



# Briefing Paper 13: National Guidance on Learning from Deaths, and the Learning Disabilities Mortality Review (LeDeR) programme

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This briefing paper summarises the main points of the national guidance on Learning from Deaths, published in March 2017, and how it relates to the LeDeR programme. The national guidance provides a framework for NHS Trusts and NHS Foundation Trusts to identify, report, investigate and learn from deaths that occur in their care.

## **Summary of main points of national guidance on Learning from Deaths**

1. Trusts should ensure their governance arrangements and processes include, facilitate and give due focus to the review, investigation and reporting of deaths. Trusts should also ensure that they share and act upon any learning derived from these processes.
2. Providers need to ensure that staff have appropriate skills through specialist training and protected time under their contracted hours to review and investigate deaths to a high standard.
3. Providers should have a clear policy for engagement with bereaved families and carers, including giving them the opportunity to raise questions or share concerns in relation to the quality of care received by their loved one. Providers should make it a priority to work more closely with bereaved families and carers and ensure that a consistent level of timely, meaningful and compassionate support and engagement is delivered and assured.
4. Since September 2017 each Trust should publish a policy on how it responds to, and learns from, deaths of patients who die under its management and care.
5. Acute Trusts should use an evidence-based methodology for reviewing the quality of care provided to those patients who die, such as the Structured Judgement Review (SJR) case note methodology. Reviews of deaths of people with learning disabilities by acute, mental health and community Trusts should adopt the methodology developed by the Learning Disabilities Mortality Review (LeDeR) programme.
6. From April 2017, Trusts have been required to collect and publish on a quarterly basis specified information on deaths. The data that providers publish must be summarised in Quality Accounts (from June 2018), including evidence of learning and action and an assessment of the impact of actions taken.



7. The Care Quality Commission will strengthen its assessment of providers' including the management and processes to review deaths and engage families and carers in relation to these processes.
8. NHS England has developed guidance for bereaved families and carers (see: <https://www.england.nhs.uk/ourwork/part-rel/nqb/national-guidance-for-nhs-trusts-engaging-with-bereaved-families/>)

### **The LeDeR programme and its relation to Learning from Deaths guidance**

The National Guidance on Learning from Deaths suggests that additional scrutiny should be placed on the deaths of people with learning disabilities across all settings.

All deaths of people with learning disabilities aged 4 years and older that occur in hospital settings are subject to a SJR into the last episode of their care, plus a more holistic LeDeR review.

If a Trust wishes to complete its own internal mortality review, it is recommended that it uses the LeDeR initial review.

Once the LeDeR review has been completed, a copy should be sent to the relevant governance body at the Trust where the death occurred.

Trusts are encouraged to identify appropriate personnel to undertake LeDeR training and review processes. Because of the different methodology adopted by the LeDeR programme, it is not be appropriate to use the same definition of 'avoidable death' as used by the SJR, nor to compare rates of avoidable deaths across and between the two review processes.

### **Further information**

National Quality Board (2017) National Guidance on Learning from Deaths. A Framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care. Available from: <https://www.england.nhs.uk/wp-content/uploads/2017/03/nqb-national-guidance-learning-from-deaths.pdf>

NHS Improvement (2017) Implementing the Learning from Deaths framework: key requirements for trust boards. Available from: [https://improvement.nhs.uk/documents/1747/170921\\_Implementing\\_LfD\\_-\\_information\\_for\\_boards\\_JH\\_amend\\_3.pdf](https://improvement.nhs.uk/documents/1747/170921_Implementing_LfD_-_information_for_boards_JH_amend_3.pdf)