East of England Ambulance Service NHS Trust

Learning from Deaths Policy

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DOCUMENT CHANGE HISTORY		
Initiated by	**Date**	**Author (s)**
Clinical Quality and Safety Group	September 2019	Safety and Risk Lead
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Draft v0.2	September 2019	Circulated to the Clinical Quality and Safety Group for comments and request approval for publication.
v1.0	September 2019	Escalated to the Management Assurance Group for approval.

Version	Date	Comments (i.e., viewed, or reviewed, amended approved by person or committee)
V1.1	June 2021	Amendments following review circulated at Patient Safety Group
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Linked procedural documents	Serious Incident Policy Management of Incidents Policy Duty of Candour Policy Safeguarding Adults Policy Safeguarding Children and Young People Policy Learning from Deaths cohort identification (administrative) and review methodology (Structured Judgment Review) SOP
Dissemination requirements	To be shared on East24 as a publicly accessible document.
Part of Trust's publication scheme	Yes

The East of England Ambulance Service NHS Trust has made every effort to ensure this policy does not have the effect of unlawful discrimination on the grounds of the protected characteristics of: age, disability, gender reassignment, race, religion/belief, gender, sexual orientation, marriage/civil partnership, pregnancy/maternity. The Trust will not tolerate unfair

discrimination on the basis of spent criminal convictions, Trade Union membership or non-membership. In addition, the Trust will have due regard to advancing equality of opportunity between people from different groups and foster good relations between people from different groups. This policy applies to all individuals working at all levels and grades for the Trust, including senior managers, officers, directors, non-executive directors, employees (whether permanent, fixed-term or temporary), consultants, governors, contractors, trainees, seconded staff, homeworkers, casual workers and agency staff, volunteers, interns, agents, sponsors, or any other person associated with the Trust.

All Trust policies can be provided in alternative formats.

Contents

Appendices

Note: additional reading can be found in the hyperlinked documents and webpages throughout this document.

1. Introduction

The National Health Service (NHS) aims to deliver excellent and safe care to its service users. As part of continually developing the quality of care delivered, it is essential to embed lessons learnt from when things go well as well as from when things go wrong.

The national Learning from Deaths initiative was implemented in acute hospitals in March 2017 following a Care Quality Commission (CQC) report titled *Learning, candour and accountability: a review of the way trusts review and investigate the deaths of patients in England* (2016).

From April 2020, UK ambulance trusts are required to report on incidents reviewed utilising the Learning from Deaths methodology.

This policy aims to define the responsibilities for the delivery of the Learning from Deaths initiative, set out the East of England Ambulance Service NHS Trust's approach to achieving tangible outcomes from Structured Judgement Reviews, and identify the patients who will be in scope for review of their death.

"Learning from deaths of people in their care can help providers improve the quality of the care they provide to patients and their families, and identify where they could do more"

(NHS Improvement, 2017)

2. Purpose

2.1 The East of England Service NHS Trust (hereafter referred to as the Trust) is committed to reviewing practice, learning from events and improving practice.

2.2 NHS providers have the responsibility to learn from the deaths of people in our care to improve the quality of care we provide to patients and their families.

2.3 The purpose of this policy is to set out the governance structure and process for reporting on mortality reviews. This policy follows the *National Guidance for Ambulance Trusts on Learning from Deaths*, published by the National Quality Board in July 2019.

2.4 This national guidance requires ambulance trusts to:

- publish information, on a quarterly basis, regarding deaths, reviews, and investigations via an agenda item and paper to public Board meetings.
- have a considered approach to the engagement of families and carers in the mortality review process.
- publish evidence of learning and actions taken as a result of the mortality reviews in the Trust's Quality Account.

2.5 This policy will not document the methodology of selection of appropriate cases for reviewing or the methodology for Structured Judgement Reviews. This can be found in a supporting documentation.

3. Duties

3.1 Chief Executive Officer

The Chief Executive Officer will have overall accountability for the implementation of this policy and the contents within.

3.2 Medical Director

The Director of Clinical Quality and Improvement will own the responsibility to ensure that the policy and its contents are delivered.

3.3 Serious Incident Panel

The Serious Incident Panel will be accountable for reviewing any cases identified which may meet the serious incident threshold. The Panel will be accountable for making timely decisions to ensure that external reporting requirements are achieved in line with the NHS England SI Framework.

3.4 Patient Safety Lead

The Patient Safety Lead will coordinate the Trust's response to the Learning from Deaths process and ensure that relevant cases are reviewed to a high-quality standard and in a timely manner. The Patient Safety Lead will also be responsible for collating and reporting on data gathered through the process and dissemination of any lessons learnt through any reviews undertaken.

