

CQC review of investigations into deaths in NHS trusts

Expert Advisory Group notes

Friday 8 July, 1.30pm – 4.30pm

Item one: Welcome and introductions

Mike Richards (MR) welcomed those present to the second meeting of the CQC deaths review expert advisory group.

Item two: Review update

Victoria Bleazard (VB) thanked the EAG for their support with the review so far. This has included:

- Supporting the development of the assessment framework and the provider survey
- Helping to develop the plans for family engagement.

VB updated on the progress made since the last EAG meeting:

- The project team has met with senior leads at the Department of Health and NHS Improvement to seek their support for the methodology and to ensure that the work is aligned with wider national mortality work.
- Live Q&A sessions have taken place on both the public and provider online communities.
- The project team has presented at key conferences and events including the recent conference dedicated to Learning from Mazars Review into Southern Health and the Mental Health Trust Medical Director event.
- The provider survey has been sent out to trusts and discussions with trusts continue
- Sites for visit have been selected and the schedule has been confirmed.
- The assessment framework has been signed off and tools for the site visits are due to be tested with the inspection teams shortly.

Timelines for the review remain challenging, but we are currently on track to meet our December publication deadline.

Item three: Preparing for the site visits – table discussion

Kim Forrester outlined the plans for site visits:

- Teams will be interviewing a minimum of three people at each trust – this will include the person/s responsible for Board oversight (Chief Executive, Medical Director and/or Nurse Director), the governance lead for systems and processes and the operational leads for identifying, investigating and reporting individual deaths.
- Each of the interviews will focus on a specific KLOE and the questions will be aligned with those in the assessment framework.

During the discussions the group felt that the above were the right people to be speaking with but emphasised that it would be best practice to speak with the Chief Executive, Medical Director and the Nurse Director at all trusts if possible.

The group discussed some of the key questions that they felt teams should be asking on site. These included (but are not limited to):

- What does your trust currently do to identify, investigate and learn from deaths?
- How does the trust ensure that change/learning happens?
- If a patient dies two months after being discharged from your service do you hear about this? If so, who informs you?
- Do agencies share data/information records?
- What has the trust done to address any issues that might exist around identifying people who have died – particularly those that have died off-site or once off of the case-load?
- Is there anything that you think the trusts should be doing in addition to what is currently taking place?
- Do you ask families/carers and/or the GP if they have any concerns following a death? Are families involved in investigations if they want to be?
- Do you feel that your trust genuinely wants to learn and change as a result of investigations?
- Who has access to completed investigations? Do you share the learning from investigations with partners?
- Please could you describe your processes now, and then describe what you would like them to be like in the future.

The group recommended that questions be phrased in an open manner in order to encourage trusts to answer in as candid and transparent a manner as possible.

The group felt that it would be key to look for the following whilst on site:

- List of all patients that have died whilst in receipt of secondary care – does the trust identify deaths of patients who have been discharged?
- The protocols in place for identifying, investigating and reporting on deaths.
- Evidence of Board discussions around investigations of deaths and evidence of actions/learning that have been implemented as a result of the investigations.
- Example investigation reports and SI reports.
- The data available i.e. data base, data reports and the trust's ability to capture and record information.
- Copies of Mortality Review Group agendas and minutes.
- Minutes of the Quality Committee.
- Any equality information that is recorded around deaths.
- Example of training package on deaths and training records.

Item four: Engagement and evidence collecting – families and carers

Families and carers need to be at the centre of the review. VB confirmed that we now have a strengthened plan for engaging with, and collecting evidence from families and carers. Forthcoming activities include but are not limited to:

- An online 'share your experience' form for the public. It is hoped that this will go live on the CQC website within the next few weeks.
- A family event in September and one to one calls with families (where requested)
- Live Q&A sessions on the online communities and Twitter.
- Ongoing sense checking with families and carers (online and at events) around our recommendations.

VB stressed the important role that the EAG members have in helping to raise awareness of the review and the methods by which people can get involved. For example, respective organisations will be able to do this via existing engagement channels as well as on social media.

