Trust Board Meeting
04 May 2017

Title of the paper	**Summary: National Guidance on Learning from Deaths: A framework for NHS Trusts and NHS Foundation Trusts on identifying, reporting, investigating and learning from deaths in care.**
Agenda item	**11/48**
Lead Executive	**Mike Van der Watt, Medical Director**
Author	**Jacqueline Birch, Head of Risk, Assurance & Compliance**
Executive summary **(including resource implications)**	In December 2016 the CQC published Learning, candour, accountability: A review of the way NHS Trusts review and investigate the deaths of patients in England. The National Quality Board has subsequently published their report National Guidance on Learning from Deaths the purpose of which is to help initiate a standardised approach to learning and reviews of deaths. The national guidance provides details of action NHS and Foundation Trusts must take: A review of this national guidance is currently being conducted within the organisation and an action plan will be submitted to the Mortality Review Group for approval and onward monitoring.
Where the report has been previously discussed, i.e. Committee/Group	Safety & Compliance Committee 13 April 2017
Action required • The Board is asked to note the report for information.	
Link to Board Assurance Framework (BAF)	☒ **PR1** Failure to provide safe, effective, high quality care
Trust objectives	☒ To deliver the best quality care for our patients
Benefits to patients/staff from this project/initiatives A systematic approach to the review and investigation of the deaths of people who use our services and the reporting and monitoring of such will facilitate the organisation with ascertaining whether opportunities for preventing a death have been missed and to identify any improvement needed.	
Risks attached to this project/initiatives and how these will be managed Nil identified on the Trust Risk Register.	

Agenda Item: 11/48

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Summary: National Guidance on Learning from Deaths: A framework for NHS Trusts and NHS Foundation Trusts on identifying, reporting, investigating and learning from deaths in care.

Presented by: Mike Van der Watt, Medical Director

1. Purpose

1.1 To provide a summary and actions arising from the national guidance on learning from deaths: A framework for NHS Trusts and NHS Foundation Trusts on identifying, reporting, investigating and learning from deaths in care.

2. Background

2.1 In December 2016 the CQC published Learning, candour, accountability: A review of the way NHS Trusts review and investigate the deaths of patients in England. This report found that learning from deaths is not being given sufficient priority in some organisations leading to opportunities for learning being missed.

2.2 The National Quality Board has subsequently published their report National Guidance on Learning from Deaths the purpose of which is to help initiate a standardised approach to learning and reviews of deaths. The report explains that whilst many patients receive excellent NHS care in the months and years leading up to their death there are some that don't experience good quality care which can be as a result of a number of factors including poor leadership and systems wide failures.

2.3 The national guidance acknowledges that when mistakes happen providers must work more with their partners to understand the cause and that reviews and investigations of deaths to establish if problems in care have contributed to the death are only useful for learning if their findings are shared and acted on.

2.4 The link to the full report is below:

https://www.england.nhs.uk/wp-content/uploads/2017/03/ngb-national-guidance-learning-from-deaths.pdf

3. Analysis/Discussion

3.1 The national guidance provides definitions of case record review, investigation and death due to a problem in care and details action NHS Trusts and Foundation Trusts must take:

Governance and capability:

To fulfil the standards and new reporting set out in the national guidance Trusts must ensure their governance arrangements and processes include, facilitate and give due focus to the review, investigation, reporting of deaths and sharing subsequent learning, including deaths that are determined more likely than not to have resulted in problems in care.

Key points include Trusts:

- Having an executive director with responsibility for the learning from deaths agenda and an existing non-executive director responsible for oversight of progress.
- Paying particular attention to the care of patients with a learning disability or mental health needs.
- With quality improvement being the objective having a systematic process for the identification and methodology for the review of deaths, ensuring that nominated staff have the appropriate skills and time to do this, and that outcomes including learning are reported to the Board.
- Timely, compassionate and meaningful engagement with bereaved families and cares during all stages of responding to a death with providers having a clear policy in place for this.
- The inclusion of learning from reviews and investigations in the Trust's quality Account.

Improved data collection and reporting

The national guidance has set out a number of minimum requirements to complement providers' current approaches in relation to reporting and reviewing deaths and these include:

- Each Trust publishing an updated policy by September 2017 on how it responds to, and learns from, deaths of patients who die under its management and care. The policy must include:
    - How its processes respond to the death of an individual with learning disability, mental health needs, an infant or child death and a still birth or maternal death.
    - Using an evidence based methodology relating to case note reviews for reviewing the quality of care to patients who die (acute Trusts).
    - Categories and selections in deaths in scope for case record review.

- A requirement for Trusts, from April 2017, to collect and publish, on a quarterly basis at Trust Board, specified information on deaths. This quarterly report should set out the Trust's policy and approach (by the end of Q2) and publication of the data and learning points (from Q3 onwards). A summary of this data must be included in the Quality Accounts from June 2018.

Further developments

In 2017/18 further developments will include:

- The CQC will strengthen its assessments of providers learning from deaths.
- NHS England will develop guidance for bereaved families and carers.
- Acute Trusts will receive training to use the Royal College of Physicians' Structure Judgement Review case not methodology.
- NHS Digital is assessing how to facilitate the development of systems and processed so that information from reviews and investigation can be collected in a standardised way.
- The Department of Health is exploring proposals to improve the way complaints involving serious incidents are handled particular I respect to learning between providers and the wider healthcare system.

8.2 A review of this national guidance is currently being conducted within the organisation and an action plan will be submitted to the Mortality Review Group for approval and onward monitoring.

4. Risks

4.1 Nil identified on the Trust Risk Register.

5. Recommendation

4.2 The Board is asked to note the report for information.

Mike Van der Watt, Medical Director

Date 25 April 2017