3.5 Structured Judgement Reviewers

Those trained in reviewing appropriate cases will be responsible for delivering high quality reviews of care delivered by Trust staff. They will have received training to enable them to utilise Learning from Deaths methodology and complete structured judgement reviews. Further details on the methodology of reviews can be found in supporting documentation.

3.6 Patient Safety Integration Lead

The patient safety integration lead will be responsible for embedding learning which is derived from structured judgement reviews and thematic analysis.

3.7 All staff

All members of the Trust are required to engage openly and honestly with the Learning from Deaths process, to ensure that the most appropriate and beneficial learning is achieved through reviewing relevant cases.

4. Learning from Deaths

4.1 The Trust's approach to Learning from Deaths

The Trust's approach to Learning from Deaths complements existing processes such as the management of incidents and the serious incident process. It aims to enhance these processes to ensure that richer learning is achieved to develop the quality of care delivered within the Trust.

The Trust is also committed to collaborative learning with other NHS care providers and will take part in any joint reviews which it is required to do, when notified by another healthcare provider or clinical commissioning group.

4.2 Determining deaths in scope for record review

The following patient care episodes are eligible for review:

Any patient who dies whilst in the care of the ambulance service.

This is defined as the patient dying between the 999 call being made and their care being transferred to another part of the healthcare system, or to the point of the patient being discharged from ambulance care after a decision is made not to convey them to hospital. This includes cases where patients are transported using a subcontracted ambulance resource. A patient shall be considered in the care of the ambulance service:

- while the 999 call is being handled (this will include NHS111 calls transferred to the ambulance service).
- prior to the arrival of the ambulance resource.
- at scene.
- while the patient is being transported.
- prior to handover being concluded.

a) Any patient who dies after handing over care to another provider when the Trust is notified of the death. In such

cases, it is good practice to undertake a joint review with the healthcare provider where the patient died.

b) Any patient who dies within 24 hours of contact with the Trust where a decision was taken not to convey them to hospital. This contact includes "hear and treat" patients as well as patients who were visited by ambulance personnel. This criterion excludes patients at the end of life and recognised to be in the dying phase of their illness, where their documented wish was to remain at home.

Not every death, meeting these criteria, will be reviewed.

4.3 Determining which deaths shall be subject to review

The Trust will review all deaths where ambulance service personnel, other health and care staff, and/or families or carers have raised a concern about the care provided, including concerns about end-of-life care.

In addition, the Trust shall review a sample of each of the four categories listed below:

- Deaths of patients assessed as requiring Category 1 and Category 2 responses where there has been a delayed ambulance response*.
- Deaths of patients assessed as requiring Category 3 and Category 4 responses.

The Trust will determine the number of cases reviewed across the identified categories listed above within each financial quarter. It shall be noted that it is recommended that UK ambulance trusts review 40-50 per quarter. This is in line with the findings that this number produces a rich source of information on care quality and on problems in care, as described in Royal College of Physicians' *Using the Structured Judgement Review Method: A Guide for Reviewers (England)* (2016).

* A delayed response is defined as one that is double the 90th centile response time, as set out in the NHS England *Ambulance Response Programme (2017)*: >30 minutes for Category 1 calls and >80 minutes for Category 2 calls. This will be reviewed if national targets change.

4.4 Additional review requirements

Review	Requirements
Deaths of patients with learning disabilities	The Trust must report all deaths of children over four with a known learning disability to the Learning Disabilities Mortality Review (LeDeR) Programme. The Trust will contribute to their review processes when approached and share its review findings with LeDeR when relevant (Appendix 1).
Deaths of patients with severe mental illness	The Trust shall report these deaths to the relevant mental health trust and/or management team where the person was known to be under their care. The Trust shall also contribute to their review processes where approached (Appendix 1).
Maternal and neonatal deaths	These shall be reported to the HSIB (Healthcare Safety Investigations Branch) and MBRRACE (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK) (Appendix 1).
Paediatric deaths	The Child Death Review Statutory and Operational Guidance outlines the Trust's statutory duties with regards to notification and information gathering. The Trust shall participate in child death review meetings, i.e. Child Death Overview Panel (CDOP) meetings, when approached (Appendix 1).

Review	Requirements
Safeguarding concerns	Any deaths where there are safeguarding concerns shall be referred to the Trust's Safeguarding Lead in line with their statutory duties (Appendix 1).
Deaths in custody	These deaths fall under the relevant police forces' remit (Appendix 1).

