Investigating deaths across NHS mental health, acute and community settings – reviewing and improving

May 2016

Policy and Strategy Team

Care Quality Commission: Responding to Mazars' report

- **Following the publication of the Mazars report, the Health Secretary asked CQC to:**

- Undertake a focused inspection of Southern Healthcare early in the new year, looking in particular at the Trust's approach to the investigation of deaths. As part of this inspection, the CQC will assess the Trust's progress in implementing the action plan required by Monitor and in making the improvements required during their last inspection (February 2015).

- Undertake a wider review into the investigation of deaths in a sample NHS trusts (acute, mental health and community trusts) in different parts of the country. As part of this review, CQC will assess whether opportunities for prevention of death have been missed, for example by late diagnosis of physical health problems.

Proposed approach: reviewing current practice

What improvements are needed in order for NHS trusts to have robust and effective mechanisms in place to investigate the deaths of patients/service users, to allow learning to be quickly embedded to improve care within organisations and for the system as a whole?

Part 1. Review the process that providers follow to identify deaths of people who are in receipt of care from acute, mental health and community NHS trusts which may offer learning opportunities for the provider.

- An assessment of how Trusts are currently identifying, investigating and learning from deaths in their care.
- Identify the challenges experienced – both by families and Trusts.
- Showcase examples of good practice.
- Make a number of recommendations for improvement. These will outline changes required from trusts and commissioners, but also from CQC and other national bodies.

- We will look at the systems and processes in place for all deaths, with a focus on the way these may be applied where people have a learning disability or mental health problems (aligning with Mazars work).

What the review will assess - TBC

Key Line of Enquiry	
1. Identification and reporting	How are the deaths of people who use services identified, reported and the level of investigation decided?
2. Investigations	How are investigations completed effectively to identify missed opportunities for the prevention of death? Are investigations undertaken independently from the clinical team involved in delivering care?
3. Governance and Learning	What processes do provider boards have in place to monitor, review, learn and make sure improvements are made when deaths occur?
4. Involvement of families and carers	How are families and carers meaningfully involved throughout the investigation process?
5. Multiagency working	How do providers inform each other's investigations? How do providers share learning across organisations? What mechanisms are in place (e.g. information sharing / templates) to undertake joint investigations?

How the review will gather evidence - TBC

We plan to gather evidence through following:

- Online provider survey to inform review / gain data
- Telephone interviews to understand current practice (acute, community and MH trusts)
- Site visits – interviews, case tracking and record reviews (acute, community and MH trusts)
- Reviewing existing evidence – national datasets and unique CQC-held data, inspection reports and ‘share your experience reports’.
- Expert Advisory Group (including NHSI, NHSE, family representatives, charities, Trusts, legal & academic experts).
- Focus groups / workshops with experts (professionals and people with lived experience).
- Online communities
- 1:1 interviews with specialists (e.g. Medical Examiners, Coroners etc) and trade bodies.

What we hope to produce - TBC

By December 2016 CQC will:

- Publish a national report outlining our findings which assesses whether other Trusts "*fail to properly review, investigate and learn*" from deaths. This will not identify individuals trusts but will capture common challenges experienced – both by families and Trusts.

- It will also:
  - Showcase examples of good practice in reviewing, investigating and learning from deaths.

  - Make a number of recommendations for improvement. These will outline changes required from trusts and commissioners, but also from CQC and other national bodies.

- CQC will work closely with NHSI and NHSE to ensure that our findings influence their development of good practice guidance.

Your feedback to inform this approach

1. National review

- What do you believe are the biggest challenges and risks to robust and effective investigations that allow learning opportunities when service users and patients die?

- What single change do you think would have the biggest impact on allowing learning to be embedded that would lead to improvements to care within organisations and for the system as a whole?

2. Improving tools, sharing best practice and implementing change

- What do you and your colleagues need to make this easier and improve practice?

- What can CQC, NHS England, NHS Improvement, Health Education England and others do to support improvement?

Contact

Email the project team:
deathsreview@cqc.org.uk

Join the online community:
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