National Quality Board

First edition July 2019

National guidance for ambulance trusts on Learning from Deaths

A framework for NHS ambulance trusts in England on identifying, reporting, reviewing and learning from deaths in care

This document was developed by NHS England and NHS Improvement on behalf of the National Quality Board (NQB).

The NQB provides co-ordinated clinical leadership for care quality across the NHS on behalf of the national bodies:

- NHS England and NHS Improvement
- Care Quality Commission
- Health Education England
- Public Health England
- National Institute for Health and Care Excellence
- NHS Digital
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This document has been developed with the help of the National Ambulance Service Medical Directors' group and the National Ambulance Service Quality, Governance and Risk Directors' group. The Learning from Deaths Family Steering Group convened by NHS England and patient representatives who work with the national patient safety team have also contributed to its development.

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Foreword

In December 2016 the Care Quality Commission (CQC) published *Learning, candour and accountability: a review of the way NHS trusts review and investigate the deaths of patients in England*.[1] Its review found that valuable opportunities to learn from deaths were being missed across the system, and that many families and carers did not experience the NHS as being open and transparent. One reason for this was that trusts lacked a consistent approach to reviewing and learning from the care provided to those who die.

In response, in March 2017 the National Quality Board published the first national guidance on learning from deaths for NHS acute, mental health and community trusts.[2] Although there is still further to go, this has led to significant progress in the way these trusts review and learn from deaths.

In summer 2018 the Department of Health and Social Care announced its intention to extend the principles of learning from deaths to NHS ambulance trusts and to primary care.

This guidance fulfils the first of these intentions. It builds on the work that ambulance trusts already do to review and learn from the deaths of patients who had been under their care. By developing a standardised approach, ambulance trusts will find it easier to learn from each other and to identify areas where collective improvement work can be undertaken.

A continuing issue across the Learning from Deaths programme is the relative ease with which different organisations can collaborate to learn from deaths. This remains

[1] Care Quality Commission (2016) *Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England*.
[2] National Quality Board (2017) *National guidance on Learning from Deaths*.

a challenging area. This guidance points to where closer working between ambulance trusts and other organisations is recommended or required.

We would like to thank the National Ambulance Service Medical Directors (NASMeD) and the National Ambulance Service Quality, Governance and Risk Directors (QGARD) for their advice and support with this work.

We would also like to thank others who contributed to this guidance, including members of the Learning from Deaths programme board, representatives from the Learning from Deaths Family Steering Group and patient representatives who work with the national patient safety team.

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Executive summary

This guidance is to help NHS ambulance trusts in England improve the way they review and learn from the deaths of patients who had been under their care, through developing a more consistent approach within and between trusts. This document sets out a standardised framework for ambulance trusts to use to develop and implement their local Learning from Deaths policies.

This national guidance closely reflects that on learning from deaths for NHS acute, mental health and community trusts, published by NQB in March 2017[3] as a response to CQC's 2016 finding that the NHS should improve the way it learns from deaths.[4] However, there are some differences in requirements, reflecting ambulance trusts' different role and operational context.

Publishing a Learning from Deaths policy

Ambulance trusts should use this guidance to develop their local Learning from Deaths policies and publish a board-approved version on their public website by 1 December 2019.

Local policies should describe:

- the trust's approach to learning from deaths;
- which deaths the trust considers to be in the scope of their local policy;
- which deaths the trust reviews itself;
- the trust's arrangements for reporting deaths to other bodies or review programmes where relevant;
- the trust's method for reviewing deaths;

[3] National Quality Board (2017) *National guidance on Learning from Deaths*.
[4] Care Quality Commission (2016) *Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England*.

- a reference to the trust's serious incident investigation policy or its successor: the trust's patient safety incident response policy and associated patient safety incident response plan, as supporting documents;[5]
- the trust's approach to involving and engaging with bereaved families and carers;
- the trust's processes for supporting staff following the death of a patient; and,
- how the trust records its learning from reviews and investigations and how this learning is integrated into quality improvement work. Learning includes recognising good quality care and measuring the impact of this work to demonstrate enduring improvements in service quality.

Reporting requirements

Ambulance trusts should publish their first quarterly Learning from Deaths data in Quarter 1 of 2020/21, drawing on learning from deaths occurring in Quarter 4 of 2019/2020.

Ambulance trusts should provide a summary of their learning from deaths activity over the previous year in their quality accounts published in summer 2021. NHS England and NHS Improvement will let ambulance trusts know exactly what information should be reported by December 2019. Requirements are likely to be similar to those for acute, community and mental health trusts.[6]

[5] The Patient Safety Incident Response Framework (PSIRF) will shortly be published as an introductory framework and will sit initially alongside the Serious Incident Framework. Ambulance trusts should give consideration to the PSIRF once published and familiarise themselves with the concepts in it.

