NHS
Improvement

Implementing the Learning from Deaths framework: key requirements for trust boards

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Introduction

Introduction – purpose

This pack is for acute, specialist, mental health and community trust boards and specifically trust non-executive directors (NEDs) and non-clinical executive directors. It explains what boards are expected to do in relation to the new Learning from Deaths framework.

NEDs and non-clinical executives may be less familiar with case record review and serious incident investigation as means to supporting quality improvement. However, recent reports from the Care Quality Commission (CQC) and others show that the whole board must support and encourage these activities to identify areas in need of change and to inform improvement.

Trust NEDs in particular have been identified as having a critical role to play in holding their organisations to account for: conducting robust case record reviews and serious incident investigations; and crucially for implementing effective and sustainable changes designed to improve safety and wider quality in response.

We explain the requirements of the National Quality Board's (NQB) new Learning from Deaths framework, which requires acute, specialist, mental health and community trusts to adopt a more standardised and transparent approach to learning from the care provided to patients who die, and what boards need to do to implement this. We also outline what NHS Improvement will do.

Introduction – background

CQC published its report *Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England* in December 2016, making recommendations about how the approach to learning from deaths could be standardised across the NHS. The Secretary of State accepted all these recommendations and asked NQB to develop a framework for the NHS on identifying, reporting, investigating and learning from deaths in care.

The NHS has a long tradition of learning from care provided to patients. The framework builds on that tradition but recognises that the NHS can do better particularly in relation to the care of vulnerable people.

Key findings of the CQC report

- Families and carers are not treated consistently well when someone they care about dies.
- There is variation and inconsistency in the way that trusts become aware of deaths in their care.
- Trusts are inconsistent in the approach they use to determine when to investigate deaths.
- The quality of investigations into deaths is variable and generally poor.
- There are no consistent frameworks that require boards to keep deaths in their care under review and share learning from these.

Introduction – background (contd)

CQC's recommendations have been translated into seven national workstreams.

The Department of Health (DH) has set up a Learning from Deaths programme board to support their implementation. Each workstream is led by the relevant healthcare body.

The first step in this programme was the publication of the new Learning from Deaths framework in March 2015.

In particular this identifies a need to focus on learning from the care provided to patients with learning disabilities and severe mental health needs who die. Most of these deaths will occur in acute settings.

Workstreams

1. Delivering a new national Learning from Deaths framework (DH)
2. Improving how trusts engage with and support bereaved families/carers (NHS England)
3. Improving learning from deaths of service users with learning disabilities or serious mental illness (NHS England)
4. Improving the recording of information about patient deaths and sharing of this between organisations to learn from review of the care provided to patients who die (NHS Digital)
5. Improving the quality and consistency of investigations into patient deaths (Health and Safety Investigation Branch – HSIB and Health Education England – HEE)
6. Supporting trust boards to implement the new requirements (NHS Improvement)
7. Improving how CQC assesses trusts' learning from deaths (CQC)

An explanation of key terms

Some terms used in the Learning from Deaths framework and in relation to case record review and investigation can be misunderstood. In this framework the following terms have specific meanings:

Case record review: A structured desktop review of a case record/note carried out by clinicians to determine whether there were any problems in the care provided to a patient. Case record review is undertaken routinely in the absence of any particular concerns about care, to learn and improve. This is because it can help find problems where there is no initial suggestion anything has gone wrong. It can also be done where concerns exist, such as when the bereaved or staff raise concerns about care (see also page 8).

Investigation: A systematic analysis of what happened, how it happened and why, usually following an adverse event when significant concerns exist about the care provided. Investigation draws on evidence, including physical evidence, witness accounts, organisational policies, procedures, guidance, good practice and observation, to identify problems in care or service delivery that preceded an incident and to understand how and why those problems occurred. The process aims to identify what may need to change in service provision or care delivery to reduce the risk of similar events in the future. Investigation can be triggered by, and follow, case record review, or may be initiated without a case record review happening first (see also page 8).

Death due to a problem in care: A death that has been clinically assessed using a recognised method of case record review, where the reviewers feel the death is more likely than not to have resulted from problems in care delivery/service provision. Note, this is not a legal term and is not the same thing as ‘cause of death’. The term ‘avoidable mortality’ should not be used as this has a specific meaning in public health that is distinct from ‘death due to problems in care’.

