South East Coast Ambulance Service NHS
NHS Foundation Trust

Learning from Deaths Policy

Contents

1 Purpose

1.1. South East Coast Ambulance Service NHS Foundation Trust (the Trust) is committed to reviewing practice, learning from events and improving practice.

1.2. It is recognised by the Trust that learning from quality of care provided to those who have died has the potential to improve the quality of care we provide to patients and their families.

1.3. The purpose of this policy is to set out the governance structure and process for undertaking and 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.

1.4. This national guidance requires Ambulance Trusts to:

- Have a Learning from Deaths Policy that reflects national guidance which has been agreed by the Trust Board of Directors, shared with stakeholders and published by 1 December 2019.

- Publish information, on a quarterly basis, of deaths, reviews and investigations via an agenda item and paper to public Board meetings.
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- 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 Scope

2.1. This policy is applicable to all staff including volunteers and those working on behalf of the organisation.

3 Duties and Responsibilities

3.1. The **Trust Board** is accountable for the quality of the healthcare the Trust provides, including safety. The Learning from Deaths policy places particular accountabilities on the Board, including;

- Ensuring effective systems for recognising, reporting and reviewing or investigating deaths where appropriate are in place.

- Ensuring learning identified by reviews or investigations as part of a wider process that links different sources of information provides a comprehensive picture of care provided.

- Ensuring effective, sustainable action to address key issues associated with problems in care are taken.

- Ensuring the needs and views of patients and the public are central to how the Trust operates.

3.2. The **Non-Executive Director** identified by the Trust to oversee the Trust's approach to Learning from Deaths is responsible for;

- Understanding the review process and ensuring the processes for reviewing and learning from deaths are effective and can withstand external scrutiny.

- Championing quality improvement that leads to actions that improve patient safety.

- Assuring published information accurately reflects the Trust's approach, achievements and challenges.

3.3. The **Executive Medical Director** is the director responsible for the learning from deaths agenda.

3.4. The **Executive Director of Nursing & Quality** is the director responsible for the patient safety investigation process and the patient experience/patient engagement processes.

3.5. All **Clinical Staff** are responsible for being aware of the Learning from Deaths policy, escalating any concerns regarding the death of a patient to their line manager and recording this on Datix and sharing learning from deaths with their colleagues.

3.6. Learning from Deaths is overseen by the Trust's Learning from Deaths Group.

3.7. The Learning from Deaths Group reviews the data of the number of deaths in each quarter by category, the numbers of deaths which have been selected for a mortality review, the outcomes of those reviews and the learning taken from those reviews. The Group will also monitor how families and friends have been engaged in mortality reviews (where relevant).

3.8. The learning taken from the Learning from Deaths Group will be cascaded to each Operating Unit, Emergency Operation Centres (EOCs) and 111 by the Quality Governance Leads assigned to each of these services.

3.9. The Learning from Deaths Group reports to the Trust Clinical Governance Group which is chaired by the Executive Director of Nursing and Quality or Executive Medical Director. Any areas of concern are further escalated

to the Executive Management Board. Assurance reports are reported to the Quality and Patient Safety Committee of the Trust Board.

4 Learning from Deaths

4.1. Determining Deaths in Scope for Review

4.1.1. The following deaths will be in scope for the review process, this does not mean that all deaths in scope must be reviewed, only that they are eligible for consideration for review and should be reviewed as considered appropriate as described in 4.2.

4.1.2. Any patient who dies whilst under the care of the ambulance service (999/111). This is defined as the patient dying between the 999/111 call being made and their care being transferred to another part of the 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 subcontracted alternative ambulance resource. This means that a patient should be considered under the care of the ambulance service

- While the 999 call is being handled (this will include 111 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.

4.1.3. Any patient who dies within 4 hours after handover. It is acknowledged that identification of these patients may be an issue and that the Trust is only under this obligation when notified of these deaths. In such cases, it is good practice to undertake a joint review with the setting where the patient died.

4.1.4. 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.

