trust

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# Quarter 1: 01 April 2021 - 30 June 2021

## Purpose

1. The purpose of this paper is to provide assurance to the members of 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. The principles around Duty of Candour are also overseen within this group.

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. This includes cases which are under investigation by the coroner.

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. This includes working with Public Health England and the Local Authority to analyse the effect of COVID-19 by utilising a population-based approach to identify areas of inequality and its association with deaths due to this disease.

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.

**Bereaved Families**

19. Families will be treated as equal partners following a bereavement and will always receive a clear, honest, compassionate and sensitive response in a supportive environment and receive a high standard of bereavement care which respects confidentiality, values, culture and beliefs, including being offered appropriate support.

20. Families are informed of their right to raise concerns about the quality of care provided to their loved one and their views help to inform decisions about whether a review or investigation is needed.

21. Families will receive timely, responsive contact and support in all aspects of an investigation process, in line with duty of candour and with a single point of contact and liaison.

22. Families are partners in an investigation to the extent, and at whichever stages, that they wish to be involved and voice their experiences of the death of their loved one, as they offer a unique and equally valid source of information and evidence that can better inform investigations; bereaved families and carers who have experienced the investigation process help us to embed the learning to continually improve patient safety.

## Q1 2021/22 WCHC Reported deaths (Datix incident reporting)

23. During Q1 there were a total of 12 reported deaths within scope.

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

| **Recording data on Structured Judgement Reviews:** | | |
|---|---|---|
| Total Number of Deaths in scope | 12 | |
| April (7)<br>W41008 – Community nursing, no learning for the Trust<br>W41049 – Safeguarding, LeDeR review, rapid learning review revealed system-wide learning<br>W41114 – Access and Intermediate Care (T2A), learning identified for external providers<br>W41165 – Safeguarding, SUDIC process followed, no care delivered by the Trust, no learning identified<br>W41180 – ICCT, no learning for the Trust<br>W41239 – Safeguarding, SUDIC process followed, no care delivered by the Trust, no learning identified<br>W41249 – Access and Intermediate Care (T2A), learning identified for external providers<br><br>May (3)<br>W41544 – Community nursing, no learning identified by the Trust<br>W41659 – ICCT, learning identified for external providers<br>W41799 – Safeguarding, SUDIC process followed, no learning identified for the Trust<br><br>June (2)<br>W41919 – Safeguarding, currently awaiting outcome of learning review<br>W42085 – Safeguarding, no care delivered by the Trust, no learning identified<br><br>There are no outstanding cases from previous quarters<br>There were no unexpected deaths which were associated with a positive diagnosis of Covid-19. | | |
| Total Number of Deaths considered to have more than 50% chance of being avoidable | 0 | |
| | | |
| **Recording data on LeDeR reviews: - Please note that these are undertaken by the mental health trust** | | |
| Total Number of Deaths in scope | 1 | |
| Total Deaths reviewed through LeDeR methodology | 1 | |
| Total Number of deaths considered to have been potentially avoidable | 0 | |
| | | |
| **Recording data on SUDIC reviews:** | | |
| Total Number of Child Deaths | 3 | |
| Total Deaths reviewed through SUDIC methodology | 3 | |

## Summary of Thematic Learning

25. 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.

26. Of the 12 cases reported, after investigation, there were lessons identified which the Trust and system partners could learn from.

27. The learning themes include:

- Mechanisms to identify frequent attenders to urgent care services
- Importance of End of Life communication between care home providers and GPs
- Review of pathways of communication between Out of Area Adult Social Care services

**Mechanisms to identify frequent attenders to urgent care services**

28. Robust mechanisms across system partners to identify frequent attenders to urgent care services have historically been in place but were suspended due to the Covid pandemic. Following learning from deaths, these meeting has now been restarted with system partners to identify and proactively manage people who frequently attend urgent or emergency care services.

**Importance of End of Life communication between care home providers and GPs**

29. Learning from our investigations revealed potential improvements in care if robust communication occurred between care home providers and general practices, especially relating to proactive planning for End of Life care. This learning has been shared with commissioners.

**Review of pathways of communication between Out of Area Adult Social Care services**

30. Learning has been identified which revealed potential gaps in communication between social care services where a person straddles different local authorities. Discussions are underway to explore how communication links can be strengthened.

**Recommendations**

31. 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.

32. 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**

20 July 2021

**Appendix 1**

## Learning from Deaths Q1 21/22 Report

The following data represents the high-level reporting of deaths which occurred within our services over the period of Quarter 1 2021/22.

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

There were 12 deaths reported within scope during this period and all have been reviewed in accordance with Trust policy. Duty of Candour was met in all cases where this was appropriate.

None of the deaths were deemed attributable to the care received by our Trust.

Following investigation of these cases, learning themes were identified and a high-level summary is provided below:

### Identification of frequent attenders to urgent care services

Learning was identified which emphasised the importance of strong links with system partners to proactively manage care for people who frequently attend urgent or emergency care services.

### Communication between care home providers and general practices

Learning from our investigations revealed the importance of clear communication surrounding proactive care planning especially involving end of life care and this learning has been shared with appropriate partners.

### Review of pathways of communication between Out of Area Adult Social Care services

Learning has been identified which revealed potential gaps in communication between social care services where a person straddles different local authorities. Discussions are underway to explore how communication links can be strengthened.

There were 3 child deaths, which was appropriately reported, scrutinised, and followed the SUDIC process. There was no learning for the Trust identified following the investigative process.

We continue to promote shared learning across the health and care sectors and work collaboratively with our system partnership to identify and address the impact of Covid-19 on the Wirral and Cheshire East populations, focusing on addressing health inequalities on a population-based approach.

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

20th July 2021