The Trust may review additional patient care episodes which are not defined in this scope and this is at the Trust's discretion.

The Trust will consider each additional case individually to determine whether it shall undertake a review in each circumstance. This will be in liaison with the relevant review programme, to minimise duplication.

5. The Trust's approach to reviews

5.1 When a case is identified, a review will be undertaken within one month of the identification. This will be undertaken using approved methodology by a member of staff trained in its use. The member of staff will not have been involved in the care of the patient.

5.2 When the overall care of the patient is rated as an overall 'poor' or 'very poor'.

5.3 the case will be presented to the Serious Incident Panel to decide whether the case meets serious incident criteria. The case will then follow recognised Trust processes.

5.5 Feedback shall be sent to the members of staff who were involved in the patient care.

5.6 A sample of reviews shall be quality assured during each reporting period.

6. Bereaved families and carers

6.1 The Trust is committed to engaging with bereaved families or carers of patients in a meaningful and compassionate manner. The Trust aims to ensure that all questions or concerns raised by a family are addressed within any case review or investigation which it undertakes.

6.2 The Trust will ensure that it complies with Regulation 20 of the Health and Social Care Act (2014), the Duty of Candour. Further details of the Trust's approach to the management of Regulation 20 can be found in the Duty of Candour Policy.

6.3 When it is found that the patient experienced 'very poor' care as part of the structured judgement review, the Trust is committed to notifying the patient's family under the Duty of Candour regardless of if the event meets serious incident criteria or not.

6.4 The Trust will engage with families related to all deaths identified through compliments and complaints in order to identify and share learning.

7. Supporting staff affected by the death of a patient

7.1 The death of a patient, whatever the circumstances, can have a considerable impact on the staff involved. The Trust is committed to supporting staff members when this occurs.

7.2 The Trust encourages and supports staff members to raise and discuss concerns which they may have at any time.

7.3 The Trust has a range of support options available to staff in these circumstances, including (but not limited to):

- Chaplaincy services
- Wellbeing Services
- Employee Assistance Programme

- Freedom to Speak Up Guardian

7.4 It shall be the responsibility of the member of staff's locality leadership team to arrange the necessary referral and offer pastoral support at such times. If enhanced support is required at any stage of the process, this shall be arranged as necessary.

8. Learning from reviews and thematic analysis

8.1 The Trust is committed to learning from care delivered.

8.2 Each review, structured judgement review, or serious incident investigation, shall identify lessons learnt.

8.3 The Trust is committed to sharing and embedding any lessons identified through this process.

8.5 Internal learning will be shared amongst staff utilising the communication and engagement mechanisms which the Trust has in place. These include the intranet, internal publications, and professional update programmes.

8.6 Learning can also be shared externally by reporting into the National Ambulance Risk and Safety Forum, where all UK ambulance trusts can benefit from the learning achieved from such reviews.

9. Reporting arrangements

9.1 The Trust will present the outcomes of the Learning from Deaths reviews to the Patient Safety Group, the Compliance and Risk Group, and the Quality Governance Committee. The report shall also be made available to the Board and may be published in public Board papers.

9.2 The minimum data set provided within the report will include:

- The number of eligible deaths identified whilst in the

Trust's care.

- The number of completed reviews, including the overall rating of care.
- A summary of the learning themes identified in the previous reporting period and resulting recommendations and actions taken. This includes recognising examples of good quality care.

9.3 The Trust will produce an annual summary of learning from deaths within its Quality Account.

10. Monitoring

10.1 The implementation of this policy will be monitored via the reporting arrangements set out within section 9 of this policy.

11. References

11.1 The following documents informed the development of this policy:

National Guidance for Ambulance trusts on Learning from Deaths, National Quality Board, June 2019;

Learning From Deaths: Guidance for NHS Trusts on Working with Bereaved Families and Carers, National Quality Board, 2018;

Just Culture Guide, NHS Improvement, 2018;

Learning, Candour and Accountability: A Review of the Way NHS Trusts Review and Investigate the Deaths of Patients in England, CQC, 2016;

Serious Incident Framework, NHS England, 2015;

Using the Structured Judgement Review Method: A Guide for Reviewers (England), Royal College of Physicians, 2016.

Appendix 1 - Linking reviews with external organisations

Where the death in question meets multiple nationally-agreed criteria for review, ambulance trusts are encouraged to engage with all relevant organisations, as set out below. Legal duties such as the coronial process take precedence over non-statutory processes.

