To: **National Quality Board**

For meeting on: 1 March 2017

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Report for:

Decision	Discussion	Information
X	X	

LEARNING FROM DEATHS

A. Summary: This paper builds upon the discussion by the NQB on 1 February and covers three areas:

1. Guidance: Seeks the NQB's views on an advanced draft of a *National Framework on Learning From Deaths* on behalf of the NQB ("the guidance"). A **working draft** is planned for publication on **Tuesday 14 March** and presentation at the national *Learning from Deaths* Conference on **Tuesday 21 March** to test views from provider and family/carer representatives.

2. Family/Carers: **Annex A (paras 3-9) and section C(e) below** provide an update on how we are engaging family/carer representatives in the development of the guidance. For example, the draft reflects initial feedback from these representatives as well as other members of the CQC's Expert Advisory Group. Annex A also updates the NQB about the workshops being facilitated by Sir Michael Barber's team at Delivery Associates.

3. Alerting Trusts: We have provided with this note the letter that was sent to Trusts on 22 February from CQC and NHS Improvement alerting them to preparations needed for their new responsibilities from April 2017. This includes new data collection/reporting requirements in relation to deaths assessed as more likely than not to be due to problems in care.

B. Recommendation

NQB is asked to consider the guidance and provide **conditional approval** of the draft at your meeting on 1 March (the overall feedback from stakeholders so far from is positive), pending our resolution of any issues arising from the meeting. In particular, we would be grateful for:

1. Feedback on the **questions** provided in section C below.
2. Agreement for the two chairs to sign-off the draft guidance by **Friday 10 March.**
3. Agreement to publish a "working draft" guidance on NQB's webpage by **Tuesday 14 March**.

C. Draft Guidance: We are seeking views on the following questions.

a. ***Broader approach/scope of the guidance****:* The guidance sets out expectations of acute, mental health and community NHS Trusts and FTs, reflecting the Trust types which the CQC review examined, as well as SofS's requirements for new data publication from April 2017. However it states that "*Over time, [regulators] expect the same requirements and expectations of this framework to be applied to* ***other providers of NHS funded care***" (Foreword, page 4). Our approach is about combining a gradual approach with realistic expectations. *Is the NQB content with this approach?*

b. ***Categories and selection of deaths in scope for review****:* The guidance expects Trusts to publish a policy for how they respond to deaths of patients who die under their management and care by June 2017 (Q1), including the approach to undertaking case reviews:

   i. Categories: The guidance says it is for Trusts to decide which deaths should be in scope of their policy for reviewing deaths and that, *as a minimum and from the outset*, this must draw upon all **in-patient deaths** (To support Trusts' quarterly data publication, the guidance will provide a reporting dashboard for total inpatient deaths, those subjected to review and of those, how many were avoidable). However the guidance says that "*In particular contexts, and as these processes become more established, it should also include cases of people who have been an in-patient but have left hospital at the time of death. For example, from the outset Mental Health Trusts are likely to find it beneficial to include anyone who has been an in-patient and/or out-patient within the last six months of the time of death*" (Paragraph 14 "Categories of deaths in scope for case review"). *Is the NQB content with this approach or should we recommend the inclusion of post discharge deaths for all Trusts of anyone who has been an in-patient within* ***the last 30 days?***

   ii. Selection: The guidance provides **minimum requirements for the selection of reviews** including all deaths where family/carers have raised a concern about care quality, deaths of all inpatient, outpatients and community patients with learning disabilities and severe mental health needs etc (Paragraph 17 (ii) "Case Record Review"). *Is the NQB content with the proposed minimum criteria for review selection?*

   iii. Quarterly data publication: This is **not about creating league tables** to compare Trusts on avoidable mortality (the data will not be comparable between them) however concerns have been raised, for example from the RCP, that this could look like an attempt to 'rank' providers. *Should we emphasise in the guidance that data publication is not about ranking rather increased transparency through improved data collection and reporting, to support a systemic, NHS-wide approach to learning from deaths?*

c. ***Review methodology***: The guidance expects acute Trusts to use the Structured Judgement Review case note methodology (delivered by the RCP) which prioritises acute care (Acute, mental health and community Trusts are expected to adopt the LeDeR methodology for deaths of patients with learning disabilities in regions where the

programme is available, or otherwise to use SJR). For MH and community Trusts, the guidance states that SJR can be used as a starting point but will require adaptation to reflect their individual circumstances (Paragraph 14 "Policy on Responding to Deaths"). **Humber FT** has been successfully adapting SJR in mental health in-patient and community care under the Yorkshire and the Humber Improvement Academy programme and has offered to provide a **mental health case study** for the guidance. However family/carer representatives have raised concerns about highlighting Humber FT given the high profile case of Sally Mays' death and the ongoing police investigation into staff withholding information from the inquest. Therefore, it may be prudent to frame the case study in a more general way that examines the way in which Trusts under the Academy programme are adapting the SJR methodology. The guidance also says that "*We will engage with mental health and community providers to determine whether further tools that build on SJR would be beneficial*". *Does the NQB agree with that overall proposed approach, including the use of a more general case study?*

d. ***Objectivity of reviews:*** The guidance states in paragraph 29 that reviews should, wherever possible, be undertaken by **clinicians other than those directly involved** in the care of the deceased. Even where the specific clinical expertise needed lies with those involved with the care of the deceased, we state that the review should involve clinicians who were not involved in order to provide peer challenge. The guidance says that objectivity should be integral to the provider's clinical governance processes, and that reviews *could* additionally become the responsibility of a designated NED (We plan to further explore the feasibility of these proposals at the conference). *Is the NQB happy with this approach or might this place an unrealistic burden on front-line staff?*

