Scoping paper

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

1. Background

The Health Secretary has asked CQC to undertake a review of the way in which NHS Trusts investigate deaths and learn from these investigations. This request was part of the Government's response to the Mazars report[1], which was published in December 2015. NHS England commissioned Mazars to review the deaths of people with a learning disability or mental health problem in contact with Southern Health NHS Foundation Trust between April 2011 and March 2015. This was in response to public concern following a series of deaths which the Trust had described as 'expected' and had not investigated, most notably Connor Sparrowhawk's death in July 2013.

Mazars' report was critical of the Trust and found that there had been no effective, systematic management and oversight of the reporting of deaths and the investigations that follow. The Health Secretary and wider stakeholders have questioned whether these issues may be found in other providers across the country, including those beyond mental health and learning disability services, and has asked CQC to review this. Specifically, the Secretary of State for Health, Jeremy Hunt, has asked the CQC to:

- Undertake a review into the investigation of deaths in a sample of all types of 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.

2. CQC's proposed approach

In scoping this work, CQC has identified that many trusts and commissioners are unclear about how they should determine which deaths require investigation, how those investigations should be conducted (including how families should be involved), and how best to embed learning from these investigations to improve practice.

Given this, CQC recommends undertaking a three-part approach to answer the following question:

'What improvements are needed in order for NHS trusts to have robust and effective mechanisms in place to identify when opportunities for prevention of death have been missed and investigate the deaths of patients/service users, allowing learning to be quickly embedded that improves care within organisations and for the system as a whole?'

[1] Mazars (2015); Independent review of deaths of people with a Learning Disability or Mental Health problem in contact with Southern Health NHS Foundation Trust.

This approach incorporates the review of current practice requested by the Secretary of State, but also includes an intervention to ensure that the CQC's efforts, in conjunction with those of its partners in the national system, encourage improvement. This is consistent with CQC's draft strategy for 2016-2021, which includes CQC 'implementing a single shared view of quality' by working with both providers and other system partners and ensuring 'organisations that deliver care are encouraged to improve quality'.

The review will comment on the provider systems in place for investigating deaths in Trusts. In addition, it will pay particular attention to the deaths of individuals who have a learning disability or mental health condition as these will highlight important challenges around local multi-agency working.

This work will involve the following:

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. This will include an assessment of the issues raised by the Mazars report relating to decision making, governance, oversight and the involvement of families. The review will look at the different methods providers apply to identify where opportunities for preventing deaths have been missed, this includes at the point of deaths being reported, during investigations and how this learning is being used to improve practice. For mental health trusts, the review will include processes related to the reporting and investigation of deaths of people in detention (under the Mental Health Act).

This information will be gathered as part of CQC's existing inspection programme and by arranging focused interviews and visits to additional Trusts, as well as data from sources such as NRLS, STEIS, ONS and CQC.

Timeframe: A national report will be published in winter 2016. This will complete the review that has been required by the Secretary of State.

Part 2: In parallel with part 1 of this work, CQC will engage with the work that will be led by national system partners (including NHS Improvement, NHS England, Department of Health and Health Education England) to define and share best practice. This will inform the development of a co-produced framework and tools.

Timeframe: We understand these products will be available by winter 2016

Part 3: To support implementation, the review findings will be used to inform the NHS Improvement, NHS England and Department of Health work to develop system levers to bring about improvement. For CQC, this will include making changes to regulatory processes to take account of our findings.

Timeframe: We understand revised system levers will be in place from spring 2017

3. Coproduction

There has been significant criticism of NHS organisations for not involving families in investigations and related work. CQC is keen to adopt a coproduction approach in this work, through the involvement of individuals and organisations that have been directly affected, as well close work with NHS trusts and providers.

CQC is currently developing an expert reference group, with the support of colleagues in NHS England and NHS Improvement and INQUEST.

4. Project leads

Professor Sir Mike Richards is CQC sponsor for this project, with Paul Lelliott (Deputy Chief Inspector of Hospitals (Mental Health)), Victoria Bleazard (Head of Mental Health Policy) and Kim Forrester (Mental Health Act Policy Manager) leading this work.

5. Next steps

CQC looks forward to receiving feedback on this approach from Department of Health colleagues, and having discussions around how they may wish to be involved in this work.

6. Contact details

Please contact deathsreview@cqc.org.uk