Quality improvement: A systematic approach to achieving better patient outcomes and system performance by using defined change methodologies and strategies to alter provider behaviour, systems, processes and/or structures.

Why focus on engaging bereaved families and carers?

The recent CQC report and other evidence show that too often the NHS exacerbates the distress felt by families and carers of patients who die.

The transformation required in response to the Learning from Deaths framework is first and foremost about the way carers and families are engaged after a death.

Families and carers are unlikely to be greatly concerned about the minutiae of the methodology used for case record review or trust clinical governance structures. People do highlight the unacceptable way in which they are sometimes treated, the inconsiderate and unthinking communications they sometimes receive, and the lack of information sometimes provided.

Trusts should:

- ✓ Provide a clear, honest and sensitive response to bereavement in a sympathetic environment
- ✓ Offer a high standard of bereavement care, including support, information and guidance
- ✓ Ensure families and carers know they can raise concerns and these will be considered when determining whether or not to review or investigate a death
- ✓ Involve families and carers from the start and throughout any investigation as far as they want to be
- ✓ Offer to involve families and carers in learning and quality improvement as relevant

NHS England is leading work to determine what support bereaved relatives and carers can expect from trusts (likely to be published early in 2018). Some guidance is already available in the Learning from Deaths framework and the Serious Incident framework, summarised on page 21.

Why focus on case record review and investigation?

Case record review can identify problems with the quality of care so that common themes and trends can be seen, which can help focus organisations' quality improvement work. Review also identifies good practice that can be spread.

Investigation starts either after case record review or straight after an incident, where problems in care that need significant analysis are likely to exist. Investigation is more in-depth than case record review as it gathers information from many additional sources.

The investigation process provides a structure for considering how and why problems in care occurred so that actions can be developed that target the causes and prevent similar incidents from happening again.

Trusts should focus on how case record review and investigation lead to effective and sustainable quality improvement work. Our framework for leadership and improvement sets out how trusts can begin to implement their quality improvement approach.

Data generated from case record review and investigation, for example estimates of the number of deaths thought more likely than not to be due to problems in care, are subjective and so not useful for making external judgements about the safety of trusts.

> "Case record review assessment is finely balanced and subject to significant inter-reviewer variation. It does not support comparison between organisations and should not be used to make external judgements about the quality of care provided.
>
> Research has shown that when case record review identifies a death that may have been caused by problems in care, that death tends to be due to a series of problems, none of which would be likely to have caused the death in isolation but which in combination can contribute to the death of a patient."
>
> (*National guidance on learning from deaths*, March 2017)

New requirements

The Learning from Deaths framework placed a number of new requirements on trusts:

- From **April 2017** onwards, **collect** new quarterly information on deaths, reviews, investigations and resulting quality improvement (see page 10 for the required information).
- By **September 2017**, publish an **updated policy** on how the trust responds to and learns from the deaths of patients in its care (pages 17 to 21 give more detail on what this policy should include, as does the Learning from Deaths framework published in March 2017 and other information available from the NHS Improvement Learning from Deaths website).
- From **Q3 2017** onwards, **publish** information on deaths, reviews and investigations via a quarterly agenda item and paper to its public board meetings (see page 10 for the required information) including information on reviews of the care provided to those with severe mental health needs or learning disabilities.
- From **June 2018**, **publish** an annual overview of this information in Quality Accounts, including a more detailed narrative account of the learning from reviews/investigations, actions taken in the preceding year, an assessment of their impact and actions planned for the next year.

NHS Improvement is fully aware that many organisations, particularly mental health and community care providers, have less clarity on methodologies and scope for the new requirements. We are clarifying with national partners and providers what good looks like and we do not expect providers to have developed perfect processes by Autumn 2017. We will support the system to learn over the course of the next 12 months.

The main purpose of this initiative is **to promote learning** and improve how trusts **support and engage with the families and carers** of those who die in our care; it is not to count and classify deaths.