[6] Current reporting requirements for acute, community and mental health trusts. Please see pages 14 and 15.

1. Introduction

This guidance sets out a framework for ambulance trusts in England to develop and implement local Learning from Deaths policies. It provides a standardised approach for all ambulance trusts to adopt but has the flexibility to allow individual trusts to do more where capacity allows.

It builds on the work that ambulance trusts already do on learning from incidents and on mortality reviews, and on the experience of implementing the Learning from Deaths guidance that focused on secondary care. It should result in policies that complement trusts' serious incident investigation policies and succeeding patient safety incident response policies.

Its purpose is to produce a valuable source of learning by enabling recognition of good quality care provided to those who die as well as areas for improvement, including improving end-of-life care.

Ambulance trusts should study this document with reference to the Serious Incident Framework, the introductory Patient Safety Incident Response Framework (PSIRF), the statutory Duty of Candour[7] and NQB's *Learning from Deaths: Guidance for NHS trusts on working with bereaved families and carers*.[8] Trusts should also be familiar with the Just Culture Guide.[9]

This guidance is also aligned with the new NHS Patient Safety Strategy.[10]

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[7] NMC and GMC (2015) *Openness and honesty when things go wrong: The professional duty of candour*.
[8] National Quality Board (2018) *Learning from Deaths: Guidance for NHS trusts on working with bereaved families and carers*.
[9] NHS Improvement (2018) *Just Culture Guide*.
[10] NHS Improvement (2019) *The NHS Patient Safety Strategy.*

The focus of this guidance is on routine case record reviews of deaths.[11] A minority of these reviews may, through the review processes, be identified as patient safety incidents and escalated accordingly. All deaths identified as a patient safety incident, at whatever stage this is identified, should be reported according to the trust's usual reporting procedures and the trust's incident response process takes priority over any review process that may be in train. More detail on this is given in Section 2.6 Investigations.

[11] This is the structured review of a case record or note carried out by clinicians which is undertaken routinely to learn and improve care.

2. Publishing a Learning from Deaths policy

By 1 December 2019, ambulance trusts should have published on their public website a Learning from Deaths policy that has been agreed by their board and shared with key stakeholders.

This chapter of the guidance describes what local policies should include.

2.1 Approach to learning from deaths

This section should provide an overview of the trust's approach to learning from deaths and how this integrates with its wider work on clinical governance, patient safety, quality planning, quality assurance and quality improvement.

Trusts should describe how they communicate any concerns they have about the person's care before ambulance trust contact to the relevant organisation(s) and how they notify relevant external organisations of deaths, contribute to reviews when requested and/or take part in joint reviews.

Trusts should cover how they ensure a partnership approach to sharing information and learning within the ambulance service sector. More broadly, trusts should outline how they work with others, including commissioners and other providers for example acute, community and mental health trusts, primary care and the independent sector, to facilitate cross-agency learning.

Trusts should also make reference to the requirements of the Public Sector Equality Duty (Equality Act 2010)[12] and how they will apply these in this context.

2.2 Determining deaths in scope for case record review

This section should describe how the trust determines which patients were under its care prior to their death. These constitute the deaths in scope for review.

It is recommended that all ambulance trusts adopt the criteria below to determine deaths in scope for review. Ambulance trusts should consider on a case-by-case basis whether to review any deaths which fall outside this scope but have potential learning value.

This does not mean that all deaths in scope must be reviewed. It means that all these deaths should be considered for review and then reviewed if this is considered appropriate as described in Sections 2.3 and 2.4.

Deaths in scope for review are:

a) **Any patient who dies[13] while under the care of the ambulance service.** These are patients who die between the 999 call being made and their care being transferred to another part of the system, or to the point they are discharged from ambulance care after a decision is made not to convey them to hospital. This category includes patients who are transported using subcontracted alternative patient transport.

This means that a patient should be considered under the care of the ambulance service:

[12] Equality Act 2010.

[13] A death is pronounced in line with the Recognition of Life Extinct (ROLE) protocol.

i. while the 999 call is being handled;[14]
ii. in the time between the 999 call being handled and the ambulance or subcontracted alternative patient transport arriving at the scene;[15]
iii. at the scene;
iv. while the patient is being transported; and,
v. before handover concludes.

b) Any patient who dies after handover.[16]

As it is acknowledged that patient identification may be an issue, ambulance trusts are only obliged to consider these deaths in scope when they are notified of them.

c) Any patient who dies within 24 hours of contact with the ambulance service where a decision was taken not to convey them to hospital.[17]

Contact includes 'hear and treat' as well as a visit by ambulance personnel. This should exclude patients at the end of life, where their documented wish was to remain at home.