e. ***Bereaved families/carers:*** The guidance, including a bespoke section on engaging families/carers, was tested with the HSIB Expert Advisory Group and CQC Expert Advisory Group (EAG) on 20 and 21 February. We have now reflected on initial feedback from representatives of families/carers (e.g. the solicitor who acted for the family of Connor Sparrowhawk, Charlotte Haworth-Hind, and George Julian) to strengthen the bespoke section in the guidance (Section 7 "Bereaved Families and Carers", paragraphs 54 to 69) and other areas. We will continue to consider their feedback, as well as that of the conference. The guidance also confirms that **NHSE will lead the development of further guidance for bereaved families and carers**, in particular how they can expect to become involved during an investigation (CQC Recommendation 3). Lastly, concern has been raised that we have not as yet engaged **directly with families**. We intend to do this directly after the conference to ensure that we continue to strengthen messaging around the fundamental shift in values needed from providers. However we could undertake some limited engagement with families themselves prior to the conference. *Is the NQB content with the section on bereaved families/carers (section 7), where that section is positioned in the guidance and how families/carers are addressed more generally in the guidance - pending input from families/carers themselves post conference? Or does the NQB feel we should undertake some limited testing with families prior to the conference?*

f. ***Deaths involving multiple organisations in that patient's care:*** The guidance sets out the importance of ensuring that investigations and the cause of death are attributed correctly in such cases, also so that providers do not count/publish avoidable deaths that are attributed to others (Section 6, paragraphs 44 to 53). *Is the NQB content with the approach set out in the guidance?*

ALB Involvement in development and sign-off of paper:

Care Quality Commission	NHS England	NHS Health Education England	NHS Improvement	NICE National Institute for Health and Care Excellence	Public Health England	DH Department of Health
✓	✓		✓			✓

ADDENDUM

The *National Guidance on Learning from Deaths* and accompanying suggested *Trust Dashboard* were published by the National Quality Board in March 2017. To access both of these, please click on the following link.

ANNEX A LEARNING FROM DEATHS

Background

1. The CQC report *Learning, candour and accountability: A review of the way NHS trusts review and investigate deaths of patients in England* was published on 13th December 2016.

2. In a statement to Parliament on the same day, SofS accepted all of the CQC's recommendations and made a series of commitments. A key recommendation (recommendation 2) was a request to the NQB to draw up a **national framework on learning from deaths**. The guidance currently being developed emphasises that its purpose is to develop and instil a learning culture, while being firm and clear about the need for providers to improve and setting out key steps that need to be taken. The guidance:

    - will set out expectations of acute, MH and community Trusts and FTs, advise on the role of their non-executive directors in relation to challenging boards on mortality governance and Trusts' reporting of avoidable deaths (it will include a suggested reporting dashboard for avoidable mortality) and provide tools for Trusts without being prescriptive on implementation;
    - is scheduled for publication as a working draft ahead of the *Learning From Deaths Conference* on 21 March. We will actively reflect on the feedback from providers and representatives of families/carers at the conference, as well as feedback from families themselves after the conference, to finalise the guidance.

Family/carer engagement

3. We are engaging family and carer representatives on the content of the guidance and providing them with information about the broader programme.

4. Initial sessions were held with members of the HSIB Expert Advisory Group (20 February) and the Expert Advisory Group (EAG) for the CQC 'Deaths Review' (21 February). These events are the start of a conversation that we will continue to have with representatives of families and carers. For example, NHS England will be developing guidance for bereaved families and carers as part of the broader programme, including what they can expect from providers when they are involved in an investigation process (CQC recommendation 3)

5. Family and carer representatives are being invited to the *Learning from Deaths Conference* on 21 March. We have proposed to the organiser (NHS Improvement) that a speaker should be invited to give the perspective of families and that one of the afternoon sessions should provide an opportunity for a similar discussion.

6. We will engage directly with families/carers after the conference.

7. Following the EAG meetings above, we have reflected their wide ranging feedback in the draft guidance, including from family/carer representatives as well as NHS Providers, NHS Clinical Commissioners, Professor Peter Furness, James Titcombe etc. We have in the time available addressed the key points including:

    - **Stronger emphasis on provider engagement with bereaved families and carers** which we will inevitably need to build upon in our discussions with families and their representatives;
    - **Greater interaction with the coronial system, including inquests, Reports on Action to Prevent Future Deaths and the risk of parallel investigations by the NHS;**
    - **Greater emphasis on the role of NHS England and CCGs in supporting the learning from deaths framework;**
    - **Greater emphasis on good quality, professionalised investigations in the NHS;** we have at the same time ensured consistency with the Serious Incident Framework. However a number of stakeholders feel that the Serious Incident Framework needs to be modernised and updated e.g. family representatives argue that it failed to prevent the failures identified in the Mazars review into Southern FT.
    - **Low threshold for external investigations as per the CQC recommendation.**

8. We will continue to reflect on the feedback provided to us as we develop the guidance for publication prior to the conference.

9. Delivery Associates have been contracted to carry out a mapping of the learning from deaths process and the delivery chain that will drive implementation. A model was presented at the CQC EAG meeting mentioned in paragraph 4 and a meeting of the Medical Examiners Strategic Programme Board. Leigh Sandals on behalf of Delivery Associates will summarise the process for NQB and set out the key issues that are beginning to emerge and which we are factoring into the development of the guidance.

Letter to Trusts

10. For Trusts to meet the expectation to publish data on avoidable mortality from April 2017 onwards they will need sufficient time to prepare. This will involve establishing internal processes for selecting deaths for Structured Judgement Review, building capability in relation to the SJR methodology for reviewers and embedding all this within existing mortality and morbidity governance processes. To support Trusts, Mike Richards and Kathy McLean wrote jointly to all acute, mental health and community Trusts on 22 February. The letter is provided with this note.