To: **National Quality Board**

For meeting on: 1 February 2017

Report author: **Paul Stonebrook / Martin McClenaghan (DH)**

Report for:

Decision	Discussion	Information
X	X	

Title: Learning from Deaths

Summary: This paper addresses three items

- An early structure of a National Framework on Learning From Deaths on behalf of the NQB, which represents a key commitment, for delivery in March (see Annex A):
    - The National Framework ("Guidance") includes the most up to date version of the reporting dashboard for Trusts and a flow chart.
    - The flow chart is intended for Trusts for inclusion as part of the final guidance.
    - It also incorporates previous work to require trusts to publish in a dashboard specified information on deaths that were potentially avoidable and consider what lessons need to be learned from common factors on a regular basis.

- A proposal to write to Trusts and FTs in February to inform them that the guidance will be published in March and describe its purpose, with a particular focus on the reporting that trusts will need to start from April 2017.

- A new programme to deliver Secretary of State's commitments and response to recommendations following the publication of the CQC report *Learning, candour and accountability*. (See Annex B.)

Recommendations / Action(s) requested:

- NQB is asked to consider the draft National Framework and provide comments. In particular, **we are seeking advice on the following questions**:

  Broader purpose/ approach of the document

a. Is the NQB content for the guidance to set out expectations of NHS providers, advise on the role of Non-Executive Directors and provide tools / resources for trusts without being prescriptive on implementation?

Questions specific to the content of the guidance with cross reference to the text

b. Is it sufficient for this guidance (Chapter 1, Section 1) to make links to clinical governance guidance at appropriate points to explain how learning from case reviews of deaths should feed into quality improvement actions? Or should this guidance be more prescriptive about how clinical governance should implement findings of these case reviews?

c. Should the guidance (Chapter 1, Section 2) require all NHS providers to publish a protocol for how they conduct case reviews to learn from deaths, including on how they select deaths to be subject to case review? If so, is the NQB content that the guidance also sets minimum requirements for this selection process, for example that it include all deaths:

    - of those who are identified as significantly disadvantaged, including those with learning difficulties and some mental health needs;
    - where family/carers have raised a concern about the quality of care provision;
    - that occur for care interventions for which death would be wholly unexpected, for example in some elective procedures; and
    - that it sets out how it samples for review deaths that do not meet these criteria?

d. How prescriptive should the guidance (Chapter 1, Section 2) be about the period following discharge from its care that a provider should be expected to review the death of a patient? Current approaches vary between providers but the guidance could set a minimum requirement of 30 days (Summary Hospital-level Mortality Indicator), six months (CQC window for considering deaths of patients after discharge from acute care or an inpatient setting) or another period of time.

e. For deaths of patients who have received care judged to be deficient from more than one trust or provider, are current arrangements for coordinating local investigations (including NHS England's assurance and oversight processes) sufficient or should we be setting further expectations in the guidance? (Chapter 1, Sections 3 and 4)

f. The RCP case note methodology and training programme has prioritised acute care and does not extend to mental health and community trusts. Are there any equivalent methodologies that are appropriate to help community and mental health trusts learn from and report on deaths? If not, should an equivalent methodology for mental health and community trusts be commissioned? (Chapter 1, Section 7)

- NQB is asked to agree that a letter should be sent to NHS providers in mid-February explaining the Learning from Deaths programme, and that the NQB will need to sign off a draft of this by correspondence in early February.

- NQB is asked to note the work-streams and high-level plan for the programme.

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.

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. In a statement to Parliament on the same day in response to the recommendations of the report, Secretary of State made a series of commitments. These included a request to the NQB to draw up guidance on reviewing and learning from the care provided to people who die, in consultation with Keith Conradi, the new Chief Investigator of the Healthcare Safety Investigation Branch. These guidelines are to be published in March for implementation by all trusts in the year starting April 2017.

Programme

2. We have established a programme to deliver the Secretary of State's commitments, with work-streams that align with the recommendations of the CQC report. We anticipate that this will be delivered as two tranches:

    - Publication in March 2017 of draft guidance promised by Ministers – the National Framework on Learning from Deaths and the associated products, such as the reporting dashboard and RCP methodology - with a final version available in June. This will need to reflect as far as possible the broader range of recommendations of the CQC report, but this will need to be updated in due course to reflect the outputs of the second tranche, below.

    - Further work to deliver the outputs of the other work-streams, including guidance for engagement with bereaved families, training to improve investigations and information systems to identify deaths and patient characteristics.

3. We propose that the Avoidable Mortality Programme Board is expanded to cover the more comprehensive Learning from Deaths programme and will report to the NQB. The work-streams, immediate deliverables and high-level milestones are set out in the enclosed slides.

National Framework on Learning from Deaths

4. This guidance is intended to set out expectations of NHS providers, advise on the role of Non-Executive Directors and provide tools and resources for them without being prescriptive on implementation. The guidance is divided into two main chapters setting out the expectations of organisations and providing Non-Executive Directors with a framework to challenge boards on mortality governance and their reporting of avoidable deaths.