New requirements (contd)

The Learning from Deaths framework states that trusts must collect and publish, via quarterly public board papers, information on:

- number of deaths in their care*
- number of deaths subject to case record review (desktop review of case notes using a structured method)
- number of deaths investigated under the Serious Incident framework (and declared as serious incidents)
- number of deaths that were reviewed/investigated and as a result considered more likely than not to be due to problems in care
- themes and issues identified from review and investigation (including examples of good practice)
- actions taken in response, actions planned and an assessment of the impact of actions taken.

Information on deaths should be published in the quarter after that in which the death occurred. Where reviews or investigations are ongoing, state how many are ongoing and update this in subsequent publications.

An example dashboard for publication is available from the NHS Improvement Learning from Deaths webpage.

The Learning from Deaths framework requires trusts to collect and publish information on deaths of both adults and children (under 18s). Note however that the child death review process is distinct (see page 19).

* Trusts can define locally which patients are considered to be 'in their care' according to what makes sense for their services. At a minimum this must include all inpatients but, if possible, also patients who die within 30 days of discharge from inpatient services. Be aware that this means all inpatients are **in scope** for review, not that all inpatient deaths need to be reviewed. On page 18 we propose which inpatient deaths acute trusts should review.

A simple rule of thumb is that trusts should consider leading the review of the care of a patient if that trust is the healthcare provider best placed to do so.

New requirements (contd)

Publication is designed to:

- ✓ support trusts to learn from each other
- ✓ ensure transparency and openness as part of a publicly funded healthcare system
- ✓ highlight good and innovative practice
- ✓ encourage action in relation to identified problems in care.

Publication is **not** designed to:

- ✖ name and shame
- ✖ support comparison of trusts on the basis of the number of deaths or the number of deaths judged likely to be due to problems in care
- ✖ encourage blame.

! There is no meaningful measure of ‘avoidable’ mortality at trust level.

! Case record reviews involve finely balanced judgements. Different reviewers may have different opinions about whether problems in care caused a death. That is why this data in not comparable.

! Case record reviews and Serious Incident investigations are not inquiries into how people died – that is a matter for coroners. Criminal investigations are a matter for the police.

! Any publication that seeks to compare organisations on the basis of the number of deaths thought likely to be due to problems in care is actively and recklessly misleading its readers.

In the period leading up to publication, NHS Improvement will develop further support resources for providers that will help them to help the public understand this data.

The trust board's role

Boards are responsible for the quality of the healthcare their trusts provide, including its safety. The Learning from Deaths framework places particular responsibilities on boards, as well as reminding boards of their existing duties.

Board responsibilities

- Ensuring their trust has robust systems for recognising, reporting and reviewing or investigating deaths where appropriate.
- Ensuring their trust learns from problems in healthcare identified by reviews or investigations as part of a wider process that links different sources of information to provide a comprehensive picture of their care.
- In this context 'learning' means taking effective, sustainable action (via appropriately resourced quality improvement work) to address key issues associated with problems in care.
- Providing visible and effective leadership to support their staff to improve what they do.
- Ensuring the needs and views of patients and the public are central to how the trust operates.

Boards should ensure the case record review process sits within their wider clinical governance processes:

- incident reporting and response
- risk management
- clinical audit
- staff management
- patient and public involvement
- research and development
- education and training
- clinical effectiveness
- information management.

Evidence shows that deaths caused by problems in care will occur in every single NHS trust and every hospital worldwide. The key is to learn from them as part of well-functioning clinical governance processes.

The trust board's role – NEDs

NEDs play a crucial role in bringing an independent perspective to the boardroom, constructively challenging the executives to satisfy themselves that clinical quality controls and risk management systems are robust and defensible.

The Learning from Deaths framework requires each trust's board to identify a NED to oversee the trust's approach to Learning from Deaths.

NEDs need to be curious about their organisation's approach to the delivery of healthcare and constructively challenge their trust to identify where care can be improved, then support that improvement. Evidence shows that adverse events are usually due to weaknesses in systems rather than the fault of individuals. Blame is therefore not a useful approach.

Within this role, NEDs have an opportunity to model the behaviour within high reliability organisations, which treat problems as an opportunity to genuinely learn and encourage 'problem sensing' not 'assurance seeking' among teams and organisation-wide.

