Wirral Community Health and Care NHS Foundation Trust

Mortality Report: Learning from Deaths Framework Quarter 2: 01 July 2020 - 30 September 2020

Meeting	Board of Directors		
Date	02/12/2020	**Agenda item**	**14**
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 Q2 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.

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

Board 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 Trusts website

Report history

Submitted to	Date	Brief summary of outcome
Quality and Safety Committee	25/11/2020	Provided assurance

Wirral Community Health and Care NHS Foundation Trust

Mortality Report: Learning from Deaths
Quarter 2: 01 July 2020 - 30 September 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.

Q2 2020/21 WCHC Reported deaths (Datix incident reporting)

23. During Q2 there were a total of 17 reported deaths within scope.

24. During Q2 1 death met the criteria for StEIS reporting.

Recording data on Structured Judgement Reviews:		
Total Number of Deaths in scope	17	
July (7) W36729 – T2A, 72 hour review revealed external learning for care homes W36783 – STAR, suspected COVID, no learning for the Trust W36899 – 0-19 Cheshire East, Neonatal death, SuDIC policies followed, no learning for the trust W36896 – STAR, no learning for the Trust W36898 – T2A, Covid +, Rapid learning review revealed learning for the Trust W36916 – ICCT (Wallasey), no learning for the Trust W36929 – 0-19 Cheshire East – StEiS, SuDIC processes followed, no learning for the Trust August (5) W37130 – STAR – No learning for the Trust W37216 – ICCT (Wallasey) – 72 hour review revealed learning for the Trust W37239 – T2A – No learning for the Trust W37470 – T2A – Rapid learning review revealed learning for the Trust W37556 – STAR – no learning for the Trust September (5) W37566 – 0-19 Cheshire east, SuDIC process followed, no learning for the Trust W37645 – IMC (Birkenhead), no learning for the Trust W37894 – ICCT (Birkenhead), no learning for the Trust W37937 – 0-19, Not in receipt of care from the Trust, SuDIC processes followed, no learning W38004 – ICCT (Wallasey) – 72 hour review reveal some learning for Care homes There are no outstanding cases from previous quarters		
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	4	
Total Deaths reviewed through SUDIC methodology	4	

Summary of Thematic Learning

25. Each unexpected death reported during Q2 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 17 cases reported, after investigation, 5 identified lessons which the Trust and system partners could learn from.

27. Themes from the learning included:

External Learning for Care Providers

Understanding the difference between verification and certification of death by care homes

This was identified as an issue and raised within the Care Home Manager's Forum. If training is required, then the Trust will try to facilitate this if needed.

Communication of DNACPR information

It was identified that in some circumstances the DNACPR form has not been visible within care home notes and this has resulted in inappropriate resuscitation attempts. This external learning has been raised at the Care Home Manager's forum to highlight the importance of having correct systems and processes in place.

Internal Service Specific Trust Learning

Recognition of the deteriorating patient

An action plan is in place and being actively monitored specifically focusing on:

- NEWS2 and RESTORE2 risk stratification scoring system among both Trust and care home staff
- Sepsis training with T2A staff
- Improved data capture on SystmOne
- Escalation pathways in the event of a deterioration

Training need assessment

It was identified that there is a training need for some therapists working within T2A teams, which focusses on pain assessment and safeguarding training. As a result, there is an action plan in place to address these issues which is being actively monitored.

Recommendations

28. 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.

29. 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

19 November 2020

Appendix 1

Learning from Deaths Q2 20/21 Report

The following data represents the high-level reporting of deaths which occurred within our services over the period of Quarter 2 2020/21.

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

There were 17 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:

External Learning for Care Providers

Understanding the difference between verification and certification of death by care homes

This was identified and raised within the Care Home Manager's Forum. If training is required, then the Trust will try to facilitate this if needed.

Communication of DNACPR information

It was identified that in some circumstances the DNACPR form has not been visible within care home notes.

The Trust is working closely with care providers to address both of these issues.

Internal Service Specific Trust Learning

Recognition of the deteriorating patient

The Trust is committed to ensure that staff training and awareness of this importance aspect of care is embedded within our services and teams along with access to appropriate escalation pathways in the event that they are required.

Training need assessment

As a Trust, we continually assess the training requirements of our workforce, to ensure they are armed with the best skills to support the people we serve. As a result of our learning, the Trust is expanding its training for some specific teams (for example, pain assessments).

There were 4 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.

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

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

19 November 2020