EXPLANATORY MEMORANDUM TO

THE NATIONAL HEALTH SERVICE (QUALITY ACCOUNTS) (AMENDMENT) REGULATIONS 2017

2017 No. 744

1. Introduction

1.1 This explanatory memorandum has been prepared by the Department for Health and is laid before Parliament by Command of Her Majesty.

2. Purpose of the instrument

2.1 These Regulations amend the National Health Service (Quality Accounts) Regulations 2010. They require NHS Trusts and NHS Foundation Trusts (apart from ambulance Trusts) to report on the number of their patient deaths which have occurred during a reporting year (1 April to 31 March) as part of their Quality Accounts. The information provided in the Accounts must include the number of deaths in the reporting period which have been reviewed (whether by case record review or an investigation), how many of those deaths the Trust considers are more likely than not to be due to problems in care provided to the patient, and a description of what the Trust has learnt and the action it has taken as a result of the reviews.

3. Matters of special interest to Parliament

Matters of special interest to the Joint Committee on Statutory Instruments

3.1 None.

Other matters of interest to the House of Commons

3.2 As this instrument is subject to negative resolution procedure and has not been prayed against, consideration as to whether there are other matters of interest to the House of Commons does not arise at this stage.

4. Legislative Context

4.1 Section 8 of the Health Act 2009[1] requires NHS healthcare providers to publish annual reports on the quality of their services (Quality Accounts).

4.2 The National Health Service (Quality Accounts) Regulations 2010 ("the 2010 Regulations") specify the information which must be contained in Quality Accounts. These Regulations amend the 2010 Regulations to specify additional information on patients which must be included.

5. Extent and Territorial Application

5.1 The extent of this instrument is England and Wales.

5.2 The territorial application of this instrument is England.

[1] Health Act 2009 (c.21) - http://www.opsi.gov.uk/acts/acts2009/ukpga_20090021_en_1

6. European Convention on Human Rights

6.1 As the instrument is subject to negative resolution procedure and does not amend primary legislation, no statement is required.

7. Policy background

What is being done and why

7.1 On 13 December 2016, the Care Quality Commission (CQC) published *Learning, candour and accountability: A review of the way NHS trusts review and investigate deaths of patients in England*[2].

7.2 The review was commissioned by the Secretary of State for Health and examined how acute, mental health and community NHS Trusts and NHS Foundation Trusts identify, review, investigate and learn from deaths of people under their care and management.

7.3 The CQC's review report concluded that learning from deaths is not being given enough consideration in the NHS and that opportunities to improve care for future patients are being missed. None of the Trusts that the CQC approached could demonstrate best practice across every aspect of identifying, reviewing and investigating deaths and ensuring that learning is implemented. The CQC also reported that Trusts need to do more to engage bereaved families and carers and to recognise their insights as a vital source of learning.

7.4 In an oral statement made to Parliament[3] on the same day, the Secretary of State accepted all the CQC's recommendations for improvement.

7.5 In that statement, the Secretary of State also made commitments to improve the way that Trusts identify and learn from deaths of patients in their care. This included a requirement for individual Trusts to publish specified data on the deaths of their patients on a quarterly basis from 2017-18, including estimates of those deaths assessed as more likely than not to have due to problems in healthcare, and evidence of learning and improvements that are happening as a result of this data in annual Quality Accounts from June 2018. The Secretary of State said that these changes would be made in accordance with regulations that he would lay before Parliament.

7.6 A key recommendation from the CQC was that there should be a national framework for Trusts to support good quality reviews and investigations of deaths, learning and implementing quality improvements, and improved engagement with bereaved families and carers. The National Quality Board responded to the recommendation by publishing the first edition of *National Guidance on Learning from Deaths* on 15 March 2017[4]. The guidance applies to NHS Trusts and NHS Foundation Trusts (apart from ambulance Trusts) to mirror the Trust types that the CQC approached during its review. The guidance clarifies that each Trust is expected to publish every quarter (from Q3 of 2017-18) through a paper and agenda item to a public Trust Board meeting:

(a) the total number of deaths of people who its considers to be within its scope;

(b) the number of deaths that have been reviewed whether by case record review or an investigation; and,

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[2] http://www.cqc.org.uk/content/learning-candour-and-accountability

[3] https://www.gov.uk/government/speeches/cqc-review-of-deaths-of-nhs-patients

[4] *National Guidance on Learning from Deaths* is available at https://improvement.nhs.uk/resources/learning-deaths-nhs-national-guidance/

(c) an estimate of how many deaths were thought more likely than not to have resulted from problems in care.

7.7 These Regulations require Trusts to set out in annual Quality Accounts the total number of their deaths in a reporting year (from 1 April to 31 March), the number of those deaths reviewed or investigated, and of those, the number of deaths judged to have been avoidable due to problems in healthcare. Trusts are required to set out these figures in their Quality Accounts broken down by each quarter where this information may be taken from quarterly information they published in response to *National Guidance on Learning from Deaths*. Trusts are also required to report in their Quality Accounts how they are making their data publically available on a quarterly basis. Where a limited number of reviews or investigations may not have been completed in time for inclusion in the Quality Accounts for the year in which the deaths occurred, these Regulations require them to be reported on separately in the Accounts for the following year.

7.8 The Regulations also require Trusts to provide a narrative description about what they have learnt from their case record reviews and investigations of deaths in the reporting period, a description of what actions they have taken in the reporting period and propose to take following that reporting period, and an assessment of the impact of actions that they have taken.

