

Date:  
**22 February 2017**

To:  
**Medical directors of acute, mental health and  
community foundation trusts and NHS trusts**

Dear colleagues,

### **Learning from Deaths**

In December last year, the Care Quality Commission published its review *Learning, candour and accountability: A review of the way NHS trusts review and investigate deaths of patients in England*. In response, the Secretary of State accepted the reports' recommendations and made a range of commitments to improve how the NHS learns from reviewing the care provided to patients who die.

This letter gives an initial indication of what these commitments mean for Trusts and Foundation Trusts, including new requirements that will come into effect from April this year. It is a reminder that in some areas, providers will need to make preparations now to be ready to fulfil their new responsibilities from April.

Fundamental to the commitments are strengthened governance and capability, increased transparency through improved data collection and reporting, and better engagement with families and carers. This letter covers each of these and concludes with next steps and further tools that will be available to support implementation by NHS Trusts and Foundation Trusts. A non-executive director along with an executive director responsible for mortality have been invited to a national *Learning from Deaths* conference on 21 March to discuss this agenda and to input into further development of guidance and associated tools.

Learning from the care provided to patients who die is, of course, a key part of clinical governance and quality improvement work. These new requirements are designed to complement your existing approaches, introducing minimum standards and reporting in some areas but not seeking to replace current good practice.

These new requirements are part of a broader programme of initiatives on learning from the care provided to patients who die that flows from the Secretary of State's commitments. This programme will be rolled out over the coming year, and will include new guidance, training and processes, the most immediate of which are covered in the last section of this letter.

### **Governance and capability**

To fulfil these new expectations Trusts will need to adapt **governance arrangements and processes** to accommodate the review and reporting of deaths,

including those that are assessed as having been more likely than not to have been caused by problems in care, as well as sharing and acting upon the learning derived from this process.

An important early step is for each Trust or Foundation Trust to identify an **executive director** to take responsibility for this agenda and a **non-executive director** to be responsible for oversight of progress. Executive directors responsible for leading on mortality and non-executive directors responsible for quality oversight are likely to be well-placed to take on these responsibilities.

Providers should also review **skills and training** required to support this agenda. For example, this should include ensuring that staff reporting deaths have appropriate skills through specialist training to review and investigate deaths associated with problems in care. The Royal College of Physicians has been commissioned to provide training in case record review skills to all acute NHS providers and more information on this will be provided in due course.

The Care Quality Commission's report stressed the importance of **how providers engage with bereaved families and carers**, including enabling more effective learning from the care provided to their loved ones. Further guidance on this is being developed. In the meantime, Trusts and Foundation Trusts should ensure that they have appropriate engagement processes in place so that families and carers receive candid, sensitive and timely communications in the event of a family member's death, and are invited to express any concerns about the care their loved one received.

### **Improved data collection and reporting**

From April, NHS Trusts and Foundation Trusts must **collect and publish, on a quarterly basis, specified information on deaths**, including those that are assessed as more likely than not to be due to problems in care, and evidence of learning and action that is happening as a consequence of this information:

- This should cover the total number of the provider's in-patient deaths, the subset of these that the provider has subjected to case review and, following application of the Structured Judgement Review methodology, estimates of how many deaths were thought more likely than not to have been related to problems in care.
- A full version of the Structured Judgement Review methodology under development by the Royal College of Physicians will be provided to you as part of more detailed guidance, for imminent publication. This will be accompanied by a suggested dashboard.
- The data in the dashboard should be collected and published on a quarterly basis together with relevant qualitative information, interpretation of the data, and what learning and related actions your organisation has derived from it.
- This data should be collected from April for an initial quarterly publication in June. Our suggested best practice in publication would be a paper and an agenda item to a public Board meeting in each quarter.

Forthcoming changes to the **Quality Accounts** regulations will require these data to be summarised in your Trust's June 2018 Quality Accounts. This will need to include an assessment of the impact of actions that your Trust has taken as a result of the information that you have collected.

To underpin this improved data collection and reporting each Trust and Foundation Trust should publish its **policy for undertaking case record reviews**. We would expect this policy to be aligned with the Structured Judgement Review methodology.

For mental health and community trusts, this guidance should be used as a starting point, but will require adaptation to reflect patient and clinical circumstances. Further, imminent guidance from the National Quality Board, see below, will include more detail on how adaptations can be made. Case reviews of patients with learning disabilities should also be aligned with guidance developed as part of the Learning Disabilities Mortality Review (LeDeR) Programme.