NED responsibilities in relation to the framework

- **Understand the review process:** ensure the processes for reviewing and learning from deaths are robust and can withstand external scrutiny.
- **Champion quality improvement** that leads to actions that improve patient safety.
- **Assure published information:** that it fairly and accurately reflects the organisation's approach, achievements and challenges.

The following pages give more detail on these responsibilities.

Understanding the review process – what questions should NEDs ask?

- How is the case record review process carried out?
- How are cases selected for case record review (see advice for acute hospitals on page18)?
- What is the quality of data collected by the trust and what are its limitations?
- Are those reviewing cases trained to do so according to a robust method such as PRISM or structured judgement review?
- Is the LeDeR method used to review deaths of people with learning disabilities?
- How are deaths of those with severe mental illness reviewed (see page 19)?
- How are perinatal and maternal deaths reviewed (see page 19)?
- How are infant and child deaths reviewed (see page 19)?
- Is there multidisciplinary review of cases?
- Is there objective review of cases – wherever possible **not** carried out by those involved in the care of the patient who died?
- Are there arrangements for periodic review of the trust's processes and findings by peer trusts?
- Are families/carers given the opportunity to request a review?
- Are all cases where problems with care are thought likely to have led to the death investigated in line with the best practice outlined in the Serious Incident framework?
- Are all families and carers engaged properly where problems are found?
- Are all families and carers involved in investigations from the start, and kept informed of subsequent improvement work if they wish to be?
- How is case record review data triangulated with other quality data collected outside the review?
- What does the data say about what drives mortality in the trust?

Championing learning and quality improvement – what questions should NEDs ask?

- What are the trust's most significant problems? Where should quality improvement be prioritised?
- What is the organisation's strategy for improving the quality of the care it provides?
- What approach and method(s) does it use?
- How well is quality improvement work resourced?
- How does the trust use Learning from Deaths, Serious Incidents and other patient safety-related events to inform quality improvement work? Is good practice identified as well as problems?
- Who is the board executive lead and how well sighted is the board on this work?
- How are the necessary changes in clinical practice supported and enabled?
- How are the wider themes and trends from case record reviews or investigations shared across the organisation and with any others that may have an interest? Are these processes effective?
- How are patients, families and carers involved in quality improvement and sharing learning?
- What changes have been made as a result of this work? Has quality of care improved as a result? How do you know?

Changing trust policies, training staff and reminding them how something should be done are all relatively weak barriers to error. NEDs should consider how their trust avoids resorting to these weak, simplistic barriers to risk wherever possible and instead invests in more effective and sustainable changes to practice, underpinned by human factor approaches, systems thinking and quality improvement techniques.

Assuring published information – what questions should NEDs ask?

- Do I understand the information we publish? Do I know how many deaths occur and where, and what problems are associated with them?
- What is **not** shown by the data? Are there gaps/incomplete information?
- Is the information published in board papers:
  - easy to understand and interpret
  - accurate
  - timely
  - proportionate?
- Does the information identify improvement needs and how these could be met?
- Does the information reveal how previous information was acted on and what has changed as a result? Sharing both successful and unsuccessful quality improvement work is important.
- Does the information clearly describe how the trust uses Learning from Deaths, Serious Incidents and other patient safety-related events to inform quality improvement work?
- How well sighted is the board on this published work?
- How are arrangements for gathering stakeholder feedback in response to published information working?
- Does the information demonstrate that the trust has done what it said it would do?

Policy publication requirements

By the end of September 2017, trusts should publish on their website an **updated policy** on how they respond to and learn from the deaths of patients in their care.

The policy should include:

- The trust's case record review process, including the method used, how the scope of deaths for potential review is determined and how deaths are selected for review.
- How the trust responds to the death of someone with a learning disability or severe mental health needs, of an infant or child, or a stillbirth or maternal death.
- How the trust decides which deaths – whether reviewed or not – require an investigation under the Serious Incident framework.
- How the trust engages with bereaved families and carers, including how they are supported by the trust and involved in investigations where relevant.

The policy should set out what trusts are doing currently. It should reflect the requirements of the Learning from Deaths framework and related policies (for example, the Serious Incident framework). NHS Improvement will not routinely assess the content of published trust policies or collate those policies. Publication is designed to support openness and transparency and enable peer learning.