4.2. **Determining Which Deaths Should be Reviewed**

4.2.1. Annex A provides a flowchart summarising the process for selecting deaths for review.

4.2.2. The national guidance stipulates that the Trust must 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. This includes any concern raised that cannot be answered fully at the time or anything not answered to the satisfaction of the person raising the concern.

4.2.3. In addition, the Trust will review a sample of each of the four categories listed below (see 4.4.2 for the process of identifying these deaths).

4.2.4. Deaths of patients assessed as requiring category 1 and category 2 responses where there has been a delayed ambulance response*.

4.2.5. Deaths of patients assessed as requiring category 3 and category 4 responses*.

4.2.6. Deaths that occur following handover to an NHS acute, community or mental health trust or to a primary care provider, when this information is known.

4.2.7. Deaths of patients who were initially not conveyed to hospital and who then subsequently had re-contact with the ambulance service within 24 hours. The death should have occurred as part of that episode of care and not during a subsequent episode of care.

4.2.8. The Trust will determine a number across the four identified categories listed above which equates to 40 to 50 case reviews per quarter in total. 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 (2016) ‘Using the Structured Judgement Review Method: A Guide for Reviewers (England)’.

*A delayed response is as defined by the Ambulance Response Programme.

4.3. **Additional Reporting Requirements**

4.4. **Deaths of Patients with Learning Disabilities**

4.4.1. The Trust must report all deaths of those aged 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.

4.5. **Deaths of Patients with Severe Mental Illnesses**

4.5.1. Serious mental illness (SMI) is defined as a mental, behavioural, or emotional disorder resulting in serious functional impairment, which substantially interferes with or limits one or more major life activities. The Trust should 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 should also contribute to their review processes where approached.

4.6. **Maternal and Neonatal Deaths**

4.6.1. These should be reported to the Care Quality Commission Maternal Deaths department (formerly Healthcare Safety Investigations Branch) and MBRRACE (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK).

4.7. **Paediatric Deaths**

4.7.1. The Child Death Review Statutory and Operational Guidance outlines the Trust's statutory duties with regards to notification and information gathering. The Trust should participate in child death review meetings, i.e. Child Death Overview Panel (CDOP) meetings, when approached.

4.8. **Safeguarding Concerns**

4.8.1. Any deaths where there are safeguarding concerns should be referred to the Trust's Safeguarding Department in line with statutory duties.

4.9. **Deaths in Custody**

4.9.1. These deaths fall under the relevant police forces' remit.

4.9.2. In some cases, in addition to reporting arrangements listed above, there may be occasions when the Trust will make the decision to conduct its own review of the death, for example, to identify early learning improvement actions in advance of the national review process or where there are concerns about the care towards the end of life. However, this is discretionary and is in addition to the Trust's requirements to notify the national review programmes of the death.

4.10. **The Trust's Approach to Case Review**

4.11. **Concerns raised by staff, relatives, carers and other professionals**

4.11.1. Concerns about the care of a patient who has died may be raised by staff (via Datix), relatives and carers (via complaints or PALs) and other professionals (via correspondence received). All of these concerns will be notified to the Learning from Deaths Lead (Deputy Medical Director) in the Medical Directorate. All such concerns will receive a Structured Judgemental Review and if poor care is identified will be referred to the Trust's Serious Incident Group for consideration of further investigation.

4.11.2. Concerns will be managed through the Trust's current processes (e.g. relatives or carer complaints will be managed through the complaints processes). Relatives and Carers will be fully involved with meaningful and compassionate engagement in the review and will be encouraged to give their views of the care and will receive feedback once the review has been complete. Duty of Candour processes will be followed. This immediate action could also include contacting the Police, Coroner and/or regulators.

4.11.3. **Quarterly Review of Deaths**

4.11.4. The Clinical Audit Team will provide a list of all deaths within the Trust on a monthly basis. The Deputy Medical Director will randomly select 20 patients who have died per month for review. These will be selected from the following four categories: -

- 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.
- Deaths that occur following handover to an NHS acute, community or mental health trust or to a primary care provider, when this information is known.
- Deaths of patients who were initially not conveyed to hospital and who then subsequently had re-contact with the ambulance service within 24 hours. The death should have occurred as part of that episode of care and not during a subsequent episode of care.

