Compassion Open Trust

NHS
Wirral Community Health and Care
NHS Foundation Trust

Freedom to Speak Up Bi-Annual Report 2023/2024			
Meeting	Board of Directors		
Date	13/12/2023	**Agenda Item**	14
Lead Director	Nick Cross, Medical Director		
Author(s)	Alison Jones, Freedom To Speak Up Guardian		
Action required (please select the appropriate box)			
To Approve ☐	**To Discuss** ☐	**To Assure** ☒	

Purpose

The purpose of this bi-annual report is to provide assurance regarding Freedom to Speak Up activity and learning during the reporting period 01 April 2023 – 30 September 2023

Executive Summary

This bi-annual report provides an overview of Freedom to Speak Up (FTSU) activity during Q1 and Q2 of 2023/24. It covers the following areas:

- Summary of Concerns Reported
- Concerns Reported by Service
- Predominant Themes identified
- Outcomes and Learning
- Feedback from satisfaction questionnaires sent to reporters when a concern is closed
- Next Steps

Risks and opportunities:

Whilst this does not link to any specific risk, the existence of a healthy speaking up culture remains pivotal to ensure a strong focus on safe, effective practice for both staff and people accessing services

Quality/inclusion considerations:

Quality & Equality Impact Assessment completed and attached No.

<table>
<tr><td colspan="3">This is an assurance report detailing Freedom To Speak Up concerns reported in the last financial year. The Speaking Up policy, which supports the governance and process of speaking up, contains the Quality & Equality Impact Assessment</td></tr>
<tr><td colspan="3">Financial/resource implications:

None identified</td></tr>
<tr><td colspan="3">The Trust Vision – To be a population health focused organisation specialising in supporting people to live independent and healthy lives. The Trust Objectives are:

• Populations – We will support our populations to thrive by optimising wellbeing and independence
• People – We will support our people to create a place they are proud and excited to work
• Place - We will deliver sustainable health and care services within our communities enabling the creation of healthy places
Please select the top three Trust Strategic Objectives and underpinning goals that this report relates to, from the drop-down boxes below.</td></tr>
<tr><td>People - Improve the wellbeing of our employees</td><td>Populations - Safe care and support every time</td><td>People - Better employee experience to attract and retain talent</td></tr>
<tr><td colspan="3">The Trust Social Value Intentions

Does this report align with the Trust social value intentions? Yes.

If Yes, please select all of the social value themes that apply:

Community engagement and support ☐
Purchasing and investing locally for social benefit ☐
Representative workforce and access to quality work ☒
Increasing wellbeing and health equity ☒
Reducing environmental impact ☐</td></tr>
<tr><td colspan="3">Quality & Safety Committee is asked to consider the following action</td></tr>
<tr><td colspan="3">The Board is asked to be assured by the Freedom To Speak Up Annual Report for H1 2023/2024.</td></tr>
<tr><td colspan="3">Report history (Please include details of the last meeting that received this paper, including the title of the meeting, the date, and a summary of the outcome)</td></tr>
<tr><td>Submitted to</td><td>Date</td><td>Brief summary of outcome</td></tr>
</table>