Policy publication requirements – case selection and review method

A trust's published policy should include the case review method used, how it decides which deaths are in scope for potential review and how it selects the cases for review.

Trusts can use any relevant evidence-based case record review method (see page 19 for requirements for certain specific patient categories), but the chosen method must collect the required information (see page 10). Options include structured judgement review (SJR; training and documentation is available from the Royal College of Physicians – note this is adult inpatient specific) and the PRISM method. We encourage trusts to avoid tick-box/checklist review tools if possible as these only assess the issues listed, missing those not directly assessed, and do not consider the right care for a specific patient (they consider the right care for a 'typical' patient).

Acute trusts: The Independent Advisory Group to RCP's national mortality case record review programme recommends that **all inpatient deaths in the following categories** are reviewed:

- deaths where the **bereaved or staff raise significant concerns about the care**
- deaths of those with **learning disabilities or severe mental illness**
- deaths in a **specialty, diagnosis or treatment group where an 'alarm' has been raised** (for example, an elevated mortality rate, concerns from audit, CQC concerns)
- deaths where the patient was **not expected to die** – for example, in elective procedures
- deaths where **learning will inform the provider's quality improvement work**.

A sample of other deaths should be reviewed to clarify where learning and improvement are needed most. If possible, patients who die within 30 days of discharge from inpatient services should be considered in scope for potential review.

Mental health and community trusts: Taking a proportionate approach, trusts should develop and publish a rationale for the categories of outpatient/community patient considered in scope. It is assumed all inpatient deaths will be reviewed.

Policy publication requirements – how the trust responds to the death of particular patients

A trust’s published policy should include how the trust examines the care provided to specific types of patients as outlined below:

Learning disability

Trusts must have systems to flag patients with learning disabilities.

Once available in their area, trusts should adopt the LeDeR method for reviewing the deaths of people with learning disabilities. For guidance on reviewing deaths see: http://www.bristol.ac.uk/media-library/sites/sps/leder/Guidance%20for%20the%20conduct%20of%20reviews%20%20FINALv2.2.pdf

Trusts should also conduct an initial case note review of all deaths of people with learning disabilities using SJR or another robust and evidence-based methodology. This ensures that there is appropriate clinical review of the last episode of care.

Perinatal or maternal death

All perinatal deaths should be reviewed, using the new perinatal mortality review tool once available. Maternal deaths and many perinatal deaths are very likely to meet the definition of a Serious Incident and should be investigated accordingly.

Severe mental health needs

Trusts must have systems that flag those with severe mental health needs so that their care can be reviewed. NHS England is co-ordinating work to develop a mental health review method. Acute trusts can use SJR or another relevant method to review the acute care of those with severe mental health needs who die in an acute hospital.

Infant or child (under 18) death

Reviews of these deaths are mandatory and must be undertaken in accordance with *Working together to safeguard children* . The Department for Education Form C should be used for these deaths. New child death review guidance is being developed and will be published by the end of 2017.

Policy publication requirements – selection of deaths to investigate

A trust’s published policy should include how it determines which deaths should be investigated under the Serious Incident framework.

This framework defines what constitutes a Serious Incident. These are so designated because the consequences of the adverse event are so significant to patients, families and carers, staff or organisations, or the potential for learning is so great that a heightened level of response is required.

The required response is an effective investigation involving patients, families and others to the extent they wish to be, focused on learning why things went wrong and identifying effective and sustainable changes to reduce the risk of recurrence.

Serious incident investigations are **not** undertaken:

- to hold individuals or organisations to account
- to determine the cause of death.

Trusts should describe how they:

- decide which deaths are declared and investigated as Serious Incidents
- keep an audit trail of these decisions.

Deciding whether an incident should be declared a Serious Incident or not can require finely balanced judgement, taking account of the costs and benefits of investigation. This means there can well be a range of opinions about whether a particular death constitutes a Serious Incident.

But the way in which the decision is reached to declare a Serious Incident should always be clear and defensible.

Policy publication requirements – engagement with families/carers

Trust policies should describe how the trust engages with bereaved families and carers, including how they are supported and involved in any investigation process. We summarise below content from the Serious Incident and Learning from Deaths frameworks, setting out what needs to be done following an incident. But trusts should ensure effective engagement with **all** bereaved people in a sensitive manner, including, for example, support for the practical aspects of burial (or equivalent).

