

Care Quality Commission's Learning from deaths – a review of the first year of NHS trusts implementing the national guidance

Introduction and summary

The Care Quality Commission (CQC) has today published **Learning from deaths – a review of the first year of NHS trusts implementing the national guidance**. The report reviews CQC inspectors' observations from the first year of assessing how well trusts are implementing national guidance on learning from deaths. National guidance for trusts on a standardised approach to learning from deaths and working with families were introduced in response to the findings of CQC's 2016 thematic review **Learning, candour and accountability**, which made a number of recommendations to help to improve the quality of investigations into patient deaths. This briefing summarises key findings from today's report, but for a comprehensive overview of the enablers and barriers to putting the guidance into practice, we encourage providers to read the report in full.

Key points:

- CQC's review finds that awareness of the guidance is high. Inspections have found evidence of some trusts having taken action to revise policies and establish more robust oversight of the investigation process to ensure learning is shared and acted on.
- Overall, CQC found that the key to enabling good practice is: an open and learning culture; clear and consistent leadership; values and behaviours that encourage engagement with families and carers; positive relationships with other organisations; and the ability to support staff with training and the wider resources needed to carry out thorough reviews and investigations.
- However, progress made to date varies between trusts and some organisations have found it harder than others to make the changes needed. In particular, improving engagement with bereaved families and carers is an area where some providers have struggled.
- Issues such as fear of engaging with bereaved families, lack of staff training, and concerns about repercussions on professional careers, suggest that cultural issues within some organisations may be a barrier to putting the guidance into practice.
- The report includes a case study analysis of three NHS hospital trusts – West Suffolk NHS Foundation Trust, Greater Manchester Mental Health NHS Foundation Trust and Norfolk Community Health and Care Trust – that have demonstrated areas of good practice in implementing changes to improve investigations and learning when patients in their care die.

- Following this review CQC has committed to further strengthening its assessment of how trusts are investigating and learning from patient deaths and to providing additional support and training for inspection staff involved in monitoring and inspecting trusts progress.
- CQC also set out where the challenges lie for the Learning from Deaths programme to continue to support implementation, and to make sure that learning from deaths remains a priority for the NHS so there is the necessary investment made by trusts.

How well are trusts implementing the guidance?

- How trusts are implementing the learning from deaths guidance varies. Trusts are at different stages of implementing the guidance, with some finding it more difficult than others to make the changes needed.
- Awareness of the national guidance is high, and some trusts are taking action to revise policies and establish oversight of learning from deaths.
- However, there is some, albeit limited, evidence to suggest that the guidance is better suited to acute trusts rather than mental health or community services.

Enablers and barriers to good practice

This chapter looks at the themes that CQC found were supporting or inhibiting trusts' ability to improve. In addition to the factors highlighted below, CQC identified existing capabilities, good governance and oversight, and the financial resources of a trust as other contributing factors.

Values and behaviours that encourage engagement with families and carers and support for staff

- There was variation in how well trusts are engaging meaningfully with bereaved families and carers. CQC saw ad hoc engagement with families and carers in some trusts, where contact with families and carers had only taken place after a serious incident or complaint. More needs to be done to make sure that bereaved families and carers are involved from the start.
- CQC inspection staff found that staff can sometimes be fearful of engaging with bereaved families and carers. The reasons for this could be linked to a lack of skills or confidence to contact bereaved families, a fear of adding to families' distress and grief, a culture of blame and concerns about potential repercussions on professional careers. Trusts need to invest and support their staff so they have the appropriate skills and resources to engage with bereaved families and carers in a meaningful and compassionate way.
- However, CQC has seen some examples of positive engagement with families and carers, where trusts had clear pathways of contact, an open and transparent approach to engagement, and showed compassionate communication with families.

Clear and consistent leadership and governance

- CQC's first year of inspecting trusts' implementation of the guidance suggests that having a specific person, at a reasonably high level in the trust, responsible for leading on the learning from deaths agenda is key to driving the work forwards.
- Clarity over who is responsible, 'churn' in the leadership team and support from the board were potential influences on trusts' ability to implement the national guidance.
- CQC saw evidence that strong existing governance and processes, such as review groups and systems for learning from deaths, was also a factor.
- CQC has seen that challenge and interest at board level are important to make sure that these governance arrangements are robust and well adhered to. CQC found good governance is also important in ensuring that the lessons learned from reviews are shared and acted on.

Open and learning culture

- CQC found that the existing culture of an organisation can be a key factor in trusts' ability to implement the guidance on learning from deaths. CQC inspection staff observed a difference between an open, transparent, no-blame culture that is focused on learning, and an inward-looking, fearful culture, which can manifest in defensiveness and blame.
- As highlighted in the section on engagement with families and carers, negative cultural factors can include a fear of litigation, public perception, or confrontation with families, and a failure to engage staff with the trust's cultural values or empower them to raise concerns.
- To truly learn from serious incidents in the NHS, there needs to be a culture where staff, patients and leaders all feel able to speak up and work collaboratively to learn.
- Positive cultural factors observed by the CQC included staff at all levels feeling able to speak up, a working environment that feels like "a collaborative team, rather than a directional board downwards team", strong patient focus, engagement of medical staff (particularly consultants), and a desire to learn as a central value of the organisation. It can also have an effect on how quickly processes are put in place and how likely any learning from reviews of deaths is shared.
- CQC found that culture can also influence other factors in learning from deaths, including how a trust works with partner organisations who share the responsibilities for caring for that person, and how a trust involves bereaved families in the review, investigation and learning process.