Quality and Safety Committee	08/11/2023	Assured

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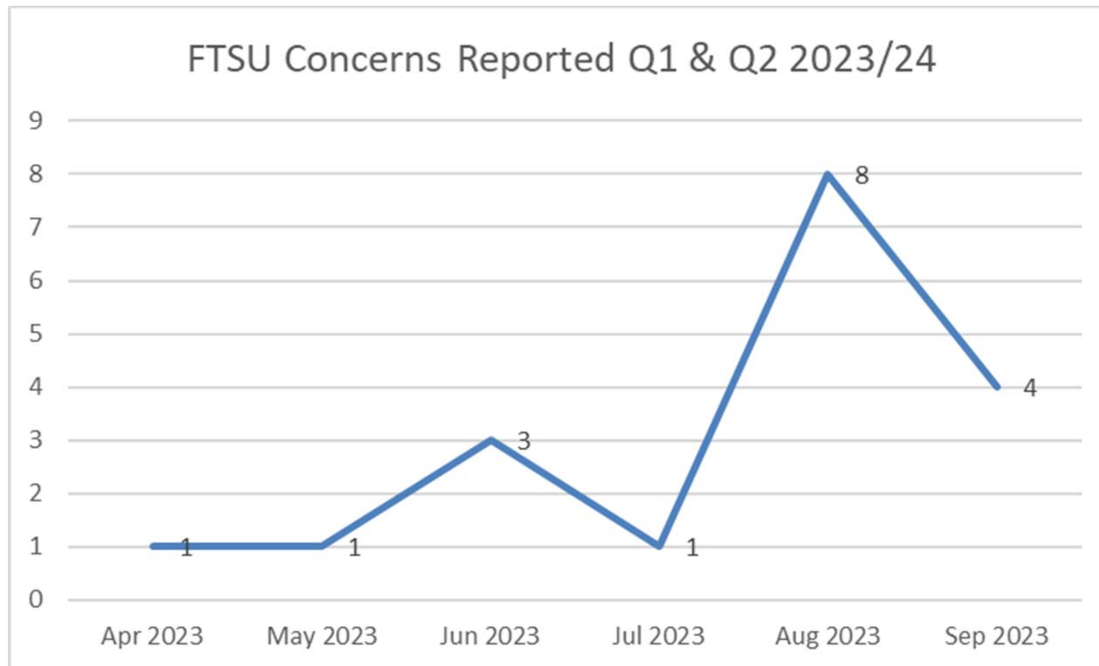
Freedom To Speak Up
Bi-Annual Report
April – September 2023

Board Meeting
December 2023

Alison Jones, Freedom To Speak Up Guardian
Dr Nick Cross, Executive Medical Director

Summary Of Concerns Reported



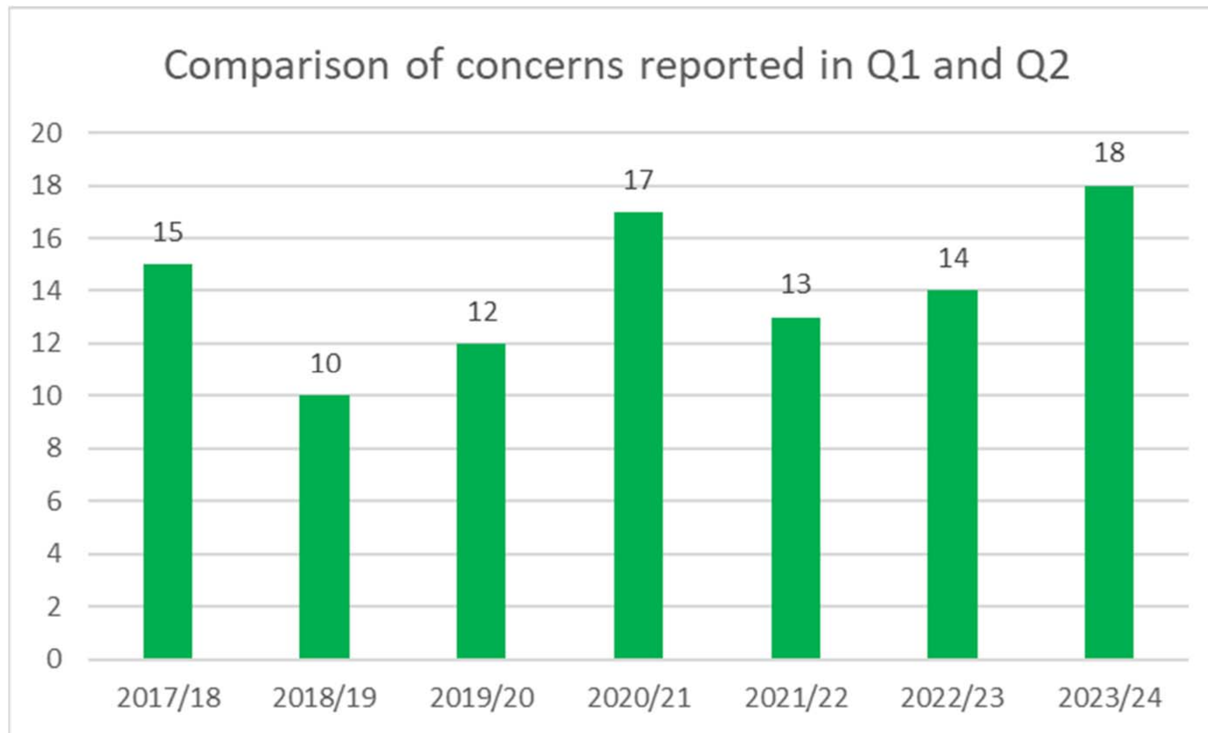
18 Concerns were reported in Q1 and Q2 2023/24

