Northumberland, Tyne and Wear NHS Foundation Trust

Board of Directors Meeting

Meeting Date: 25 January 2017

Title and Author of Paper:
Trust Update on the Care Quality Commission (CQC) Deaths Review and publication of "Learning, Candour and Accountability".
Dr Damian Robinson, Deputy Medical Director – Safety, Tony Gray – Head of Safety & Security

Executive Lead: Gary O'Hare – Executive Director of Nursing and Operations

Paper for Debate, Decision or Information: Information

Key Points to Note:

Northumberland, Tyne & Wear NHS Foundation Trust was not one of the Trusts visited by the review group, the Trust did participate in webinars and teleconferences during the process and also completed data requests. The Trust's Incident, Serious Incident processes, Trust's Incident and Being Open Guidance were all subject to scrutiny as part of the CQC comprehensive inspection carried out in 2016, no concerns were identified amongst the Trust processes. Trust Safety Leads were interviewed by assessors during the inspection. This gave the CQC an insight into the approaches taken when someone dies in NTW, and was also an opportunity to give an insight into the work-plans to improve this area moving forward.

The CQC has undertaken a review of how Trusts investigate and learn from deaths. The full and summary report was published on 13th December 2016. The summary report is available here . The Full 76 page report is available here

The major findings were:-

- Families and carers were inconsistently involved in the investigation process and felt un-listened to.
- There was variation and inconsistency in how Trusts reported, identified and investigated deaths.
- There was a lack of any consistent framework for informing Boards, or learning from incidents.
- CQC found no single Trust which it considered to have a gold standard system but was able to identify areas of good practice.

The report makes seven recommendations of which only one is directly targeted at provider services (recommendation 7). The remainder are directed to the Secretary of State, National Quality Board, Royal Colleges, Health Education England and NHS Digital. A key overall recommendation was that a single national framework for learning from deaths should be developed.

Recommendation 7 in full states that:-
Provider organisations and commissioners must work together to review and improve their local approach following the death of people receiving care from their services. Provider boards should ensure that national guidance is implemented at a local level, so that deaths are identified, screened and investigated, when appropriate and that learning from deaths is shared and acted on. Emphasis must be given to engaging families and carers.
Provider boards should ensure:

- *Patients who have died under their care are properly identified.*
- *Case records of all patients who have died are screened to identify concerns and possible areas for improvement and the outcome documented.*
- *Staff and families/carers are proactively supported to express concerns about the care given to patients who have died.*
- *Appropriately trained staff are employed to conduct investigations.*
- *Where serious concerns about a death are expressed, a low threshold should be set for commissioning an external investigation.*
- *Investigations are conducted in a timely fashion, recognising that complex cases may require longer than 60 days.*
- *Families and carers are involved in investigations to the extent that they wish.*
- *Learning from reviews and investigations is effectively disseminated across their organisation, and with other organisations where appropriate.*
- *Information on deaths, investigations and learning is regularly reviewed at board level, acted upon and reported in annual Quality Accounts.*
- *That particular attention is paid to patients with a learning disability or mental health condition.*

The findings and recommendations support work the Trust is already doing to improve the investigatory process and subsequent learning.

Risks Highlighted:

- Failure to learn from deaths and prevent future incidents
- Regulatory action from CQC
- Reputational risk from non-compliance with guidance

Does this affect any Board Assurance Framework/Corporate Risks:
Please state Yes or No: No

Equal Opportunities, Legal and Other Implications: None

Outcome Required / Recommendations: For information

Link to Policies and Strategies: Incident Policy NTW(O) 05 . Being Open – Fulfilling Our Duty of Candour – IP-PGN-06

Background

The issue of reporting, investigating and learning from deaths has been of high profile since the review of Southern Health identified serious deficiencies and discrimination against elderly persons and persons with a learning disability (*Independent review of deaths of people with a Learning Disability or Mental Health problem in contact with Southern Health NHS Foundation Trust April 2011 to March 2015"*, published December 2015).

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While Northumberland, Tyne & Wear NHS Foundation Trust were not one of the Trusts visited by the review group, the Trust did participate in webinars and teleconferences and also completed data requests.

The Trust's Incident, Serious Incident processes, Trust's Incident and Being Open Guidance were all subject to scrutiny as part of the full CQC inspection carried out in 2016. No concerns were identified amongst the Trust processes. Trust Safety Leads were interviewed by assessors during the inspection. This gave the CQC an insight into the approaches taken when someone dies in NTW, and was also an opportunity to give an insight into the work-plans to improve this area moving forward.