2.3 Determining which deaths should be subject to case record review

This section should describe how the trust determines which of the deaths in scope it will review.

[14] This includes 111 calls transferred to the 999 directory from the time the ambulance service accepts these calls.
[15] This includes welfare calls made to the patient.
[16] Ambulance trusts are encouraged to undertake a joint review with the setting where the patient died.
[17] This includes calls made by frequent service users.

Ambulance trusts must review:

- All deaths where ambulance service personnel, other health and care staff and/or families or carers have raised a concern[18] about the care provided, including concerns about end-of-life care.

Ambulance trusts are also requested to review a specified number of deaths from across each of the categories below.[19]

- deaths of patients assessed as requiring category 1 and category 2 responses where the ambulance response was delayed;[20]
- deaths of patients assessed as requiring category 3 and category 4 responses;[21]
- deaths of patients following handover to an NHS acute, community or mental health trust or to a primary care provider, where the ambulance is notified that the patient died; and,
- deaths of patients who were initially not conveyed to hospital and contacted the ambulance service again within 24 hours. These deaths need to have occurred in that episode of care and not during a subsequent episode of care.

[18] This includes any concern raised that cannot be answered fully at the time or is not answered to the satisfaction of the person raising the concern.
[19] It is recommended that trusts review 40 to 50 cases per quarter. This number produces a rich source of information on care quality and on problems in care (Royal College of Physicians (2016) *Using the structured judgement review method: A guide for reviewers (England)*). Ambulance trusts should distribute this number across the four categories at their discretion and decide between using random or practical sampling strategies depending on which are most useful in their local circumstances.
[20] A delayed response is defined as one that is double the 90th centile response time, as set out in the NHS England (2013) *New ambulance standards*: >30 minutes for category 1 calls and >80 minutes for category 2 calls. This will be reviewed if national targets change.
[21] This is regardless of whether the categorisation was considered to have been correct.

In addition, ambulance trusts may wish to review other categories of deaths for clinical audit or quality improvement work. Trusts should describe these categories, or how they will be determined, in this section.

It is important to note that learning can come from reviewing the care provided to people considered to be at the end of life as well as care provided to those who were not expected to die when they did.

Annex A gives a flow chart for and further guidance on the selection of deaths for review.

2.4 Additional reporting requirements

This section should describe how the trust deals with deaths that fall within national mortality review or investigation programmes or that meet other mandatory review or investigation criteria.

The main categories of these deaths and the approach the ambulance trust should take for each are described below.

a) **Deaths of patients with learning disabilities**[22]
   All deaths of those aged over four with a known learning disability must be reported to the Learning Disabilities Mortality Review (LeDeR) Programme. The ambulance trust should contribute to this programme's review processes when approached and share its review findings with LeDeR when relevant. See Annex B for more guidance on this.

[22] Defined by LeDeR as a "significant reduced ability to understand new or complex information, to learn new skills (impaired intelligence), with a reduced ability to cope independently (impaired social functioning), which started before adulthood".

b) **Deaths of patients with severe mental illnesses**[23]

These deaths should be reported to the relevant mental health trust and/or management team where the person was known to be under their care, and ambulance trusts should contribute to their review processes when approached. See Annex B for more guidance on this.

c) **Maternal and early (<6 days) neonatal deaths of babies born at term**

These should be reported to the Healthcare Safety Investigations Branch (HSIB) and Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE-UK). See Annex B for details on how to do this.

d) **Paediatric deaths**[24]

The Child Death Review Statutory and Operational Guidance outlines ambulance trusts' statutory duties with regards to notification and information gathering. Neonatal deaths are also covered by this guidance. Ambulance trusts should participate in child death review meetings or Child Death Overview Panel (CDOP) meetings when approached. See Annex B for further guidance on this.

e) **Safeguarding concerns**[25]

These deaths should be referred to the ambulance trust's named professional/safeguarding lead manager, in line with their statutory duties. See Annex B for further guidance on this.

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[23] The Royal College of Psychiatrists defines such 'red flag' patients as *"*patients with a diagnosis of psychosis or eating disorders during their last episode of care, who were under the care of services at the time of their death, or who had been discharged within six months prior to their death; all patients who were an inpatient in a mental health unit, or who had been discharged within the last month; all patients who were under a crisis resolution and home treatment team (or equivalent) at the time of death".

[24] Deaths of patients under 18 years.

[25] A concern can be defined as ambulance staff making two or more safeguarding referrals for the deceased within the last 12 months.

f) **Deaths in custody**

These deaths fall under the police forces' remit. See Annex B for further guidance on this.