All deaths where the patient was known to have a learning disability

All deaths of people aged four and above with a learning disability shall be reported to the Learning Disabilities Mortality Review programme (LeDeR).

When requested, trusts shall provide LeDeR reviews with information on the circumstances leading to the person's death, for example, by sharing information or participating in a multiagency review. Ambulance trusts shall also share the findings from their own review into the death with the LeDeR programme as soon as they can.

Ambulance trusts may find LeDeR's e-learning tools help them to understand the LeDeR review process.

Ambulance trusts can submit their findings as an attachment to the LeDeR notification web-based platform at: http://www.bristol.ac.uk/sps/leder/notify-a-death/

All deaths where the patient had a known severe mental illness

In addition to conducting their own reviews, ambulance trusts are requested to notify the relevant trust and/or relevant management services of the patient's death when this organisation or service is known. This could be the mental health trust, crisis resolution and home treatment team or equivalent. Maximum learning is likely to come from these trusts and/or services leading these reviews. Therefore, ambulance trusts are

requested to contribute information to these processes when approached.

Ambulance trusts may find the Royal College of Psychiatrists' Mortality Review Tool helps them to understand how mental health trusts may review the deaths of patients with a severe mental illness under their care.

All maternal and neonatal deaths

There are multiple reporting channels for these deaths and the appropriateness of each depends on whether deaths meet certain clinical criteria. The trust's responsibilities are to:

- Determine whether the death falls within scope of Healthcare Safety Investigation Branch's (HSIB) maternal investigations or neonatal investigations – that is, using the Each Baby Counts (EBC) criteria. See HSIB's maternity webpage for more detail on its investigation criteria, investigation process and how it works with trusts, as well as trusts' HSIB-specific responsibilities;
- Report the maternal or neonatal death to MBRRACE-UK when deaths meet its criteria;
- Report the neonatal death to Each Baby Counts and NHS Resolution's Early Notification Scheme where deaths meet their EBC criteria; and
- Ensure neonatal deaths are reviewed and investigated as set out in the Child Death Review Statutory and Operational Guidance; see below for more detail on this.

Use of MBRRACE-UK's Perinatal Mortality Review Tool (PMRT) is mandated to support standardised perinatal mortality reviews.

All paediatric deaths

In reviewing these deaths ambulance trusts shall be guided by the Child Death Review Statutory and Operational Guidance. This guidance sets out the responsibilities of ambulance trusts in relation to notification and information gathering. Where

indicated, ambulance staff are required to provide information (on a standardised reporting form) and, on occasion, contribute to other specific investigations (eg coroner, patient safety incident investigations, Healthcare Safety Investigation Branch) and shall anticipate being asked to participate in child death review meetings or Child Death Overview Panel (CDOP) meetings.

In most circumstances, it is not appropriate or helpful for ambulance trusts to conduct their own mortality review when a child's death is already being investigated through wider child death review processes. Such duplication may add little to the overall understanding of how and why the child died and can confuse and add unnecessary burden on bereaved families.

Deaths in custody – that is, police and prison suites, youth offender institutions, immigration removal centres and under Section 135 and 136 of the Mental Health Act

Police forces have a statutory obligation to refer relevant deaths to the Independent Office for Police Conduct (IOPC). Ambulance trusts shall contribute to its investigation process when approached.

Deaths where safeguarding concerns have been raised

Ambulance trusts have statutory obligations with regards to these deaths. Staff shall refer relevant deaths to their named professional/safeguarding lead manager and director of nursing, who will undertake a review and refer to relevant multi-agency processes to ensure compliance to statute and a wider review of potential learning. Relevant deaths shall also be referred for review by the Clinical Commissioning Group Accountable Officer.

Appendix 2 – Equality Analysis

Equality Analysis
What is the aim of the policy/procedure/practice/event? To highlight the Trust's commitment to learning from the deaths of our service users, whether that be from when things go well or when things don't go to plan.
Who does the policy/procedure/practice/event impact on? **Race** ☐ **Religion/belief** ☐ **Marriage/Civil Partnership** ☐ **Gender** ☐ **Disability** ☐ **Sexual orientation** ☐ **Age** ☐ **Gender re-assignment** ☐ **Pregnancy/maternity** ☐
Who is responsible for monitoring the policy/procedure/practice/event? Anthony Brett, Patient Safety Lead
What information is currently available on the impact of this policy/procedure/practice/event? It will have some impact on the capacity of the safety team to complete the reviews when appropriate patients are identified. It will impact on service users or their families as the Trust may need to discharge the statutory Duty of Candour if things did not go to plan. The impact on staff will be limited to their involvement in any reviews and remaining open and honest when being asked some potentially challenging questions (as per the Management of Incidents Policy and Serious Incident Policy).
Do you need more guidance before you can make an assessment about this policy/procedure/ practice/event? No
Do you have any examples that show that this policy/procedure/practice/event is having a positive impact on any of the following protected characteristics? Yes/No, If yes please provide evidence/examples:

Race	☐	**Religion/belief**	☐	**Marriage/Civil Partnership**	☐
Gender	☐	**Disability**	☐	**Sexual orientation**	☐
Age	☐	**Gender re-assignment**	☐	**Pregnancy/maternity**	☐

Please provide evidence:
There are no examples as yet as this is a new policy and process which has not yet started. However, the process will have a positive impact on all service users, including those with protected characteristics.

Are there any concerns that this policy/procedure/practice/event could have a negative impact on any of the following characteristics? No

Race	☐	**Religion/belief**	☐	**Marriage/Civil Partnership**	☐
Gender	☐	**Disability**	☐	**Sexual orientation**	☐
Age	☐	**Gender re-assignment**	☐	**Pregnancy/maternity**	☐

Please provide evidence:

Action Plan/Plans - SMART

Specific

Measurable

Achievable

Relevant

Time Limited

Evaluation Monitoring Plan/how will this be monitored?
Who – Patient Safety Lead

How – through monitoring of the use of the policy and upon the policy review date

By – as above

Reported to – the medical director

Appendix 3 – Monitoring Table

What	*Who*	*How*	*Frequency*	*Evidence*	*Reporting arrangements*	*Acting on recommendations*	*Change in practice and lessons to be shared*
Eligible cases are identified	Patient Safety Lead	The LfD coordinator will continue to populate spreadsheet with relevant data	Monthly	LfD spreadsheet	Reported to the Patient Safety Group, the Quality Governance Committee, and the Board.	Should number of eligible cases rise or decrease, to escalate accordingly	Nil
Minimum number of cases are reviewed	Patient Safety Lead	The LfD coordinator and LfD lead (PSS) to ensure that case reviewers return cases in a timely manner	Monthly	LfD spreadsheet	Reported to the Patient Safety Group, the Quality Governance Committee, and the Board.	Escalation to LfD lead and patient safety lead if not compliant	Nil
Quality of case review	Patient Safety Lead	The LfD coordinator and LfD lead (PSS) to ensure that the minimum number of case reviews are QA'd monthly	Monthly	Minimum QA as per SOP	Reported to the Patient Safety Group, the Quality Governance Committee, and the Board.	Escalation to LfD lead and patient safety lead if not compliant	Nil

What	*Who*	*How*	*Frequency*	*Evidence*	*Reporting arrangements*	*Acting on recommendations*	*Change in practice and lessons to be shared*
Lessons are embedded	Patient Safety Lead	The patient safety integration specialist to take thematic learning and devise ways to share with relevant staff groups	Monthly	LfD spreadsheet	Reported to the Patient Safety Group, the Quality Governance Committee, and the Board.	Escalation to LfD lead and patient safety lead if not compliant	Nil
Duty of Candour is discharged for all eligible cases	Patient Safety Lead	The LfD coordinator to highlight those cases to reviewers and PSSs to discharge DoC as required by Regulation 20	Monthly	LfD spreadsheet and Quality Report	Reported to the Patient Safety Group, the Quality Governance Committee, and the Board.	Escalation to LfD lead and patient safety lead if not compliant	Nil
Staff are fed back to when a case is reviewed	Patient Safety Lead	The LfD coordinator and LfD lead (PSS) to ensure that staff are regularly receiving feedback following a case that they were	Monthly	LfD spreadsheet	Reported to the Patient Safety Group, the Quality Governance Committee, and the Board.	Escalation to LfD lead and patient safety lead if not compliant	Nil

What	*Who*	*How*	*Frequency*	*Evidence*	*Reporting arrangements*	*Acting on recommendations*	*Change in practice and lessons to be shared*
		involved in being reviewed					
Ensure the style and format of the document is in line with the Trust's requirements and is reviewed within policy date	Patient Safety Lead	The patient safety lead will review this aspect of the document prior to it being proposed for recommendation for approval. Other stakeholders will be involved in the review	At each review of the document.	The document register / library will act as an audit trail	Reported to the Patient Safety Group, the Quality Governance Committee, and the Board.	The document author will address any actions or changes required.	Required changes to practice will be identified and actioned. The patient safety lead to take each change forward where appropriate. Lessons will be shared with all the relevant stakeholders.