Care Quality Commission: How can we assess how well providers review, investigate and learn from deaths?

Survey questions

1. Do the proposals we've set out meet the recommendation for CQC at the end of our report 'Learning, candour and accountability'?

Yes, Fellows of the College and members of our Lay Advisory Committee felt the proposals set out a comprehensive approach. There are at least two key facets: firstly, timely investigation of a death where there are concerns – a process similar to Serious Untoward Incident (SUI) investigation where there is NHS Trust scrutiny and disseminated learning. Secondly is encouraging broader mortality review – ideally at specialty level, deaths are screened and triaged and a proportion subject to local review. The key is to ensure that there is local learning. Cases with concern are escalated centrally but for most the process supports localism. The CQC should be interested in both facets. The first, which will be centrally driven in a Trust, can seem distant from the frontline of the workforce.

This call for views is welcome especially at a time where patients and relatives are more empowered (and have a voice) to inquire into the circumstances of care/deaths. The process for ensuring that the system is robust and meets the needs of the public who represent patients and relatives is essential.

2. Which element of our approach do you think is the most valuable? Please number them in order of priority

- Monitoring and relationship management **2**
- Inspection interviews **1**
- Risk based review of investigations of individual deaths **3**

3. What do you think the most important information we should be monitoring is?

The College feels that this should include basic data such as the proportion of deaths that were reviewed; setting out the arrangements for screening deaths and establishing how the Trust engages with families and any concerns? What do service users and their supporters think of the service? Systems for the dissemination of learning should also be monitored: understanding of the lessons to be learned and how this translates into medical training/ education / and a culture manifested by candour and honesty.

4. When we inspect care providers, who should we talk to?

1. Where possible, present service users.

2. Staff working at the frontline: junior staff and consultants to assess how well Trust wide learning is cascading downwards.

3. Families /carers and guardians.

4. Service managers: including, senior management, as part of the well-led domain; the risk lead or whichever department has responsibility for mortality review; the education lead to assess how well information goes from board to ward to junior doctors and nurses.

5. What questions should we ask?

These should include questions around systems and processes, screening and triage; involvement of families around concerns; and establishing how is learning disseminated in the Trust.

The questions should be standardised as much as possible to allow consistency of approach. Before questioning begins, it will be necessary to have had access to policies and procedures in order to ascertain if there are gaps between theory and reality of practice.

6. We plan to review up to four cases of deaths that have been investigated in a selection of trusts. How should we decide which trusts to look at?

It has been suggested that three should be selected from Trusts about which concerns have been expressed either by service users or staff and one at random.

7. What else should we consider when assessing whether the trust has an open and learning culture?

Only the actions of the Trust, its 'leaders' and the reactions of service users, families and staff will reveal this.

8. Tell us what you think is good practice. What *should* NHS trusts do?

- An open culture, driven from the board level is vital: there should be a board member with specific responsibility for driving forward this agenda.
- An effective triage system of all deaths with a mechanism to feed in family views.
- A timely response from trained staff that have time to investigate, coupled with a collation process and effective cascade throughout the institution.
- Evidence of strong local processes, so that there is learning from deaths even when they don't trigger a Trust wide response.