Current Trust assessment against recommendation 7

This is an initial report to the Board of Directors. A full plan will be shared as part of the next Unexpected Death report which is due in April 2017. New national Serious Incident and Never Events frameworks are due out in March 2017.

The Board of Directors has received regular reports relating to the deaths of those patients who have been in receipt of care, and the outcomes relating to each one since 2009. However it was acknowledged in the original Mazar's report of December 2015 which led to the Secretary of State charging the Care Quality Commission to carry out their deaths review that not all Trusts have taken this transparent and candid approach.

The Safety Team is currently developing a new plan to enhance Learning from Deaths, to ensure it has full and thorough sight of every death that occurs to patients irrespective of whether they fit the current NHS England Serious Incident Framework for Serious Incident investigation.

Over the last year the Safety Team reviewed both the Trust's Incident Policy and the Trust's Complaints Policy as part of a wider review of the governance arrangements within the Trust. This was possible due to the re-alignment of all safety related support services as part of Transforming Corporate Services, and allows for the full use of resources available in which to learn from the Trust's activity.

Throughout 2016 there was a review of safety reporting to Board of Directors, which resulted in a full programme of reports being presented to Board in a more orderly way, and ensuring that the Board is sighted on Safety every month it meets. This plan will

continue throughout 2017, and each report where necessary will include updated national information in relation to any of the other recommendations that begin to be implemented. The Secretary of State has already accepted all recommendations.

All Trusts will need to report on learning from mortality in their Quality Accounts. The first report due in June 2018 covering activity over the 2017/18 financial year

The Healthcare Safety Investigation Branch also launches on April 1st 2017, which will be charged with carrying out independent investigations where there have been safety failings.

Based on all the changes that have been identified or are potentially going to impact on The Trust's Learning and Improvement processes the following draft plan has been constructed and gives a current position which will be further developed over the next 3 months

The more detailed plan will be provided to the Board of Directors in April 2017 as part of the Unexpected Deaths report.

Action:

The Board of Directors are asked to receive this report for information.

LEARNING FROM DEATHS

DRAFT Learning and Improvement Plan as at January 2017

Based on development work under way or as a direct result of Recommendation 7.

"Provider organisations and commissioners must work together to review and improve their local approach following the death of people receiving care from their services. Provider boards should ensure that national guidance is implemented at a local level, so that deaths are identified, screened and investigated, when appropriate and that learning from deaths is shared and acted on. Emphasis must be given to engaging families and carers".

Standard	Current Position	Future Direction	Timescale	Responsibility
Patients who have died under their care are properly identified.	• All deaths are reported through the Trust's Incident reporting system. • An analysis of this information from the national data submission shows a high concordance between incidents reported on the Trust Risk Management System (SafeGuard) and the Full Clinical Patient Record (RiO), which records all deaths reported through the national spine and available through Office for National Statistics around mortality.	• A mortality dashboard will be created which brings together both information systems to assess and analyse to give a zero attrition rate, based on patients that are current to services at death or have been recently discharged from services in the last 6 months.	March 2017	Tony Gray – Head of Safety & Security Dr Damian Robinson – Deputy Medical Director – Safety Kelly Collier – IT Project Team
Case records of all patients who have died are screened to identify concerns and possible areas for improvement and the outcome documented.	• Case records are screened as part of the established investigation processes in line with the NHS England Serious Incident Framework. This covers predominantly unnatural cause deaths	• The Trust Incident Policy will be reviewed to establish a mortality review process, supported by the Alliance Health Service Network and North East Quality Observatory. This will extend coverage to natural cause deaths	June 2017	Tony Gray – Head of Safety & Security Dr Damian Robinson – Deputy Medical Director – Safety
Staff and families/carers are proactively supported to express concerns about the care given to patients who have died.	• This already occurs through established Duty of Candour principles, which has a 3 stage check, and is subject to quarterly monitoring and reporting to the Clinical Commissioning Groups as part of contractual obligations.	• These principles will be extended to all deaths following an assessment of any concerns identified for any non-SI related death, which may include natural and expected deaths following discussions with Directors after implementation of the new mortality review process.	June 2017	Tony Gray – Head of Safety & Security Dr Damian Robinson – Deputy Medical Director – Safety