4.11.5. Consideration will be taken to ensure that those patients selected for review are fairly distributed between the 10 Operating Units.

4.11.6. The Learning from Deaths coordinator (Deputy Medical Director) will notify the Learning from Deaths Panel members patient care to be reviewed each month. Panel members will be asked to complete and return the Structure Judgemental Review (SJR) within 4 weeks. The Learning from Deaths coordinator will collate the reviews once they have been completed.

4.11.7. The purpose of the case review is to identify any avoidable contributory factors and good practice in relation to the person's death. Consideration will be given to if on balance, there were any aspects of care and support that, had they been identified and addressed, may have changed the outcome..

4.11.8. Any SJR that concludes that there was poor care given to the patient, will be referred to the following week's Serious Incident Group (SIG) for

consideration of whether an investigation is required. If it is considered that poor care has contributed to the death of a patient and a Serious Incident is declared, then the relatives and/or carers will be notified in accordance with the Duty of Candour legislation.

4.11.9. All Learning from Death Panel Members will receive training in how to complete a Structured Judgemental Review.

4.11.10. The SJR aims to identify lessons to learn, if there is a need to change local practices as a result of the findings or if there are any wider recommendations that should be made to other healthcare providers. The outcome of the SJR will be documented on the standard template. If a further investigation is recommended by the Serious Incident Review Group, an action plan will be developed and implemented to ensure that it is translated into improvements in the delivery of care.

5 Definitions

5.1. Some of the terms used in the Learning from Deaths Policy could be misunderstood, the terms used in this policy have the following specific meaning.

5.2. **Case record review:**

5.2.1. A structured desktop review of a case record/note carried out by the Learning from Deaths panel members to determine whether there were any problems in the care provided to a patient. Case record review is undertaken routinely in the absence of any particular concerns about care, to learn and improve. The ‘Structured Judgemental Review’ template will be used to complete the review and ensure all reviews are standardised. An SJR will also be completed where concerns exist, such as when the bereaved or staff raise concerns about care.

5.3. **Investigation:**

5.3.1. A systematic analysis of what happened, how it happened and why, usually following an adverse event when significant concerns exist about the care provided. Investigation draws on evidence, including physical evidence, witness accounts, organisational policies, procedures, guidance, good practice and observation, to identify problems in care or service delivery that preceded an incident and to understand how and why those problems occurred. The process aims to identify what may need to change in service provision or care delivery to reduce the risk of similar events in the future. Investigation can be triggered by, and follow, case record review, or may be initiated without a case record review happening first. This process is overseen by the Serious Incident Group (SIG).

5.4. **Death due to a problem in care**:

5.4.1. A death that has been clinically assessed using a recognised method of case record review, where the reviewers feel the death is more likely than not to have resulted from problems in care delivery/service provision. Note, this is not a legal term and is not the same thing as 'cause of death'. The term 'avoidable mortality' should not be used as this has a specific meaning in public health that is distinct from 'death due to problems in care'.

5.5. **Quality improvement:**

5.5.1. A systematic approach to achieving better patient outcomes and system performance by using defined change methodologies and strategies to alter provider behaviour, systems, processes and/or structures.

5.6. **Investigations**

5.6.1. The Learning from Deaths process enhances and does not replace the Trust's existing Serious Incident Policy.

5.6.2. Any concerns with care identified during the Structured Judgemental Review process will be reported immediately on the Trust's Patient Safety Management System (Datix). The case will be reported to the next Serious Incident Group (SIG) which meets weekly. If the concerns meet the criteria of the National Serious Incident Framework, these will be reported on the Strategic Executive Information System (StEIS).

5.6.3. The Trust will ensure that it meets its statutory requirements under the Duty of Candour with contact being led by the relevant investigation manager.