7.9 The Regulations will cover 2017-18 and therefore Quality Accounts of June 2018, and thereafter.

7.10 The quarterly publication of data by Trusts cannot support comparisons between organisations. Reviews of deaths in the NHS involve a complex assessment and a relatively uncertain and subjective judgement. Variation exists also because different methodologies to review or investigate deaths exist. The new reporting arrangements are not about making comparisons but about supporting a platform for Trusts to identify and act on systemic and other problems relating to healthcare that could contribute to patient harm, thereby helping to stimulate quality improvement.

7.11 The new reporting arrangements and *National Guidance on Learning from Deaths* area about complementing Trusts' existing approaches to handling deaths. Ultimately the government would like to see providers of NHS services becoming more willing to admit to and learn from mistakes so that they can reduce risks to future patients and avoid tragedies happening in the first place.

7.12 A Learning from Deaths Programme Board, comprising senior representatives from a number of organisations including the Department of Health, NHS Improvement, CQC, NHS Digital and NHS England, is overseeing implementation of the recommendations in the CQC review report. The CQC's other recommendations include:

(a) NHS England to deliver guidance for Bereaved Families and Carers;

(b) NHS England to build on existing work to reduce premature mortality for patients with a learning disability or severe mental illness;

(c) NHS Digital to assess how to facilitate the development of provider systems and processes to help alert providers to all their deaths including when patients die outside their services;

(d) Healthcare Safety Investigation Branch to work with Health Education England and others to improve Trust investigations through training and capacity building.

7.13 The CQC will also strengthen its assessment of Trusts' learning from deaths.

Consolidation

7.14 These Regulations amend the 2010 Regulations. The Department currently has no plans to consolidate these Regulations.

8. Consultation outcome

8.1 A formal consultation has not been undertaken in relation to these Regulations. Informal consultation with Trusts has included:

(a) a letter from NHS England and NHS Improvement of 6 January 2017 setting out the reporting arrangements for Quality Accounts[5];

(b) a letter from CQC and NHS Improvement of 22 February 2017 to medical directors of all acute, mental health and community NHS Trusts and NHS Foundation Trusts;

(c) an updated section on Quality Accounts on the *NHS Choices* website[6];

(d) *National Guidance on Learning from Deaths* published by the National Quality Board on 15 March 2017; and,

(e) a national conference on learning from deaths held on 21 March 2017 for medical directors and non-executive directors of all acute, mental health and community Trusts[7]. At the conference, Trusts and families:

- heard from the Secretary of State and other NHS leaders about why the new approach on learning from deaths is being implemented, including the proposed amendments to the 2010 Regulations;
- discussed what is expected of Trust boards;
- discussed how Trust boards can best ensure that *National Guidance on Learning from Deaths* is implemented at a local level including the new reporting requirements, and that learning from deaths is shared and acted on; and,
- heard from Trusts who have made good progress in implementing mortality reviews.

8.2 The national conference was attended by 456 individuals including 197 executive directors (or deputies) and 130 non-executive directors from Trusts. Attendees had the opportunity to table questions in relation to specific aspects of the learning from deaths programme and of those attendees who responded, 78% rated the event 4 or 5 out of 5 for usefulness.

9. Guidance

9.1 Guidance for these Regulations is set out in *National Guidance on Learning from Deaths* which is available at https://improvement.nhs.uk/resources/learning-deaths-nhs-national-guidance/.

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[5] www.nhs.uk/.../quality-accounts/.../nhs-quality-account-reporting-arrangements.pdf

[6] http://www.nhs.uk/aboutNHSChoices/professionals/healthandcareprofessionals/quality-accounts/Pages/about-quality-accounts.aspx

[7] https://improvement.nhs.uk/events/learning-deaths-nhs/

10. Impact

10.1 There is no impact on business, charities or voluntary bodies.

10.2 The changes in this instrument are not expected to cause Trusts additional costs in producing Quality Accounts.

10.3 An analysis of the current costs for Trusts of reviewing and investigating deaths is included in the CQC review report. It suggest that there is likely to be considerable variation between organisations, including because of the different methods and levels of staff that Trusts use when undertaking reviews and investigations. However, a common theme cited by Trusts to the CQC around the benefits of reviews and investigations included providing closure and reassurance to those close to the deceased, and learning from incidents to ensure care is improved. Quarterly reporting by Trusts (paragraph 7.6) and expectations of *National Guidance on Learning from Deaths* seek to complement Trusts' existing approaches in relation to handling deaths. For example, the guidance states that Trusts should identify an existing executive director to be 'Patient Safety Director' with responsibility for the learning from deaths agenda and an existing non-executive to take oversight of progress. The guidance also states that Trusts should update and publish policies about how they respond to and learn from deaths of patients who die under their management and care. The Learning from Deaths Programme Board will agree at which point an assessment of the impact of these developments aimed at strengthening mortality governance should be undertaken. However, variation in systems and processes will continue, meaning that the way Trusts identify, review, investigate and report on death as well as act on and share learning, and associated costs, will continue to vary between organisations.

10.4 The impact of Quality Accounts on the public sector is an improvement in the quality of NHS healthcare, and of provider boards' accountability to the public whom they serve. The policy Impact Assessment was produced for the 2010 Regulations (S.I. 2010/279)[8].

11. Regulating small business

11.1 The legislation does not apply to activities that are undertaken by small businesses.

12. Monitoring & review

12.1 Quality Accounts policy will continue to be examined between the Department of Health and its stakeholder organisations such as NHS Improvement and tested against the experiences of frontline practitioners and management, and patients and the public.

13. Contact

13.1 Shaleel Kesavan at the Department of Health (Tel: 01132 545954 or email: shaleel.kesavan@dh.gsi.gov.uk) can answer any queries regarding this instrument..

[8] http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalasset/dh_112461.pdf