Providing staff with resources, training and support

- Having sufficient resource (in terms of staff capacity and capability, support and training) is an important factor in a trust's ability to deliver effective reviews and investigations. Not all trusts are in an equally good position to allocate appropriate resource to learning from deaths. CQC has seen that trusts can face challenges in providing support and training, allowing staff time away from clinical duties and protecting time to carry out reviews.

- Factors that influence trusts' ability to allocate resources include funding and commissioning, competing priorities – such as those brought about by organisational restructures – and the willingness of the board to provide adequate resources to learning from deaths.
- Where CQC has seen good practice, this has been related to freeing people up from clinical commitments to take responsibility, protected time for reviews and training, and support from board and clinical commissioning groups (CCGs) for resource, such as a medical examiner or mortality technician.

Engaging with partner organisations delivering care

- There was some evidence that the quality of existing relationships between organisations can affect how well trusts are working with partners on investigations into deaths. A lack of incentive or support for building relationships between system partners can be a barrier to collaborative investigations into deaths.
- Difficulties in sharing information can also be a barrier. This was mentioned about obtaining information from GPs, a lack of established systems or routes for sharing information, and working across multiple CCGs.
- Inspection staff felt that CCGs could play a bigger role in encouraging learning to be shared and collaboration, but noted that differences in approach and levels of support can be a problem, particularly for trusts that work with multiple CCGs.
- CQC heard concerns about data protection when sharing information could be a barrier. Trusts need to be confident that they understand the data protection rules and regulations, and that these are being appropriately applied when implementing the national guidance on learning from deaths.
- However, CQC has seen pockets of good practice, for example one trust had begun to build relationships with primary care colleagues, which included starting to work with GPs about the standard judgement framework.
- Other inspection staff felt that CCGs were in a position to enable relationships between trusts and primary care, but felt that this would only be possible where they covered the hospital and the GP practice.

Learning, next steps and recommendations

Actions for NHS trusts

- CQC are at the beginning of the implementation of the learning from deaths guidance, but a first look at this early stage suggests that implementation of the guidance by trusts is variable.
- CQC's findings have highlighted a lot of the same issues that were raised in its original Learning, candour and accountability report, and have shone a light on the need for NHS providers to act now to build on the key drivers for change. These include:
 - encouraging values and behaviours that enable engagement with families and carers as well as support for staff.

- providing clear and consistent leadership at a senior level with challenge and oversight from non-executives.
- creating a positive, open and learning culture where people who use services, and staff, feel confident to speak out.
- providing staff with the time, support and training to carry out robust reviews and investigations of deaths.
- developing positive working relationships with partner organisations to share information and learning following the deaths of people for whom they have provided care.
- There is no one factor that guarantees good practice, with enablers and barriers to implementing the guidance interrelated. However, the existing culture of an organisation can be a key factor in trusts' implementation of guidance, and could be preventing trusts from making the progress needed.
- Where CQC has seen examples of good practice, trusts have built on existing processes, cultures and expertise in reviewing, investigating and learning from sources of feedback. This means that when trusts do not have these characteristics in place at the start, they need to take a long-term view to start to invest and build the necessary capabilities and capacities over the next few years.

Actions for the Learning from Deaths Programme Board and CQC

- There are actions that others, including the Learning from Deaths Programme Board and CQC, need to take to provide further support to NHS providers and families and carers in developing their approach to learning from deaths.
- There has been comment about what the Learning from Deaths programme needs to do next to continue to support implementation, and to make sure that learning from deaths remains a priority for the NHS so there is the necessary investment made by trusts. These challenges include:
 - how to align the work with related policy initiatives on introducing medical examiners, safety improvement, complaints and concerns so there is coherence and consistency in the approach.
 - the need to further develop a system-wide view on learning from deaths that includes clarity on which organisation leads on a death that occurs outside of a hospital, and how to encourage information sharing across providers (including GPs), when investigating the death of a person who receives care from different NHS or other organisations.
 - the need for a focused assessment of the progress made on reviews and investigations of deaths of people with mental health problems or a learning disability (working with partners such as the Learning Disabilities Mortality Review (LeDeR) programme).
 - improved support from a single set of consistent guidance for staff that is agreed across national bodies, including NHS Improvement and Healthcare Safety Investigation Branch, that helps them to carry out robust reviews and investigations of deaths and serious incidents. This should include children, people with a learning disability, people with mental ill-health and mothers.
 - the need to analyse and monitor the investment made by NHS providers in resources in learning from deaths, in terms of training and support and dedicated staff time to carry out reviews and investigations.

- CQC are committed to providing further support and training for CQC inspection and other staff in understanding what good reviews and investigations look like, as well as how to engage sensitively with bereaved families and carers to hear the learning from their experiences of care. CQC will continue to monitor progress by trusts through its monitoring and inspection processes.

NHS Providers media statement

Responding to Learning from deaths – a review of the first year of NHS trusts implementing the national guidance by Care Quality Commission, Miriam Deakin, NHS Providers Director of Policy and Strategy, said:

“When a person dies under NHS care it is vital to ensure that opportunities to learn and improve care are not missed.

“It is encouraging to see that trusts’ awareness of new national guidance on learning from deaths is high, and that some – though not all – have made good progress.

“We welcome this report which offers practical examples of good practice by trusts, together with useful insights on the changes needed to support a better approach.”

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