5.6.4. The Trust will ensure that any staff involved in the investigation are treated in a consistent, constructive and fair way throughout the process.

6 Bereaved Families and Carers

6.1. The Trust is committed to engaging in a meaningful and compassionate way with bereaved families and carers.

6.2. Bereaved families and carers who have concerns about the care provided by SECAmb normally raise these concerns through the Patient Experience Team via the Trust's complaints process or Patient Advice and Liaison Service (PALS). Please refer to the Complaints Policy for information on how these concerns are managed and how the Trust learns from patient/relatives concerns.

6.3. The Trust meets its statutory requirement of Duty of Candour, by notifying relatives and carers if an investigation is to take place into the care provided. As part of the Trust's Duty of Candour processes, relatives and carers are to be fully engaged in the investigation process and are provided with the outcome of the investigation and next steps.

6.4. If the Trust is about to undertake an investigation into the deceased person's care, the bereaved family and carers will be informed.

6.5. Bereaved families and carers will be informed of the outcome of the investigation. In particular they will be informed if the care is thought more likely than not to have contributed to the death, or indeed that the care is thought to have caused moderate to severe harm unrelated to the death, in order to fulfil the trust's duties in relation to the statutory Duty of Candour.

6.6. The Trust will involve families and carers in any learning and actions following reviews and investigations when they want to be involved.

6.7. The Trust will support bereaved families and carers and will refer families and carers to further support and to advocacy services where requested.

6.8. The Trust will engage with families where a death has been referred to the coroner and will be the subject of an inquest.

7 Supporting Staff

7.1. The Trust recognises that caring for a patient who has died can be distressing. Staff receive day to day support from their line manager and staff are encouraged to contact their manager if they would like to debrief following the death of a patient.

7.2. Staff have access to the Trust's Wellbeing Hub if they would like to receive additional support following the death of a patient. The Trust's wellbeing hub is a confidential service.

7.3. The Trust is a listening organisation and managers and leaders want to hear from staff if there are any suggestions of how the Trust can improve the care to patients.

7.4. If any member of staff has concerns about how the Trust is responding to care issues identified, they can contact the Freedom to Speak Up Guardian – contact details are available on the Trust's intranet site.

8 Learning from Reviews

8.1. Learning from death reviews will be shared and discussed at the Trust's Learning from Deaths Group which reports to the Quality Governance Group.

8.2. Immediate patient safety issues will be cascaded to staff via the Trust's Clinical Bulletin services.

8.3. Trust wide learning and suggestions for Clinical Audit will be provided to the Quality and Patient Safety committee of the Trust Board.

9 Reporting Arrangements

9.1. The Trust will present quarterly reports on the outcomes of the Learning from Death Reviews to the Board of Directors. These reports will be published and will include the following information:

9.2. A summary of the learning themes from reviews and investigations undertaken in the previous quarter and resulting recommendations and actions taken. This includes recognising examples of good quality care.

9.3. How the Trust is assessing whether its learning and actions are improving patient safety.

9.4. The number of completed reviews.

9.5. The number of deaths for which an investigation was indicated and, of these, the number of completed investigations.

9.6. The number of deaths in which a problem in care was identified which was considered more likely than not to have contributed to the death. This judgement should be made from reviews undertaken following the initial case record review.

9.7. A consolidated total of the number of live and completed reviews and investigations relating to that financial year.

9.8. The Trust will produce an annual summary of learning from deaths within its Quality Account. This will provide a consolidation of the quarterly reporting information together with a narrative analysis of learning and resulting key themes, actions taken and the outcomes of these.

10 Training Requirements

10.1. All Learning from Deaths panel members will receive training in how to complete a Structured Judgmental Review (SJR).

11 References

11.1. The following references 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.

13 Audit and Review (evaluating effectiveness)

13.1. All policies have their effectiveness audited by the responsible Management Group at regular intervals, and initially six months after a new policy is approved and disseminated.

13.2. Effectiveness will be reviewed using the tools set out in the Trust's Policy and Procedure for the Development and Management of Trust Policies and Procedures (also known as the Policy on Policies).

