News story: NHS becomes first healthcare system in the world to publish numbers of avoidable deaths

The NHS will become the first healthcare organisation in the world to publish estimates of how many patients may have died because of problems in their care.

The publication follows a promise by the health secretary after a 2016 Care Quality Commission report found that the NHS was missing opportunities to learn from patient deaths, and that too many families were not being included or listened to when an investigation happened.

The data will be published each quarter by individual trusts. 171 of the 223 trusts in England have already released or are releasing their first estimates by the end of December.

Each trust will make its own assessment of the number of deaths due to problems in care. The data will not be comparable and will not be collated centrally. This will allow trusts to focus on learning from mistakes and sharing lessons across their organisations and their local healthcare systems.

Health Secretary Jeremy Hunt said:

> Every death resulting from a failing in care is an absolute tragedy, and despite the NHS being ranked as the world's safest healthcare system for a second time, we still have a long way to go.
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> Too often I have heard from families saying that after mistakes happen they feel like a wall has gone up in the NHS, but publishing this data will help give grieving families the openness and answers they deserve. It marks a significant milestone in ensuring the NHS learns from every tragic case, sharing lessons across the whole system to prevent mistakes recurring and ultimately delivering safer care for all patients in the future.

The programme is likely to cover between 1,250 and 9,000 deaths, which research suggests is the number of deaths each year that may be down to problems in care – a fraction of the 19.7 million treatments and procedures carried out by the NHS in 2016 to 2017.

These deaths range from rare but high-profile failings in care, to those which involve terminally ill patients who die earlier than expected. These deaths may make up a large number of those caused by problems in care, showing the need to continue to focus on improving all care, including end of

life care.

By collecting this data and taking action in response to failings in care, NHS trusts and foundation trusts will be able to give grieving families an open and honest account of the circumstances that led to a death. This work is already happening in some parts of the NHS, for example at University College London Hospitals NHS Foundation Trust, which recently held its first memorial service for those who have died in its care.

The data will allow trusts to learn from every failing in care, and then share lessons across the NHS to better protect patients in the future. For example, the Pennine Care NHS Foundation Trust, which as part of the Greater Manchester Partnership is working across Greater Manchester on mortality reviews, so that lessons learned are shared with other providers for the good of patients across the area.

Prof Ted Baker, chief inspector of hospitals at the Care Quality Commission, said:

> The NHS is the first healthcare system to commit to reporting and publishing information on the number of avoidable deaths in its hospitals and the work that is being done by individual NHS trusts to learn from those deaths.
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> This new level of transparency will be central to improving care and ensuring the safety of the NHS services we all rely on. We will use this information alongside the findings of our inspections to identify where providers must make improvements and to share good practice where we find hospitals that are doing it well.
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> We can be proud of the progress made over the past year, but the challenge now is to deliver the full vision of a safer learning culture.

Executive Medical Director of NHS Improvement Dr Kathy McLean said:

> NHS trusts are undergoing a culture change in how they learn from deaths. Trusts across the country are improving how they engage and support bereaved families, how they ensure they learn from mistakes and share good practice.
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> We have been clear that the change required of trust boards is one of culture and leadership, rather than one of process and counting.