5. The guidance includes a flow chart and a suggested reporting dashboard for avoidable mortality as annexes. The preparation of a first, outline draft of the guidance has given rise to a series of questions for the NQB listed on the cover sheet.

6. We propose to publish a draft of the guidance in March to coincide with the Avoidable Mortality Conference. The final version of the guidance will be published in June to reflect responses from providers, including feedback from the conference. The guidance would be revisited at an early stage to include further content emerging from the work streams. We will engage with patients and families during March.

7. The guidance would require that a provider's protocol for learning from deaths describe how it will communicate with bereaved families about this subject, and be brought in line with the outputs of work stream 3 of this programme on bereavement support and communication with families once this is published (see Annex B).

Communication to trusts

8. In order for trusts to meet the expectation for them to publish data on avoidable deaths for quarter 1 of 2017-18, they will need sufficient time to prepare. This will involve establishing internal processes for the selecting deaths for Structured Judgement Review, communicating the RCP methodology to reviewers and embedding these within existing mortality and morbidity governance processes.

9. We remain committed to publish a draft of the National Framework on Learning from Deaths in March 2017 to coincide with the Avoidable Mortality Conference. There is, however, a more pressing need for guidance to be communicated to trusts on avoidable deaths. We propose that NHS England and NHS Improvement write jointly to all acute, mental health and community trusts in mid-February setting out the following key points:

    - The purpose of the avoidable mortality review in the context of learning from deaths.
    - The expectation that trusts will publish data on avoidable mortality, learning and actions on a quarterly basis, commencing with quarter 1 of 2017-18 and that these data will be summarised in their June 2018 Quality Accounts.
    - Our minimum expectations for the type of deaths to be selected for review and the number / proportion of deaths each quarter.
    - The methodologies we expect trusts to follow and the standard reporting template.
    - What future resources will be made available, including the National Framework on Learning from Deaths and training in the PCP Structured Judgement Review case note methodology and with reference to the conference planned for March 2017.

Conclusions / recommendations

10. We ask that the NQB:

- considers the draft National Framework and provides comments, in particular on the following questions;
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g. Is the NQB content for the guidance to set out expectations of NHS providers, advise on the role of Non-Executive Directors and provide tools / resources for trusts without being prescriptive on implementation?

Questions specific to the content of the guidance with cross reference to the text

h. Is it sufficient for this guidance (Chapter 1, Section 1) to make links to clinical governance guidance at appropriate points to explain how learning from case reviews of deaths should feed into quality improvement actions? Or should this guidance be more prescriptive about how clinical governance should implement findings of these case reviews?

i. Should the guidance (Chapter 1, Section 2) require all NHS providers to publish a protocol for how they conduct case reviews to learn from deaths, including on how they select deaths to be subject to case review? If so, is the NQB content that the guidance also sets minimum requirements for this selection process, for example that it include all deaths:

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j. How prescriptive should the guidance (Chapter 1, Section 2) be about the period following discharge from its care that a provider should be expected to review the death of a patient? Current approaches vary between providers but the guidance could set a minimum requirement of 30 days (Summary Hospital-level Mortality Indicator), six months (CQC window for considering deaths of patients after discharge from acute care or an inpatient setting) or another period of time.

k. For deaths of patients who have received care judged to be deficient from more than one trust or provider, are current arrangements for coordinating local investigations (including NHS England's assurance and oversight processes) sufficient or should we be setting further expectations in the guidance? (Chapter 1, Sections 3 and 4)

l. The RCP case note methodology and training programme has prioritised acute care and does not extend to mental health and community trusts. Are there any equivalent methodologies that are appropriate to help community and mental health trusts learn from

and report on deaths? If not, should an equivalent methodology for mental health and community trusts be commissioned? (Chapter 1, Section 7)

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- NQB is asked to note the work-streams and high-level plan for the programme.

- agrees that a letter should be sent to trusts in mid-February explaining the Learning from Deaths programme, and that the NQB will need to sign off a draft of this by correspondence in early February;

- notes the work-streams and high-level plan for the programme.