13.3. This document will be reviewed in its entirety every three years or sooner if new legislation, codes of practice or national standards are introduced, or if feedback from employees indicates that the policy is not working effectively.

13.4. All changes made to this policy will go through the governance route for development and approval as set out in the Policy on Policies.

14 Equality Analysis

14.1. The Trust believes in fairness and equality, and values diversity in its role as both a provider of services and as an employer. The Trust aims to provide accessible services that respect the needs of each individual and exclude no-one. It is committed to comply with the Human Rights Act and to meeting the Equality Act 2010, which identifies the following nine protected characteristics: Age, Disability, Race, Religion and Belief, Gender Reassignment, Sexual Orientation, Sex, Marriage and Civil Partnership and Pregnancy and Maternity.

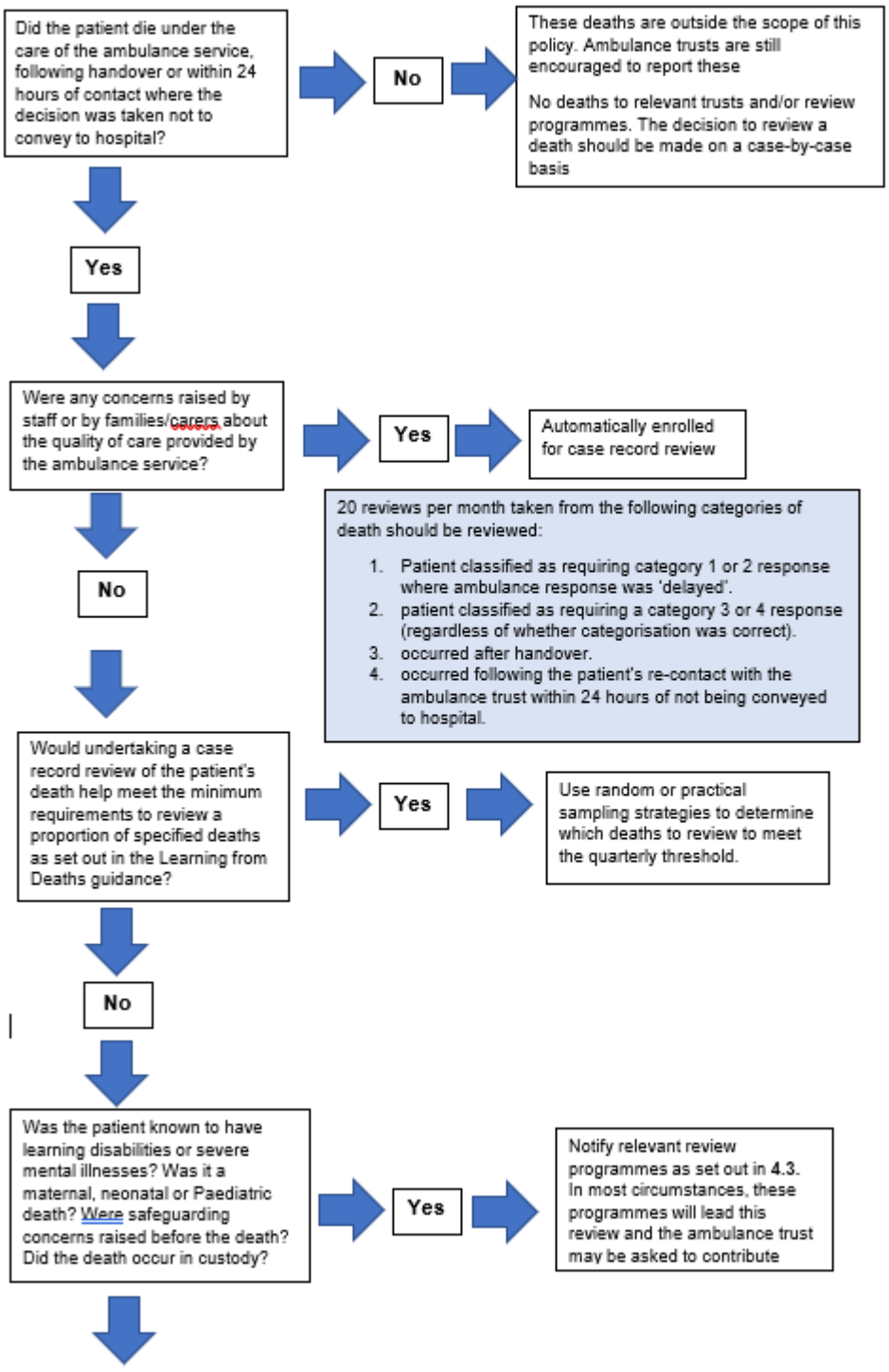
14.2. Compliance with the Public Sector Equality Duty: If a contractor carries out functions of a public nature then for the duration of the contract, the contractor or supplier would itself be considered a public authority and have the duty to comply with the equalities duties when carrying out those functions.

