Wirral Community Health and Care NHS Foundation Trust

Mortality Report: Learning from Deaths Framework Quarter 1: 01 April 2022 – 30 June 2022

Meeting	Board of Directors		
Date	19/10/2022	**Agenda item**	**20**
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 seek approval from Public Board in relation to the implementation of the Learning from Deaths framework and 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 2022/23, along with a summary of thematic learning identified during investigation into these cases.

All deaths reported to the Trust in Q1 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.

Attached as an appendix is a report detailing this information for purposes of publication of the Trust website. The report has been shared and approved by the Quality and Safety Committee.

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 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 and 2: that processes are in place to engagement with families and meet our Duty of Candour obligations.

Report history

Submitted to	Date	Brief summary of outcome
Quality and Safety Committee	07/09/2022	Committee approved

Wirral Community Health and Care NHS Foundation Trust

Mortality Report: Learning from Deaths
Quarter 1: 01 April 2022 – 30 June 2022

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 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 and 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 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.

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 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 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.

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 2022/23 WCHC Reported deaths (Datix incident reporting)

23. During Q1 there were a total of 7 reported deaths none of which were within scope for reporting.

24. During Q1 there were 0 deaths which met the criteria for StEIS reporting.

Recording data on Structured Judgement Reviews:		
Total Number of Deaths in scope	0	
April – 0 May – 0 June – 0 There are no outstanding cases from the previous quarter (Q4)		
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	0	
Total Deaths reviewed through SUDiC methodology	0	

Summary of Thematic Learning

25. Each unexpected death reported during Q1 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.

26. Of the total deaths reported in Q1, after investigation, none of these were within scope of this report and consequently there were no lessons identified which the Trust and system partners could learn from.

Recommendations

27. 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.

28. 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 August 2022

Appendix 1

Learning from Deaths Q1 22/23 Report

The following data represents the high-level reporting of deaths which occurred within our services over the period of Quarter 1 2022/23.

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

There were 7 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 no child deaths reported during this quarter.

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

20 August 2022