- 14 of the concerns (78%) were either reported openly by staff members or confidentially via the FTSU Guardian. The reporters were kept updated and provided with support and feedback
- 4 (22%) of the concerns were reported anonymously.
- This is an improved position from the same two quarters last year when 29% of concerns reported were anonymous

Number concerns reported in August 2023

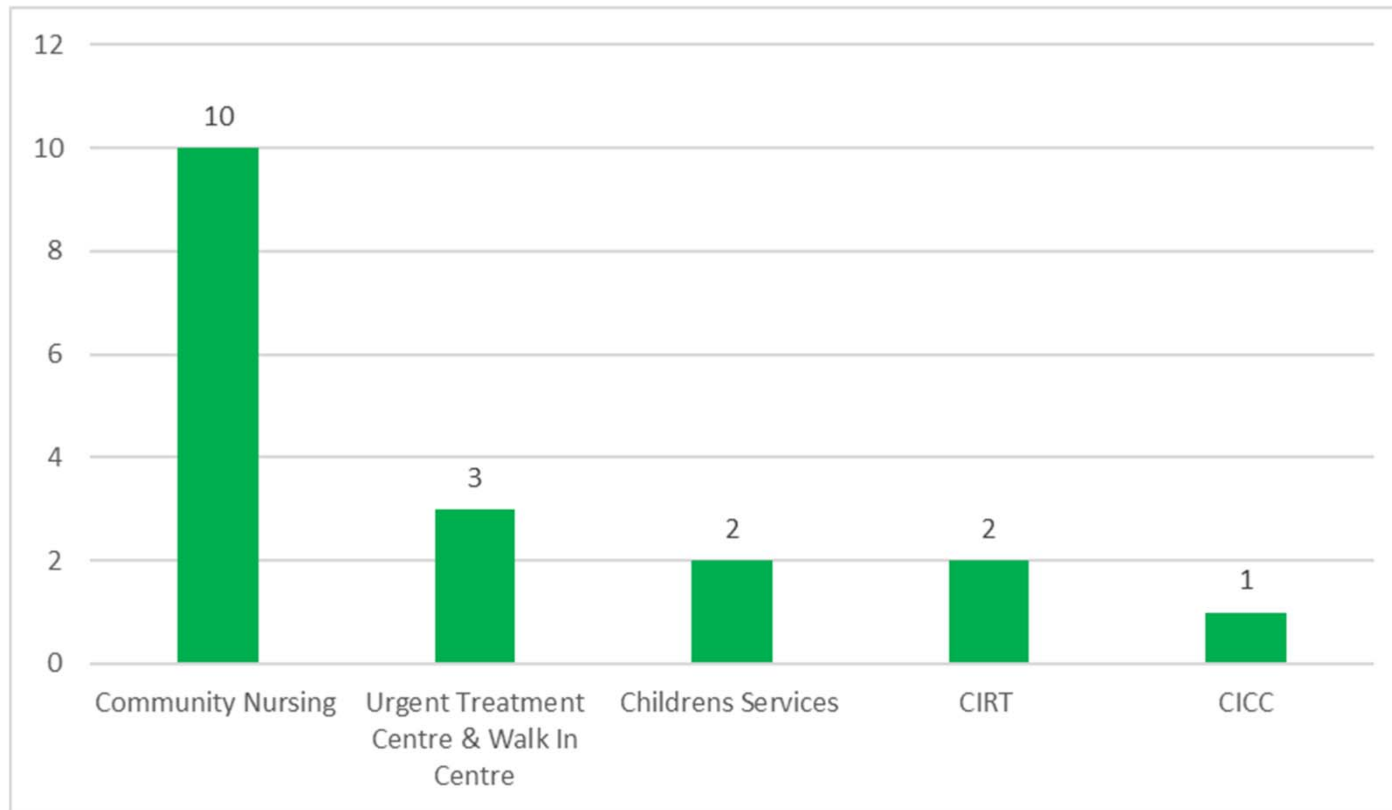
- Four of the concerns reported were from different members of the same team in relation to the same issue
- Whilst this indicates the concern being shared by multiple team members the concern itself was largely in relation to the one theme of the safer staffing model in Community Nursing
- A number of measures were put in place to support the team and an action plan was produced in collaboration with the team to provide support moving forward
- Staffing withing Community Nursing continues to be closely monitored

