Wirral Community Health and Care NHS Foundation Trust

Mortality Report: Learning from Deaths Framework Quarter 4: 01 January 2020 - 31 March 2020

Meeting	Board of Directors		
Date	06/05/2020	**Agenda item**	**12**
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 of Directors in relation to the implementation of the Learning from Deaths framework. It is also seeking approval for the statutory report along with its subsequent publication on the Trust website.

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 NQB Learning from Deaths framework. It provides anonymised details of the numbers of unexpected deaths which have occurred within the Trust throughout Q4 2019/20, 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:
Not applicable

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

Committee action

The Board of Directors 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 engagement with families and meet our Duty of Candour obligations and 3: to approve the report in Appendix 1 which can be subsequently published on the Trust's website

Report history

Submitted to	Date	Brief summary of outcome
Quality & Safety Committee	22 April 2020	Approved

Wirral Community Health and Care NHS Foundation Trust

Mortality Report: Learning from Deaths Framework
Quarter 4: 01 January 2020 - 31 March 2020

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 expedited 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.

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.

Q4 2019/20 WCHC Reported deaths (Datix incident reporting)

23. During Q4 there were a total of 21 reported deaths within scope.

24. During Q4 no deaths met the criteria for StEIS reporting.

Recording data on Structured Judgement Reviews:		
Total Number of Deaths in scope	21	

January (8)
W34042 – STAR - no learning for the Trust
W34066 – T2A bed base - no learning for the Trust
W34232 – Rapid Community Response team – system-wide learning noted
W34307 – ICCT (Birkenhead) - no learning for the Trust
W34321 – Rapid Community Response team - no learning for the Trust
W34367 – Child death – SUDIC completed, family support provided, no learning for the Trust
W34398 – Teletriage – system-wide learning noted, good practice noted
W34547 – STAR - no learning for the Trust

February (3)
W34769 – T2A bed base – system-wide learning noted
W34919 – T2A bed base – no learning for the Trust
W34935 – T2A bed base – system-wide learning noted

March (10)
W35106 – T2A bed base – no learning for the Trust
W35137 – 0-19 Birkenhead – maternal death, all processes followed, no learning for the Trust
W35160 – T2A bed base – no learning for the Trust
W35168 – 0-19 West Wirral – maternal death, all processes followed, no learning for the Trust
W35226 – 0-19 (Safeguarding) – child death, SUDIC process followed, no learning for the Trust
W35353 – T2A bed base – Review outstanding
W35374 – Rapid Community Response team – Review outstanding
W35411 – Community nursing – System-wide learning noted
W35421 – ICCT (Wallasey) – no learning for the Trust
W35247 – 0-19 (Safeguarding) – maternal death, no learning for the Trust

Update of cases outstanding from Q3 – not included in the above figures

December (3)
W33670 – ICCT (Birkenhead), no learning for the Trust
W33797 – STAR, no learning for the Trust
W33965 – ICCT (Birkenhead), in receipt of nursing and social care – RCA conducted and learning noted.

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	0	
Total Deaths reviewed through LeDeR methodology	0	
Total Number of deaths considered to have been potentially avoidable	0	

Recording data on SUDIC reviews:		
Total Number of Child Deaths	2	
Total Deaths reviewed through SUDIC methodology	2	

Summary of Thematic Learning

25. 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.

26. Of the 21 cases reported, after investigation, 5 had lessons which the Trust and system partners could potentially learn from.

27. Themes from the learning this quarter included:

- **Communication**
  - Following the investigation of a case, it was acknowledged that there was a misalignment of the expectation of the function of the Transfer to Assess bed base. This resource provides an individual with a period of reablement and rehabilitation. Confusion about its function lead to some dissatisfaction amongst family members.

  - As a result, a series of documents were created to provide clarity. These are now routinely discussed with the patient and family prior to transfer and during the initial assessment whilst on the ward. A signed copy is then scanned into the social care record to evidence these discussions.

- **Awareness of Acute Clinical Presentations within Care Homes**
  - 2 cases this quarter involved some missed opportunities for care home staff to recognise potential symptoms of clinical deterioration (such as a new episode of confusion) and share these with the community nursing staff. It is important to note that these instances did not affect or contribute to the outcome of individual cases.