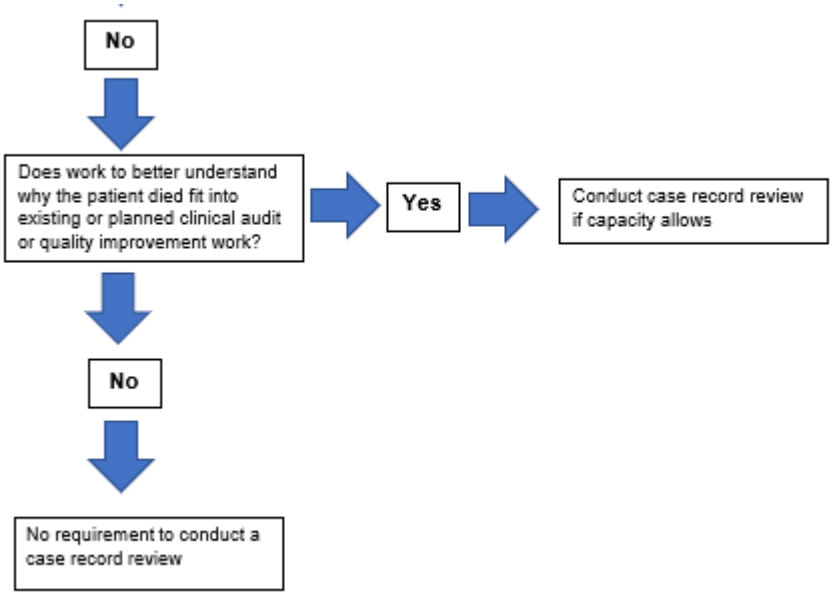
12 Resources

- Learning from deaths dashboard
- https://improvement.nhs.uk/resources/learning-deaths-nhs-national-guidance

- Resources from the national patient safety team; https://improvement.nhs.uk/resources/patient-safety-alerts/
- The Improvement Hub
- https://improvement.nhs.uk/improvement-hub/
- Using the structured judgement review method Data collection form (RCP)
- https://www.rcplondon.ac.uk/projects/outputs/national-mortality-case-record-review-nmcrrprogramme-resources

Appendix A: Process for selecting deaths for review




No
Does work to better understand why the patient died fit into existing or planned clinical audit or quality improvement work?
Yes
Conduct case record review if capacity allows
No
No requirement to conduct a case record review

Appendix B: Contents of Quarterly Public Board Papers

Frequency	Information on deaths must be published in the quarter after which the death occurred in the public Board paper. If the review or investigation is on-going this information should be included and updated in subsequent publications.
Contents	• Number of deaths in the Trust's care. • Number of deaths subject to case record review (desktop review of case notes using a structured method). • Number of deaths investigated under the Serious Incident framework (and declared as serious incidents) • number of deaths that were reviewed/investigated and as a result considered more likely than not to be due to problems in care • number of reviews/investigations on-going • themes and issues identified from review and investigation (including examples of good practice) • actions taken in response, actions planned and an assessment of the impact of actions taken.