Comparison Data for Q1 and Q2

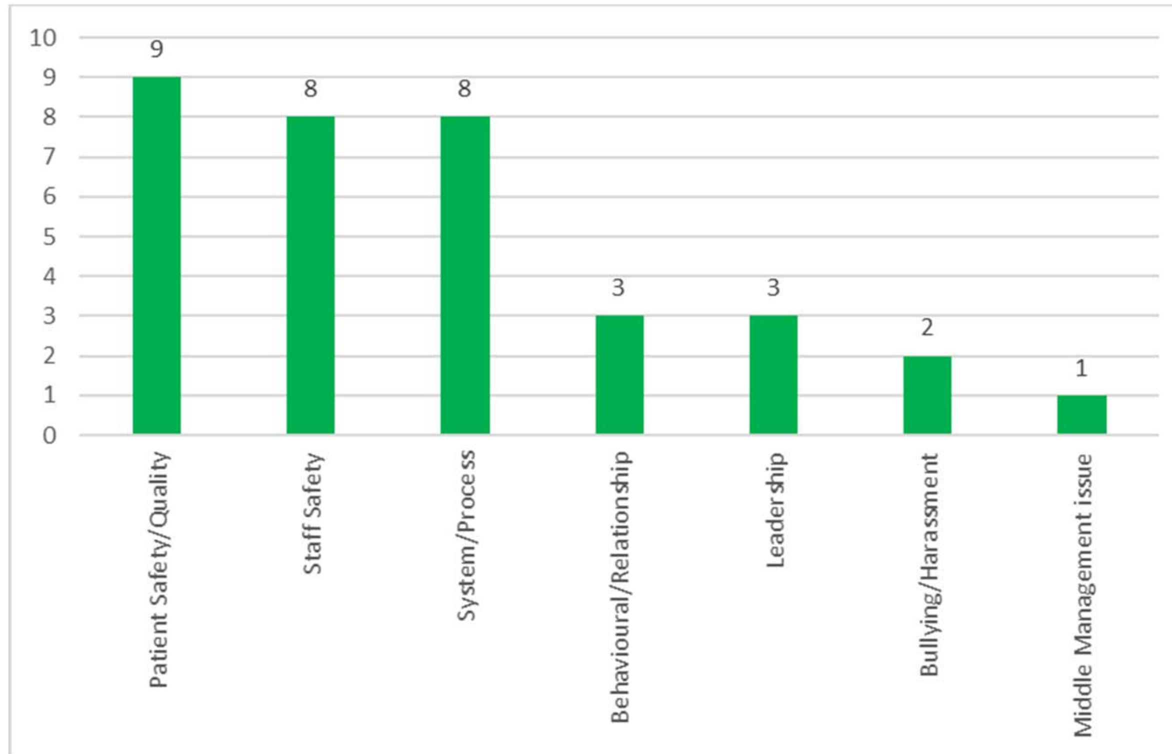


- Numbers of concerns year on year for Q1 & Q2 is showing a consistent level of reporting under FTSU