It was felt that it will be important to capture paid carers' views and experiences in addition to family and friends. The online CQC form will be able to identify different groups, i.e. family members, carers and paid carers.

Those present highlighted the importance of presenting information in plain English. The web pages and all papers relating to the review will need to be accessible for all. ACTION: CQC to check again that all information published so far is written in plain English.

The importance of establishing clear boundaries and managing participant's expectations around what the review can achieve was stressed.

For reasons of transparency it was agreed that the membership of the EAG would be published online. ACTION: CQC to add membership details to the Deaths Review web pages.

Item five: Assessment framework – KLOEs table discussion

After reviewing the four KLOEs Mike Richards requested that the first key question around effective identification and reporting of deaths be split to form two questions. Consequently there will now be five KLOEs.

The group then split into table groups to discuss the barriers and challenges around:

- Identification of deaths
- Deciding which deaths should be subject to investigation
- Completing robust and effective investigations
- Effective Board reporting and learning from investigations of deaths
- Involving families and carers and ensuring organisations are learning from their experiences.

Points raised during the discussions included:

- Systems across all levels of service need to be linked up. This is not currently the case in many organisations, which is proving to be a barrier to effective identification of deaths.
- There is currently a culture of defensiveness amongst many professionals and organisations. This may be borne out of a fear of admitting error and the risk of litigation; however it needs to change if a genuine learning culture is to be established.
- A universal template which all trusts complete when someone dies was identified as a potential solution to problems with variation.
- All present agreed that the new role of Medical Examiner will be a huge leap forward, especially in terms of involving families and carers.
- It was felt that the terms 'expected' and 'unexpected' were unhelpful when identifying deaths that warrant investigation. This also prevents learning as trusts may be missing important lessons where deaths are considered to be 'expected'.
- In many cases there is ambiguity over who is responsible for the investigation of a death. Clarity is also required with regards to the serious incident framework.
- The cost of investigations and the resources needed to investigate a death can also act as a barrier to effective investigation and learning. It was agreed that there should be proportionality between the cost of an investigation and the expected benefits – there was a concern that the review might lead to blanket investigations which wouldn't necessarily

provide value for money if the knowledge was already there and/or learning was acted upon.

- Curiosity must be encouraged amongst Board members. They should be asking for the detail rather than focussing solely on the numbers.
- Trusts may be wary of speaking to families for fear of causing further upset.
- There was a query over whether the right level of competence currently exists around investigation of deaths in trusts.
- It was felt that a single point of contact or a family liaison role could prove beneficial in improving family/carer involvement with investigations.
- Need to consider who the reports are written for. It was noted that one trust writes them for the families. This has been found to improve the quality of the reports and means that reports provide the details around what happened in a compassionate manner. Each report is signed off by the Director of Nursing Standards before it goes out and the trust then takes on board the learning from the investigation.

Item 6: AOB and close

Following the discussions, MR thanked those present for attending and assisting the review team to get a shared view of what issues currently exist and what some of the potential solutions/learning might be. There is a huge potential for this review to have a real impact.

The group queried whether the list of sites visited as part of the review and the results of the provider survey were going to be made public. Concerns were raised about the transparency of the project if the decision was made to not publish. On the other hand, the CQC has publically assured trusts that findings won't be attributable in an effort to encourage candid and honest responses. To publish the results could be seen as a breach of trust between providers and the CQC and may therefore limit the commission's ability to complete future thematic reviews effectively.

Since the meeting, and after discussions with internal colleagues, it has been confirmed that the CQC will publish a list of the sites visited during the review in the final report. However findings will not be attributable.

In addition, the quantitative results (i.e. key data / numbers) from the provider survey will be published. The qualitative responses (i.e. written feedback on what is working well / what the challenges are) won't be published unless there is a specific request. Where this happens the CQC will assess what can and cannot be published under Freedom of Information (FOI) rules.

The date for the next EAG meeting was confirmed as **Tuesday 23rd August 2016**.