- Begin with a genuine apology and early meeting.
- All staff supporting the bereaved must have the necessary skills and knowledge of the incident.
- One person should be identified as the lead for liaison with the family/carer; consider the need for an independent advocate with the skills to work with bereaved individuals.
- Involvement of the clinicians caring for the patient who died should be considered on a case-by-case basis; this is not always appropriate.
- Action being taken should be explained in person and in writing.
- Set out how the will be kept informed and supported.
- Describe what to expect from an investigation, including timescales and outcomes.
- Clearly explain the Serious Incident investigation's rationale and purpose: these investigations are conducted to support learning, not to hold anyone to account. Be clear: if wrongdoing is found, separate processes are followed.
- Give the family/carer the chance to express concerns and raise questions. Their contribution can provide valuable insight into what happened.

- Provide an opportunity for family/carers to inform the terms of reference for the investigation.
- Once agreed, terms of reference should be shown to the family/carer so they can see their questions are reflected.
- Explain how the family/carer can contribute to the investigation: for example, by providing evidence.
- Provide access to the findings, including interim findings.
- Provide the family/carer with the opportunity to comment on the findings and recommendations in the final report and ensure their comments are considered in the quality assurance process. Be clear: their feedback may not be included if it is not considered relevant/appropriate.
- Keep them informed of any delays in the process.
- Consider meeting transport, disability and language/translation costs/needs.
- Consider the need for counselling and referral to organisations that can provide this.
- Ensure there is a co-ordinated approach if multiple agencies need to contact the family/carer; for example, where regulators, coroners or the police are involved. A single point of contact with the family should be appointed to keep them engaged.

NHS Improvement’s role

NHS Improvement will **not** collect data on numbers of case record reviews or use quantitative information from reviews to direct our regulatory or performance management activity.

Trusts cannot be meaningfully compared by looking at the number of deaths judged more likely than not to be due to problems in care.

NHS Improvement’s national patient safety team reviews all patient safety incidents reported as resulting in death, to identify opportunities for national learning. We will continue to do this for any information submitted to the National Reporting and Learning System (NRLS) following case record review.

This is one reason why it is important that patient safety incidents identified from case record review are recorded via local risk management systems on to the NRLS. More information on the process of NRLS review is available on the NHS Improvement patient safety webpage and in a short animation.

NHS Improvement’s regional teams will support providers in their region to improve their mortality processes, including how they undertake case record review.

This support will primarily be advice and guidance on implementing the new requirements, signposting further advice and facilitating peer support (see page 25).

We will not be using information in relation to implementation of this policy to inform a trust’s Single Oversight Framework segmentation or our regulatory activity.

Medical examiners

Reforms to death certification, when implemented in England, will result in all deaths being either scrutinised by a medical examiner or investigated by the coroner in prescribed circumstances. Additionally, medical examiners will be mandated to give bereaved relatives a chance to express any concerns and to refer to the coroner any deaths appearing to involve serious lapses in clinical governance or patient safety.

The introduction of the medical examiner's role, expected to be in April 2019, should therefore further clarify which deaths should be reviewed under the Learning from Deaths framework. Medical examiners will be able to refer the death of any patient for review by the most appropriate provider organisation(s). This new mechanism should ensure a systematic approach to selecting deaths for review, regardless of the setting or type of care provided in the period before a patient's death.

NHS Improvement and the Department of Health have commissioned research to explore whether medical examiners are best placed to select which deaths need further review and ensure they do not inadvertently miss or over-refer certain types of cases. Before the implementation of the medical examiner system, trusts are advised to allow any doctors undertaking the certification of death to refer cases for case record review to the most relevant organisation.

A report on seven pilot medical examiner schemes in the NHS, including the two main pilot sites in Sheffield and Gloucester, was published last year and demonstrated the value of Medical Examiners. These systems appear supportive of and consistent with the requirements of the Learning from Deaths framework. Providers should feel free to consider establishing their own medical examiner systems, building on the learning from the pilot sites, ahead of the national roll-out if they consider this to be appropriate.

