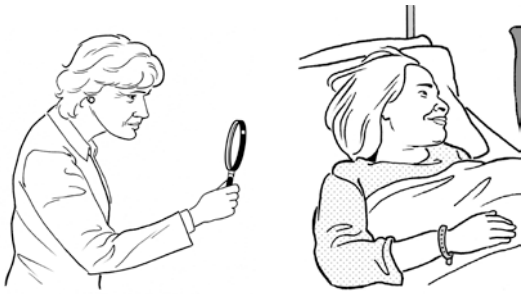
How NHS hospitals look into and learn from deaths

Easy read (June 2016)



This easy read document tells you about the report we will be writing about how NHS hospitals find out how and why a person in their care has died.

It will be written by the Care Quality Commission (CQC). We check services like hospitals, doctors' surgeries and care homes to make sure they are giving good health and social care to people.

What is the report about?

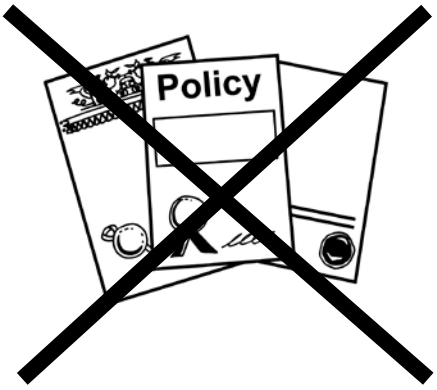
CQC is looking at the way NHS hospitals find out how and why a person in their care has died.

We want to see if the hospitals are learning from what they find and if chances to stop the person dying were missed.

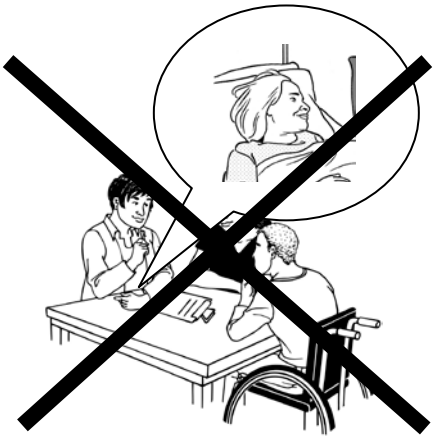
Why are we doing this report?

In December 2015, a company called Mazars wrote a report about people who had died while using the mental health or learning disability services at the hospital called Southern Health Foundation Trust.

The report found that the hospital had done some things wrong.

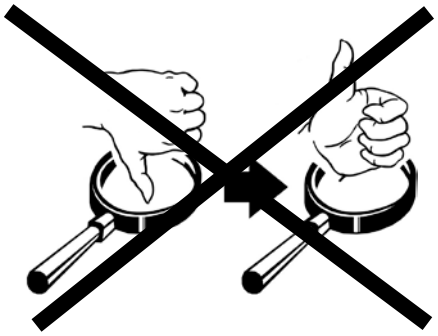


The hospital did not have a way that everyone used to:



- Tell the right people when someone dies

- Find out how and why a person died



- Learn from what they did.

After the report, the Government asked CQC to look at how other NHS hospitals find out how and why people in their care die. This is to find out if the same problems are happening in other hospitals.

What are we doing over the next few months?

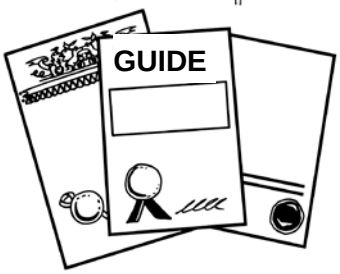
To carry out this work, we will:

- Listen to families and ask for their thoughts.

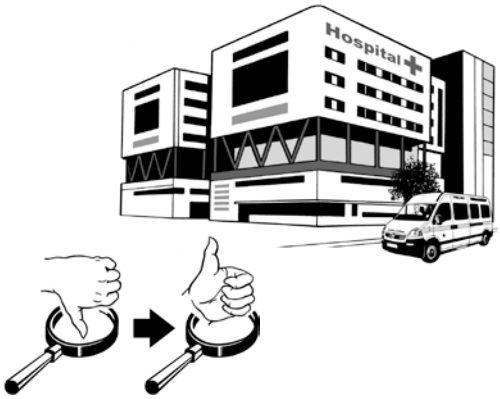
- Work with a group of people who know about this subject, like those working for charities and for the government.
- Work with other organisations, like NHS England, NHS Improvement and the Department of Health.
- Send out a questionnaire to all NHS hospitals in June 2016.
- Visit some NHS hospitals to find out more over the summer 2016.

What will happen because of this work?

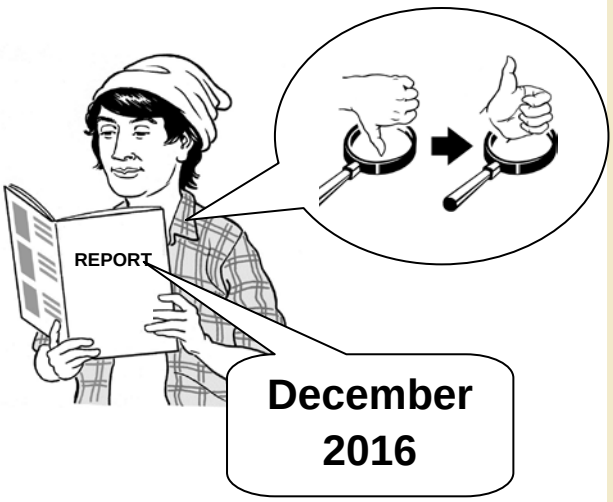
We will write a report to tell you what we found and what we think should happen to make things better.



We will work with other organisations to write guides which tell NHS hospitals how they should tell the right people when someone dies, find out why a person died, and learn from what they find.



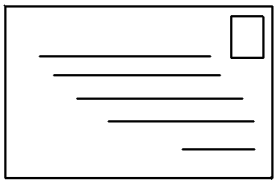
We will improve the way we check that services are doing the right things.



We will write a report to tell you what we found and what we think should happen to make things better.

We will aim to finish it and put it on our website in December 2016

Getting in contact with us



If you would like this report in another format or language, or you would like to tell us something, please contact us:

Phone: **03000 61 61 61**

Email: **enquiries@cqc.org.uk**

Website: **www.cqc.org.uk**

Post:

Care Quality Commission

Citygate

Gallowgate

Newcastle upon Tyne

NE1 4PA