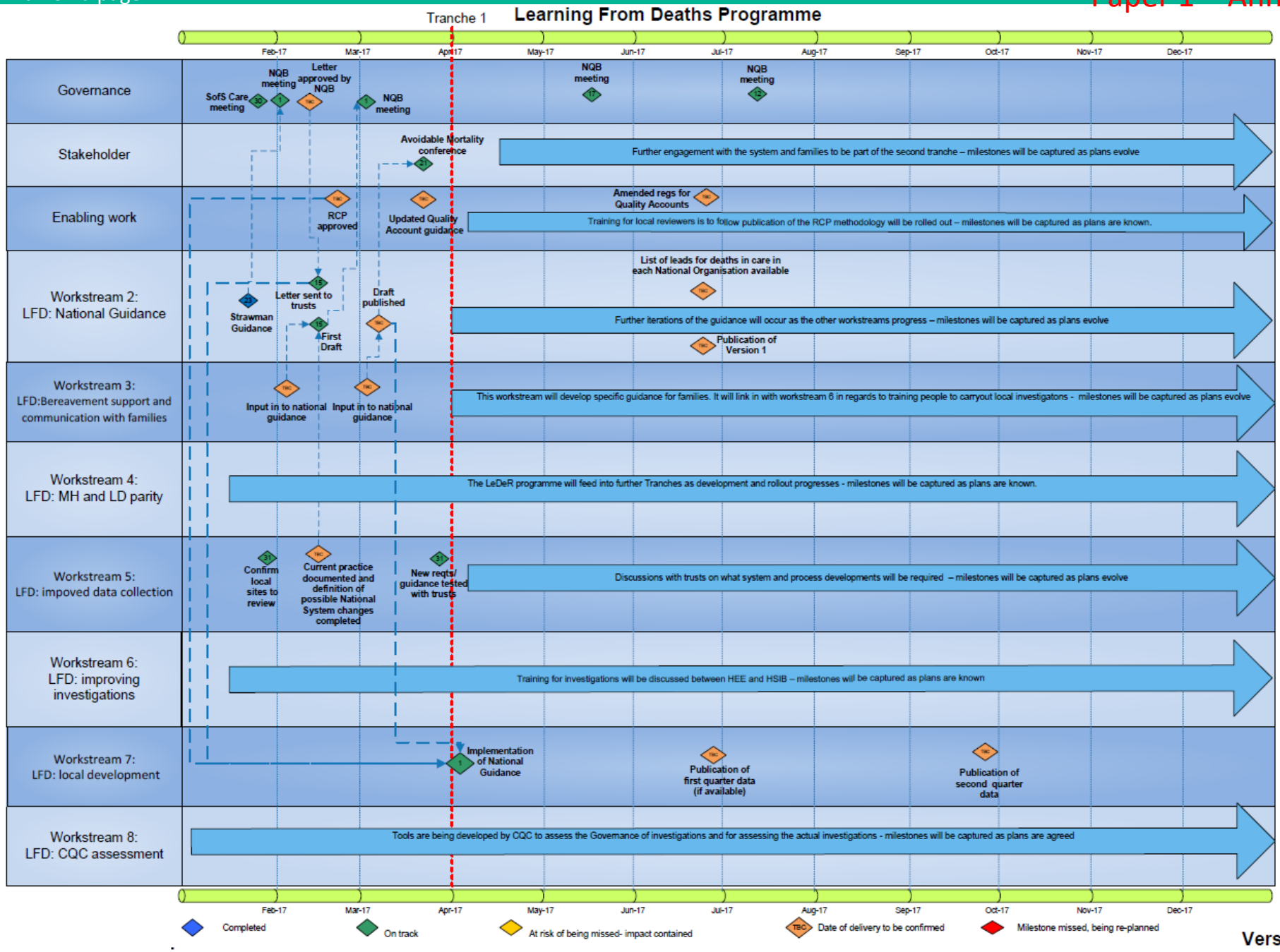
Paper 1 – Annex B

Workstream	CQC Rec	Products/deliverables	Lead	Lead agency
1. LFD coordination of response	1	• Programme established	Tim Jones	DH – William Vineall
2. LFD: National Guidance/Framework	2	• RCP guidance* • Avoidable Mortality Learning Dashboard* • National Guidance • Single lead for deaths in care	Tim Jones	DH – William Vineall
3. LFD: Bereavement support and communication with families	3	• Guidance for families and carers**	David McNally	NHSE – Jane Cummings
4. LFD: MH and LD parity	4	• TBC**	Crispin Hebron	NHSE – Dominic Slowie
5. LFD: improved data collection	5	• Identified standard set of data** • Process to collate information**	Jeremy Thorp	NHSD – Martin Severs
6. LFD: improving investigations	6	• Accredited training programme** • Updated Job Descriptions** • Updated work plans**	TBC	HSIB – Keith Conradi
7. LFD: local development	7	• Review and improve local approach following a death** • Implementation of National Guidance at a local level**	TBC	NHSI- Kathy Mclean
8. LFD: What CQC will do:		• Strength assessment of learning from deaths** • Share findings and insight about quality of systems** • Report and identify good practice examples**	Kim Forrester	CQC – Mike Richards

** Completed, require final approval* *** To be discussed and agreed with Workstream Leads*

- Early structure of National Framework/Guidance for NQB – 20th Jan
- RCP final pilot report submitted to HQIP – 2nd Feb
- Letter to trusts on expectations for April, including basic guidance – w/c 13th Feb
- First draft of National Framework/Guidance for NQB – 15th Feb
- Approved RCP methodology – March tbc
- Publish draft of National Framework/Guidance for conference – March tbc
- Avoidable Mortality Conference – March tbc
- Trust level training commences on RCP methodology – tbc (subject to approval of a satisfactory plan from the RCP-led group)
- Publication of National Framework/Guidance – June

Paper 1 – Annex B



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