  - These issues have been raised with the individual care homes and links with our Tele-triage service were promoted and reinforced as a way of discussing any clinical concerns.

  - During the Covid-19 pandemic, our trust is also supporting care homes by providing clinical leadership and actively contributing to the workforce where required.

- **Advanced Care Planning**
  - 3 cases involved lessons surrounding advanced care planning.

  - Advanced care planning in the event of a clinical deterioration is essential to ensure that any care interventions are clinically appropriate and proportionate and in keeping with the patients pre-determined ceiling of care, as agreed with them, during previous discussions. This includes documenting whether a people should be subjected to resuscitation in the event that there is a cardiorespiratory arrest. Failure to have these discussions and/or failure to complete the relevant documentation can result in people being subjected to inappropriate admissions to hospital or receipt of futile resuscitation attempts.

  - Although our workforce is not responsible for completing this documentation, where there are a series of completed care plans including DNACPR, ensures our staff can support the patient in the best and most effective way possible.

  - The issue of advanced care planning within hospital and community sectors will be discussed at the next Quality Review Meeting with the CCG, with a view to the agreement of a system-wide process to provide clarity, consistency and reduce duplication of assessments for clinicians, and provide the best and most appropriate care to our population

28. Additional Learning from Outstanding Cases in Q3

- **Multi-agency risk assessment**
  - Following a Multi-agency RCA, it was identified that in order to optimise patient safety, new processes should be put in place

- This resulted in a multi-agency risk assessment for vulnerable people receiving trust services (i.e. self-neglect and fire risk). This has since been approved by the local authority.

- A communication plan was also agreed to share, promote and implement the use of the new multi-agency risk assessment tool

Recommendations

29. 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.

30. 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

14 April 2020

Appendix 1

Learning From Deaths Q4 19/20 Report

The following data represents the high-level reporting of deaths which occurred within our services over the period of Quarter 4 2019/20.

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

There were 21 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.

Themes from the learning this quarter included:

- **Communication**
  - Following the investigation of a case, it was acknowledged that there was a misalignment of the expectation of the function of the Transfer to Assess bed base. This resource provides an individual with a period of reablement and rehabilitation. Confusion about its function lead to some dissatisfaction amongst family members.

  - As a result, a series of documents were created to provide clarity. These are now routinely discussed with the patient and family prior to transfer and during the initial assessment whilst on the ward. A signed copy is then scanned into the social care record to evidence these discussions.

- **Awareness of Acute Clinical Presentations within Care Homes**
  - 2 cases this quarter involved some missed opportunities for care home staff to recognise potential symptoms of clinical deterioration (such as a new episode of confusion) and share these with the community nursing staff. It is important to note that these instances did not affect or contribute to the outcome of individual cases.

  - These issues have been raised with the individual care homes and links with our Tele-triage service were promoted and reinforced as a way of discussing any clinical concerns.

  - During the Covid-19 pandemic, our trust is also supporting care homes by providing clinical leadership and actively contributing to the workforce where required.

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  - Although our workforce is not responsible for completing this documentation, where there are a series of completed care plans including DNACPR, ensures our staff can support the patient in the best and most effective way possible.

  - The issue of advanced care planning within hospital and community sectors will be discussed at the next Quality Review Meeting with the CCG, with a view to the agreement of a system-wide process to provide clarity, consistency and reduce duplication of assessments for clinicians, and provide the best and most appropriate care to our population

Child Deaths

There were two child deaths, all of which were appropriately reported, scrutinised and followed the SUDIC process. There was no learning for the Trust as a result of the investigative process.

Feedback from Outstanding Investigations

As a result of a death that occurred within Q3, a multi-agency investigation was performed which highlighted learning. More specifically, this involved:

- **Multi-agency risk assessment**
  - It was identified that in order to optimise patient safety, new processes should be put in place.
  - This resulted in a multi-agency risk assessment for vulnerable people receiving trust services (i.e. self-neglect and fire risk). This has since been approved by the local authority.
  - A communication plan was also agreed to share, promote and implement the use of the new multi-agency risk assessment tool.

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

Dr Nick Cross
Executive Medical Director

14 April 2020