Wirral Community Health and Care NHS Foundation Trust

Mortality Report: Learning from Deaths Framework Quarter 1: 01 April 2020 - 30 June 2020

Meeting	Board of Directors		
Date	05/08/2020	**Agenda item**	**15**
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 Quality and Safety Committee in relation to the implementation of the Learning from Deaths framework. It is also seeking approval for the statutory report to be presented to Public Board 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 Q1 20/21, 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 of the Trust website. These documents have been reviewed and approved via Quality and Safety Committee in July 2020

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 is asked to be assured that 1: processes are in place to meet our statutory obligations surrounding Learning From Deaths and 2: to approve the report in Appendix 1 which can be published on the Trusts public facing website

Report history

Submitted to	Date	Brief summary of outcome
Quality and Safety Committee	22 July 2020	Minor amendments and approval to progress to Board

Wirral Community Health and Care NHS Foundation Trust

Mortality Report: Learning from Deaths Framework
Quarter 1: 01 April 2020 - 30 June 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 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.

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 2020/21 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 (2) W35896 – 0-19 Cheshire East, child death, SUDIC process followed, no learning for the Trust W35793 – ICCT (Birkenhead), good practice noted in terms of joint MCA assessment and MDT working May (5) W35917 – T2A bed base – Rapid learning review identified learning for the Trust W35915 – ICCT (Birkenhead) – no learning for the Trust W35994 – T2A bed base - no learning for the Trust W36109 – Community Nursing – no learning for the Trust W36129 – ICCT – no learning for the Trust June (5) W36207 – STAR - no learning for the Trust W36235 – 0-19 (Safeguarding) – child death, SUDIC process followed, no learning for the Trust W36314 – ICCT (Birkenhead) – Learning for system partners, coroner's inquest in progress W36498 – T2A bed base - no learning for the Trust W36617 – 0-19 Cheshire East – SUDIC process followed, no learning for the Trust Update of cases outstanding from Q4 – not included in the above figures March (2) W35353 – T2A bed base – no learning for the Trust W35374 – Rapid Community Response team – this has been re-categorised as an expected death		
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	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, 2 had lessons which the Trust and system partners could learn from.

27. Themes from the learning included:

- **Communication**
  - A case identified an inconsistent process for transferring clinically relevant information between two organisations which potentially resulted in a sub-optimal pathway of care. For clarity, our Trust was not one of these organisations.

- However, similar system-wide themes have been identified previously and so we have taken the opportunity to review our own transfer of care processes to ensure they are robust along with encouraging system partners to collaborate with us.

- **Transportation Pathway redesign**
  - During the COVID-19 pandemic, it has been necessary to modify some pathways to reflect changes in infection prevention and control measures.
  - One case identified a potential need to re-design the pathway used to transport people to their home to perform home assessments.
  - As a result, we are in the process of exploring transport solutions and this is being actively monitored by the services.
  - In addition, advice has been written for relatives or other people who may also be present in the home during the assessment so the risk of spread of infection is minimised.

COVID-19 pandemic context

28. During the COVID-19 pandemic there has been an increased number of deaths reported within the community and the hospital environments. All death statistics are collated by Public Health England and disseminated on a monthly basis to key health and care stakeholders. As a Trust, we analyse this data to determine how services can be improved.

29. During the last quarter, there has been a reduction in total number of unexpected deaths that occurred whilst in receipt of care by the Trust, only one of which was involved a Covid-19 positive person.

30. Therefore, excess death numbers associated with Covid-19, occurring on Wirral during the pandemic are captured within the mortality figures of other organisations. These will, where appropriate, be subject to their own Learning from Deaths processes.

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

16 July 2020

Appendix 1

Learning From Deaths Q1 20/21 Report

The following data represents the high-level reporting of deaths which occurred within our services over the period of Quarter 1 20/21.

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.

Themes from the learning included:

- **Communication**
    - A case identified an inconsistent process for transferring clinically relevant information between two organisations which potentially resulted in a sub-optimal pathway of care. For clarity, our Trust was not one of these organisations.
    - However, similar system-wide themes have been identified previously and so we have taken the opportunity to review our own transfer of care processes to ensure they are robust along with encouraging system partners to collaborate with us.
- **Transportation Pathway redesign**
    - During the COVID-19 pandemic, it has been necessary to modify some pathways to reflect changes in infection prevention and control measures.
    - One case identified a potential need to re-design the pathway used to transport people to their home to perform home assessments.
    - As a result, we are in the process of exploring transport solutions and this is being actively monitored by the services.
    - In addition, advice has been written for relatives or other people who may also be present in the home during the assessment so the risk of spread of infection is minimised.

There were 3 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.

As a result of two deaths that occurred within Q4 19/20, further investigation led to a re-classification of a death to “expected”, whilst the remaining case did not reveal any learning

COVID-19 pandemic context

During the COVID-19 pandemic there has been an increased number of deaths reported within the community and the hospital environments. All death statistics are collated by Public Health England and disseminated on a monthly basis to key health and care stakeholders. As a Trust, we analyse this data to determine how services can be improved.

During the last quarter, there has been a reduction in total number of unexpected deaths that occurred whilst in receipt of care by the Trust, only one of which was involved a Covid-19 positive person.

Therefore the excess death numbers associated with Covid-19, occurring on Wirral during the pandemic are captured within the mortality figures of other organisations. These will, where appropriate, be subject to those organisations own Learning from Deaths processes.

We continue to promote shared learning across the health and social care economy and collaborate in any investigations where required.

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

16 July 2020