In particular, your organisation's policy should include its approach in the following areas:

- **Definition of the total number of deaths in scope for case review.** Some people die shortly after having been in-patients but the circumstances of their death should still be subject to case review where possible. Trusts will need to set out which of these deaths should be in scope of their policy. A minimum suggestion for acute organisations would be all in-patients, plus Emergency Department cases.
- **Selection of deaths for case review.** Providers continue to have flexibility to set their own policy, but in response to the Commission's report there should be some standardisation of approach. At a minimum, policies should require reviews of the following cases:
  - All deaths where family, carers or staff have raised a concern about the quality of care provision;
  - All deaths of those who are identified to be significantly disadvantaged, particularly all deaths of those with Learning Disabilities and all deaths of those identified with severe mental illness;
  - All deaths in a service specialty, particular diagnosis or treatment group, where an 'alarm' has been raised with the Trust through whatever means. For example, via a Hospital Standardised Mortality Ratio (HSMR) elevated mortality alert, concerns raised by audit work or by the Care Quality Commission or another regulator;
  - All deaths of patients subject to care interventions from which a patient's death would be wholly unexpected, for example in relevant elective procedures;

- Deaths where learning will inform the organisation's existing or planned improvement work, for example if work is planned on improving sepsis care, relevant deaths should be reviewed, as determined by the Trust;
- A further sample of other deaths should be selected that do not fit the identified categories, to ensure Trusts can take an overview of where learning and improvement is needed most overall. This does not have to be a random sample, and could use practical sampling strategies such as taking a selection of deaths from each day of the week.

These minimum requirements add to, rather than replace existing requirements for Trusts to undertake case reviews for specific groups of patient deaths.

### **Fit with existing processes**

Each provider's response to any findings from case record reviews must be coordinated within existing clinical governance processes. This will not only ensure this information is not viewed in isolation and that any local response is considered in the round, it will also mean that information on safety issues generated via case record review will be fed into existing local risk management systems and onwards to the National Reporting and Learning System.

Specifically, where case record review identifies a problem in care that meets the definition of a patient safety incident (any unintended or unexpected incident which could have or did lead to harm to one or more patients receiving NHS care) this should be reported via local risk management systems to the National Reporting and Learning System (NRLS).

All patient safety incidents reported as resulting in death or severe harm to a patient are clinically reviewed by the national patient safety team to determine if there are implications for national learning and if a response is appropriate. More information on the national process is available at <https://improvement.nhs.uk/resources/patient-safety-alerts/>.

All Serious Incidents that are patient safety incidents and are identified via case record review should be reported to the NRLS for the same reason.

### **Next steps, including further tools**

To support Trusts on this agenda, a range of further tools will be made available over coming months:

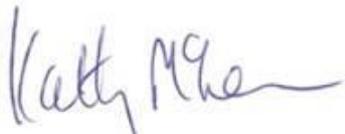
- **Guidance from the National Quality Board** on learning from deaths. This will set out expectations of NHS Trusts and Foundation Trusts, advise on the role of their non-executive directors to challenge boards about mortality governance and the reporting of deaths due to problems in care, and provide tools and resources. These will include the Royal College of Physicians Structured Judgement Review case note methodology and the reporting dashboard. This national framework will be published in March in time for the *Learning from Deaths* conference.

- A **training programme** for all Trusts is planned to support the roll out of the Royal College of Physicians Structured Judgement Review case note methodology. From April, the Healthcare Safety Investigation Branch and Health Education England will engage with relevant system partners, families and carers, and staff to understand broader training needs and develop approaches to ensuring that staff have the capability and capacity to carry out good investigations of deaths, with a focus on these leading to improvements in care.
- Further **guidance on how Trusts should support bereaved families and carers**, setting standards for local services on the information to be offered – for example, how and when families may be contacted about investigations, what local support is available, what to expect when services have identified the death as complex or needing an independent investigation so potentially involving longer timeframes and multiple agency involvement, and how this will be communicated, nationally and locally.

The national *Learning from Deaths* conference on 21 March this year is an opportunity for us to discuss implementation of these new commitments and requirements. We look forward to your engagement on these critical issues, which will be used to further develop guidance and associated tools.

This letter is intended to alert you to a forthcoming set of expectations. We are however, well aware of current pressures on you, your staff and your services and thank you for your continued commitment and support.

Yours sincerely,



Dr Kathy McLean  
Executive Medical Director  
NHS Improvement



Professor Sir Mike Richards  
Chief Inspector of Hospitals  
Care Quality Commission