Concerns Reported Q1 and Q2 by Service



Concerns by Theme



Please note : Individual concerns can have multiple themes

- Examples of the theme Patient Safety/Quality and Staff Safety would be:
  - Concern raised over staffing levels
  - Concerns raised over movement of staff between teams
  - Low staff morale reported
- Examples of the theme of Systems/Processes would be:
  - Query over shift allocation
  - Query over milage claim process
  - Request for training on new process

Outcomes and Learning

- Review of rota allocation process
- Improved communication to support understanding of milage claim process
- Additional training and support provided to a team undergoing change
- Task and finish group created to work on alignment of some processes with Chester University
- Learning and Organisational Development support provided to support team building and commination
- Clearer posters/signage displayed in public areas
- Training provided to reception staff on clinical escalation

Outcomes and Learning Continued

- Collaborative working with HR and Staff Network Groups to ensure staff members who report a concern are supported in the most appropriate way
- Collaborative working with Wirral University Teaching Hospital
- Support provided around safer staffing model in Community Nursing
- Review of maternity leave hours within Community Nursing Team
- Face to face meetings with all staff affected by the Nursing Transformation
- Review of pathways between Community Nursing and CIRT and between Community Nursing and palliative care as part of the wider community Nursing transformation

Feedback From Satisfaction Questionnaires

100% of surveys that were returned stated that the reporter would speak up again and some provided feedback:

Difficult decision to go down that route but made easier and comfortable and importantly involved and updated

This was my first experience of 'Speaking Up' and like many staff I had concerns over confidentiality, how it might affect my role, whether it would be taken seriously. From start to finish the process was simple and I was reassured that there would be no negative impact from me doing so. My concerns were taken seriously, I was involved and communicated with throughout

Was a great help and reassurance to know I could talk to somebody about my concerns.

I was feeling worried to contact FTSU person but am glad that I did as I found the process very helpful and worthwhile

It has actually made changes within our team

I'm so glad I reached out.
I feel much better about the situation now after speaking to the Guardian.
I would definitely speak to her again.
Thanks a million

Guardian was lovely and very helpful.

Fast response which answered my query

Next Steps

- Promotion of the Speak Up, Listen Up, Follow Up training across all staff groups based on role and management responsibilities
- Development of a welcome leaflet to be provided to all agency staff. This will sign post where to go for help and support as well as including the FTSU Guardian e-mail address should they wish to raise any concerns in confidence
- Support to be provided to Trust Board to complete appropriate training along with FTSU Self Review Tool Kit and board development session
- Process to be developed to follow up on closed concerns after six months to gain assurance there has been no detriment as a result of speaking up
- MIAA FTSU through an audit committee lens tool to be completed and presented to audit committee

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Promotion and Speak Up Month

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Mortality Report: Learning from Deaths Framework Quarter 2: 01 July 2023 – 30 September 2023

Meeting	Board of Directors		
Date	13/12/2023	**Agenda Item**	15
Lead Director	Nick Cross, Medical Director		
Author(s)	Nick Cross, Medical Director		

Action required (please select the appropriate box)

To Approve ☒	**To Discuss** ☐	**To Assure** ☒

Purpose

The purpose of this paper is to seek approval from the Board of Directors in relation to the publication of the learning from deaths appendix on the Trust website which is included within the report.

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 2023/24, along with a summary of thematic learning identified during investigation into these cases.

All deaths reported to the Trust in Q2 have flowed through the Trusts governance processes. There are no deaths that were attributable to the care delivery provided by our Trust and therefore no specific learning. There were no clusters or patterns identified in relation to either the cause of death or location of the deaths.

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 & Equality Impact Assessment completed and attached: No.

<table>
<tr><td colspan="3">Financial/resource implications: None</td></tr>
<tr><td colspan="3">The Trust Vision – To be a population health focused organisation specialising in supporting people to live independent and healthy lives. The Trust Objectives are:

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Please select the top three Trust Strategic Objectives and underpinning goals that this report relates to, from the drop-down boxes below.</td></tr>
<tr><td>Populations - Safe care and support every time</td><td>Populations - People and communities guiding care</td><td>Place - Improve the health of our population and actively contribute to tackle health inequalities</td></tr>
<tr><td colspan="3">The Trust Social Value Intentions

Does this report align with the Trust social value intentions? Yes.

