

Learning to do better when people die in hospital



Easy read booklet
March 2019

About CQC



We are the Care Quality Commission (CQC).



We check services like

- hospitals
- doctors' surgeries
- care homes.

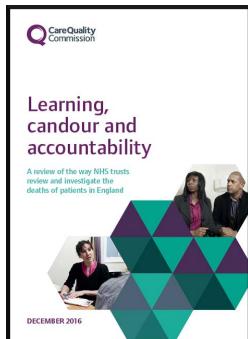


We make sure they are giving good health and social care to people.

About this booklet



In 2016 we wrote a report that looked at what happens when someone dies when they are in the care of the NHS.



The report is called 'Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England'.



The report looked at

- how families are treated when a family member dies
- what checks are done about how and why the person died
- how hospitals learn and make their services better.



In 2016 we said that there needed to be big changes to make sure that everyone learns from when a person dies.



2019

Now we have written a new report.



It is called 'Learning from deaths – a review of the first year of NHS trusts implementing the national guidance'.



The report looks at

- whether services have got better when we checked them
- what is helping or stopping them from getting better.



This booklet is a summary of the new report.

What we found out



Some services are doing better than others at learning from how a person died.



This is because

- families and carers are treated well, and everyone is treated in the same way
- there is a top manager who makes sure that the service learns from when someone dies
- staff feel they can tell a manager when something is wrong
- services give training to staff to help them give better care.



What needs to happen next



Services need to make sure that staff feel able to tell a manager when something is wrong.



Services need to read the full version of this booklet and make changes where there are problems.



The Government, health services and other organisations need to carry on working together. They need to support services to make sure they get better.

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