Link with mortality rates

The Learning from Deaths work does not replace the need to consider mortality data. Hospital standardised mortality ratio (HSMR), summary hospital-level mortality indicator (SHMI), crude mortality rates and other data are all sources of information that support trusts to understand where to focus improvement work.

Mortality governance processes should consider mortality rates **and** the results of case record reviews and investigations as part of a single clinical governance framework. Multiple sources and types of data and information – not just limited to mortality – should be used to help a trust understand how to improve care.

Boards should be aware that their organisations can have low mortality rates and discover substantial problems in care of patients who die, or high mortality rates but relatively few identified problems in care. Mortality rates are a statistical construct that is based solely on what is in the coded data and hence are limited in measures of acuity and pathology compared to the depth of clinical information available in case note reviews.

While there is no single approach to follow, boards should:

- Engage with the combined information from mortality rates, case record reviews and investigations
- Be curious and seek out issues – if case record review flags a problem in one patient's care, what do mortality rates tell you about the care of all patients in that service/pathway? Remember that problems in care may exist even if mortality rates are relatively low
- Recognise that improving mortality will likely improve the standard of care for all patients and reduce complications, speed recovery and enable faster discharge
- Provide visible leadership and establish a focus on mortality as a trust-wide issue
- Prioritise reduction in mortality and increased safety as a core strategic aim
- Link and cross-reference mortality data to other qualitative and quantitative data, outcomes, adverse incidents, feedback, complaints, social media, staff and patient surveys
- Not assume an individual death is an isolated incident.

Next steps

Sharing policies We are working with a number of trusts to identify policies and processes already being used that we can share more widely to help other trusts develop their own policies.

Guidance and support Further development of tools/guidance – particularly by NHS England concerning the engagement of bereaved families/carers – will be reflected in later versions of this guidance. HEE are working to develop eLearning by March 2018.

Role of NHS Improvement's regions We are working across NHS Improvement to ensure a consistent and pragmatic approach to supporting implementation of the Learning from Deaths policy.

Supporting boards NHS Improvement is presenting sessions on this new policy at a number of meetings over the summer, particularly board development and networking meetings.

We encourage trusts to learn from each other and challenge each other to continuously improve the quality of their Learning from Deaths processes and the implementation of effective and sustainable improvements as a result.

We anticipate that while NHS Improvement will endorse and promote a set of principles for implementing the Learning from Deaths policy, it is unlikely that a single detailed process will be mandated or enforced.

These new requirements are challenging for many trusts. NHS Improvement will take a pragmatic approach to overseeing implementation. Trusts will be supported to learn.

If you would like NHS Improvement to come and talk about Learning from Deaths at a forthcoming meeting or event, please contact us at patientsafety.enquiries@nhs.net

Resources

National guidance on Learning from Deaths
https://www.england.nhs.uk/wp-content/uploads/2017/03/nqb-national-guidance-learning-from-deaths.pdf

Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England
https://www.cqc.org.uk/sites/default/files/20161213-learning-candour-accountability-full-report.pdf

Learning from deaths dashboard
https://improvement.nhs.uk/resources/learning-deaths-nhs-national-guidance

Resources from the national patient safety team
https://improvement.nhs.uk/resources/patient-safety-alerts

The Improvement Hub
https://improvement.nhs.uk/improvement-hub/

Developing people – improving care
for leadership and improvement
https://improvement.nhs.uk/resources/developing-people-improving-care/

Mortality review resources

Royal College of Physicians mortality review materials
https://www.rcplondon.ac.uk/projects/national-mortality-case-record-review-programme

Learning disabilities mortality review programme
http://www.bristol.ac.uk/sps/leder/

Hogan et al Research on mortality review
http://www.bmj.com/content/351/bmj.h3239
http://qualitysafety.bmj.com/content/early/2012/07/06/bmjqs-2012-001159

Related guidance and publications

Serious incident framework
https://improvement.nhs.uk/resources/serious-incident-framework/

Root cause analysis tools and resources
http://www.nrls.npsa.nhs.uk/resources/collections/root-cause-analysis/

Duty of candour
http://www.cqc.org.uk/sites/default/files/20150327_duty_of_candour_guidance_final.pdf

Being open guidance
http://www.nrls.npsa.nhs.uk/beingopen/

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