If Yes, please select all of the social value themes that apply:

Community engagement and support ☒
Purchasing and investing locally for social benefit ☐
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Increasing wellbeing and health equity ☒
Reducing environmental impact ☐</td></tr>
<tr><td colspan="3">Quality & Safety Committee is asked to consider the following action</td></tr>
<tr><td colspan="3">To be assured by the report and approve appendix 1 to be published on the public facing website</td></tr>
<tr><td colspan="3">Report history (Please include history of where the paper has been presented prior to reaching this meeting, including the title of the meeting, the date, and a summary of the outcome)</td></tr>
<tr><td>Submitted to</td><td>Date</td><td>Brief summary of outcome</td></tr>
<tr><td>Quality and Safety Committee</td><td>08.11.2023</td><td>Assured and approval obtained</td></tr>
</table>

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Mortality Report: Learning from Deaths
Quarter 2: 01 July 2023 – 30 September 2023

Purpose

1. 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.

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 system partners 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 which have occurred in a place where we are commissioned to deliver services, are discussed at both the Quality and Governance Multi-disciplinary Safety Huddle and 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 investigation reports 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 and who is responsible for the Learning from Deaths agenda.

11. The membership of the Mortality Review Group includes the Trust's Child Death Overview Panel (CDOP) representative, enabling the visibility of any thematic learning across the whole of Cheshire and Mersey.

12. Minutes from the Mortality Review Group are submitted to the Quality and Safety Committee and to the Board by exception.

13. A report is produced which summarises the details of the unexpected 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.

14. In accordance with the Learning from Deaths framework, the Trust ratified and published a Learning from Deaths Policy during September 2017 and which is subject to regular review.

15. The policy provides a framework for how the Trust will evaluate those deaths that form part of our mortality review process, the criteria for review and quarterly and annual reporting mechanisms.

16. 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, Chief Nurse and Deputy Chief Nurse for all reported unexpected deaths. This includes integrating the Mortality Screening Tool with Datix.

17. The Incident Management Policy - GP08 has been updated and cross references the 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.

18. 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 the UK Health Security Agency 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.

19. 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

20. 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.

21. 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.

22. 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.

23. 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 2023/24 WCHC Reported deaths (Datix incident reporting)

24. During Q2 there were a total of 13 reported deaths none of which were within scope for reporting.

25. During Q2 there were 0 deaths which met the criteria for StEIS reporting.

Structured Judgement Reviews:		
Total Number of Deaths in scope	13	
There are no outstanding cases from the previous quarter (Q1)		
Total Number of Deaths considered to have more than 50% chance of being avoidable	0	
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	
SUDIC reviews:		
Total Number of Child Deaths	10	
Total Deaths reviewed through SUDiC methodology	10	

Summary of Thematic Learning

26. Each unexpected death reported during Q2 has been analysed and investigated appropriately, to identify if care provided by the Trust resulted in harm or contributed to the death, and if any relevant learning exists for the Trust and the wider health and social care system.

27. Of the total deaths reported in Q2, after investigation, none of these were within scope of this report as none of the deaths had been caused by gaps or omissions in the provision of NHS care. There were no learning themes identified for the Trust.

28. Of the total deaths reported, there were no patterns or clusters relating to either location or cause of death.

Recommendations

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

30. The Quality and Safety Committee is asked to approve Appendix 1 to proceed through to Public Board

Dr Nick Cross
Executive Medical Director

30 October 2023

Appendix 1

Learning from Deaths Q2 23/24 Report

The following data represents the high-level reporting of deaths which occurred within our services over the period of Quarter 2 2023/24.

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

There were 13 deaths reported to the Trust and all have been reviewed in accordance with Trust policy. On this occasion, none of the deaths were within scope of this report during this period. This is because the deaths were not associated with any care delivered or harm caused by services provided by the Trust. Duty of Candour was not applicable to any of these cases.

There were ten child deaths reported during this quarter, which followed the appropriate investigation processes and there was no learning specific to the Trust.

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 within all the communities in which we provide services, focusing on addressing health inequalities on a population-based approach.

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

30 October 2023