Appropriately trained staff are employed to conduct investigations.	• The Trust has a central dedicated team of serious incident investigators, supported by lead clinicians from services to review all unexpected deaths in line with the NHS England Serious Incident Framework. • This team has undergone routine investigation training as part of their appraisals and CPD requirements.	• A review of the levels of investigation for non-SI deaths will be agreed and capacity and demand including any increased costs will be reported through to the Trust's Business Delivery Group. • Investigators will be trained in the use of Human Factors Frameworks	June 2017	Tony Gray – Head of Safety & Security Dr Damian Robinson – Deputy Medical Director – Safety
Where serious concerns about a death are expressed, a low threshold should be set for commissioning an external investigation.	• Within existing serious incident processes wherever information comes to light, or there is concern relating to the true independence of investigation, this is escalated to the Executive Director of Nursing and Operations, to seek authorisation to allocate to an external investigator, supported by a lead clinician in the Trust. • The Trust has a panel of external investigators	• Capacity and demand fluctuates for this and likely this will be impacted by a small group of external professionals being available, and facing more request from a number of Trusts in future. • Demand and compliance will be reported through the Trust's Safety Report.	June 2017	Tony Gray – Head of Safety & Security Dr Damian Robinson – Deputy Medical Director – Safety
Investigations are conducted in a timely fashion, recognising that complex cases may require longer than 60 days.	• The Trust reports on its compliance against current 60 working day timescales through the monthly All Incident report which is shared with Clinical Commissioning Groups. Extensions are agreed in advance and by exception. • For cases reviewed in December 2016, 86% complied with the 60 day timescale. In one case an extension had been agreed with the CCG.	• Monitoring of these timescales will continue to be shared with CCG's , but information will start to be included in the Safety Report for Board in the next reporting cycle.	July 2017	Tony Gray – Head of Safety & Security Dr Damian Robinson – Deputy Medical Director – Safety
Families and carers are involved in investigations to the extent that they wish.	• Families and carers are involved at the outset in all investigations, where they are contactable following a death. • Extensions are agreed to delay the investigation at their request due to impact of bereavement. • Reports are shared that answer the specific questions they have, and agreements in place with all coroners where deaths are subject to inquest to	• This approach will need to be considered and included into the mortality review process for Non-SI deaths. •	June 2017	Tony Gray – Head of Safety & Security Dr Damian Robinson – Deputy Medical Director – Safety

	direct concerns or questions to the Trust to be included.			
Learning from reviews and investigations is effectively disseminated across their organisation, and with other organisations where appropriate.	• The Trust has in place an effective dissemination process for learning, starting with the learning from activity update that is shared with all senior staff on a Thursday, which reflects on all the Serious Incidents, Complaints, Complex issues, Coroner outcomes, serious incident reviews of the previous week. This is shared through operational groups by Tuesday at the latest for information. • Other organisations involved in an incident are included once identified as part of the serious incident process, and invited to attend after action reviews and the SI panel discussions. Non-engagement is escalated to Clinical Commissioning Groups and included in SI reports as actions for improvements.	• This approach will need to be considered and included into the mortality review process for Non-SI deaths. • The current Patient Safety Group will be reviewed to create a Trust wide Learning Lessons Group. • A regular Learning Lessons newsletter will be established. • The Trust is working with other MH Trusts in the North/Mazars to develop cross organisational learning.	June 2017	
Information on deaths, investigations and learning is regularly reviewed at board level, acted upon and reported in annual Quality Accounts.	• The Trust has a transparent and open approach to reporting and learning from deaths. • A six monthly analysis of deaths has been presented in the open part of the Board of Directors meeting since 2009. The last 4 years reports are publicly available for scrutiny	• A review of the unexpected death report will ensure that there is a learning and improving section within this, similar to the established safety report. • Data will be reported in the Quality Account from June 2018, in line with DoH guidance	October 2017	Tony Gray – Head of Safety & Security Dr Damian Robinson – Deputy Medical Director – Safety
That particular attention is paid to patients with a learning disability or mental health condition.	• This recommendation is applied across all service providers, and by default would naturally apply to a Mental Health / Learning Disability Trust	• Work needs to be completed to improve the quality of diagnosis of all patients who die, to understand their diagnosis. • In particular, to clarify the recording of a diagnosis of LD where the person is in a non-LD service.	October 2017	Executive Director of Nursing and Operations / Operational Director of Service