

CQC review of how NHS trusts investigate and learn from deaths

Expert advisory group notes

Friday 20 May, 1.30pm to 4.30pm

Item one: terms of reference

The following comments are to be considered in a re-drafted version of the terms of reference. Attendees were invited to make further comment via email.

- CQC to aim for meeting notes to be made available to attendees within 5 working days for comment.
- Emphasis of the review/report needs to be on improving care as well as preventing deaths.
- Acknowledgement that the current EAG membership does not have adequate BME representation, which CQC is working to address as a priority.
- Potential gap in the scope not including independent healthcare.
- Process for review of report by EAG before publication needs to be agreed.

Item two: Progress so far

- Discussion about poor practice and learning from mistakes – the report needs to highlight poor practice and how it can improve, as well as showcase good practice.
- Need to ensure we effectively engage families – EAG to offer advice/support.
- Trusts/services need to be able to assure themselves that they are investigating properly – currently guidance/good practice is not clear enough and needs to improve.
- Trusts must have good governance in place before they start investigations, but the review also needs to highlight the cultural aspects involved, such as a genuine sense of openness around mistakes and a commitment to act on / learn from them.
- Report needs to highlight equality aspect – everyone is treated the same, no matter what their disability or impairment.

Item three: Planning CQC's review

Key lines of enquiry

- Reiterated that the review needs to focus on improving care, not just preventing death.
- Need to look at how families are treated, not just how they are involved.
- Need to look at whether trusts have a family liaison policy and, if so, whether this is followed.
- How are commissioners involved? What is their role and learning from investigations?

- Investigations have in the past not always been about learning, but avoidance of blame. At what point should individuals from outside of a trust be undertaking the investigation?
- ACTION: CQC to send attendees a copy of the full KLOE prompts for further review and comment from the group

Provider information survey

- Concern over terminology of 'expected' and 'unexpected' – need to be careful about using this and avoid use if possible.
- Should be looking at mental health and learning disabilities together.
- How are CQC going to ensure trusts send the information – what if it isn't available? CQC to ask trusts to state any challenges they may experience in gathering this data.
- Information should be triangulated with national datasets.
- Can we be more explicit – definitions must be clearer to ensure questions are not open to different interpretation therefore skewing the data.
- ACTION: CQC to send provider survey to attendees for further review and comment.

Item four: Stakeholder engagement

- Easy read format must be made available.
- Current service users should be engaged – not just families/carers.
- Mental health advocates should be involved
- Public engagement – there may be barriers for involvement with the online community – how else will we work with the public?

Item five: Aligning with national programmes

- ACTION: Attendees were invited to submit a summary in brief of any relevant additional programmes of work via email.
- Programmes include NHS England – learning disabilities programme on premature mortality and the National Confidential Inquiry into suicide and homicide. Also discussed the new role of medical examiners reviewing deaths (from April 2018) and possibility of using independent investigations in trusts as examples.
- ACTION: Attendees to share 1-2 paragraphs on the initiatives they are involved in in this area, for CQC to collate and share.

Item six: Table discussion

What is achievable?

- Concern that the focus on mental health and learning disabilities may get lost due to tight timeframes, but equally important to engage all trusts (not just mental health) – needs to be a balance between broad and narrow.
- Concern around timeframes – being transparent means that we will need to set and manage expectations carefully.

- Can we develop useful recommendations by December?
- The scope is huge – would it be more realistic to divide into work streams to make more manageable (with work continuing past December)?
- Need to provide assurance that broader themes from the report won't be lost, and we need to all commit to future programmes of work.

What will make the most difference?

- The outcome of the review must make a difference to families – needs to be a practical 'family-friendly' solution that we are putting forward.
- Common concern about the fact that trusts do investigations differently – need better guidance to reduce variability.
- Focus on why existing systems aren't working, and highlighting good practice.
- Learning disabilities and mental health should be dominant in the review. Equally this shouldn't be an artificial emphasis, assessing processes for all deaths should be the focus.

AOB

- ACTION: CQC to share contact information of attendees
- ACTION: CQC to establish closed online forum to allow dissemination of information and sharing of ideas and comments from attendees
- ACTION: involve representative from the National Confidential Enquiry into Patient Outcome and Death