These mandatory reporting categories may be added to or amended over time. In some circumstances, in addition to reporting the death to the relevant programme or body, ambulance trusts may see merit in conducting their own review of the death: for example, to identify early learning improvement actions in advance of the national review process. However, this is discretionary and additional to the requirements to notify the national review programmes of the death.

Ambulance trusts should consider each case individually to determine whether they should undertake their own independent review and are encouraged to consider their decision in discussion with the relevant review programme, to minimise duplication.

2.5 Approach to case record review

This section should describe how the trust undertakes case record reviews of deaths, including who is involved in carrying out case record reviews, how they are trained for this role and the methodology they use. It should also include the trust's policy on informing bereaved families and carers of its review or a joint review, providing them with a point of contact and giving them feedback at the end of the process.

Annex C gives a suggested standard methodology, adapted from the Royal College of Physicians' structured judgement review.[26]

[26]Royal College of Physicians (2018) *Implementing structured judgement reviews for improvement*.

2.6 How this links with investigations

This section should reference the trust's serious incident policy and, once appropriate, its successor: the trust's patient safety incident response policy and its associated patient safety incident response plan.

Any problems or issues with care which meet the definition of a patient safety incident[27] at whatever stage in the process these are identified, should be reported directly or via local risk management systems to the National Reporting and Learning Systems (NRLS) and to the Strategic Executive Information System (StEIS) where relevant.[28]

In some circumstances, it will be immediately evident that a patient safety incident has occurred and a safety investigation, designed to understand what happened and what can be learned, should be considered.

In other circumstances, potential problems with the care a patient received may not be immediately identified at the time of death. However, where a case record review suggests that the care provided by the ambulance service was more likely than not to have contributed to the death, this incident should be immediately reported as a patient safety incident, dealt with according to the statutory Duty of Candour requirements and referred to be considered for a patient safety investigation.

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[27] A patient safety incident is any unintended or unexpected incident which could have or did lead to harm to one or more patients receiving NHS care.

[28] See NHS Improvement's advice on reporting a patient safety incident. The Patient Safety Incident Management System will succeed the NRLS and StEIS in due course.

2.7 Bereaved families and carers

CQC's initial report on this topic in December 2016 and continued work with bereaved families and carers highlights the importance of getting communication with them right.

Families continually emphasise how important it is for health and care staff to listen to them and to demonstrate empathy and kindness following a death. This is particularly important where the family has concerns about the care provided, whether or not they believe this may have contributed to the death.

In developing their approaches, ambulance trusts should refer to the National Guidance for NHS trusts on engaging with bereaved families.[29] While this guidance was written for hospital trusts, many of the principles and examples of good practice apply to ambulance trusts.

It is recognised that ambulance trusts work hard to respond appropriately to concerns raised by bereaved families. In this section, ambulance trusts should describe how they contact, listen to, work with and support bereaved families and/or their advocates through the process, with reference to their existing policies where relevant.

Where trusts are planning to re-evaluate their approaches in response to this guidance, they should actively involve patients, families and patient representatives in the development process.

[29] National Quality Board (2018) *Learning from deaths: Guidance for NHS trusts on working with bereaved families and carers*.

Trusts should describe:

- how they respond to complaints from and concerns raised by bereaved families and carers about care;
- how they implement the statutory Duty of Candour, referencing supporting documents where relevant;
- how and under which circumstances they inform bereaved families and carers that they may or will undertake a case record review of the deceased person's care;
- how they inform bereaved families and carers of the outcomes of a case record review. They must be informed where review processes find the problems in care are more likely than not to have contributed to the death or have caused moderate to severe harm unrelated to the death, to fulfil the trust's duties in relation to the statutory Duty of Candour;
- how they involve bereaved families and carers in investigations;[30]
- how they involve bereaved families and carers in any learning and actions taken following case record and investigations, providing they want to be involved;
- how they support bereaved families and carers and how they refer them to further support and to advocacy services where requested;
- how they engage with families where a death has been referred to the coroner and will be the subject of an inquest; and
- how, in undertaking the above, they will take steps to ensure that they are able to meet the needs of all bereaved families and carers, with reference to the protected characteristics under the Equality Act 2010. This should include consideration of cultural and religious requirements, and consideration of how other requirements will be met (for example provision of British Sign Language interpreters or support for people with a learning disability).

[30] Further guidance on this involvement is given in the Serious Incident Framework and will be provided in the introductory Patient Safety Incident Response Framework (PSIRF).

Ambulance trust boards are responsible for embedding a culture of learning and transparency across their organisations, and for ensuring that the needs and views of patients, families and carers are considered in everything the trust does. Boards should be committed to changing the balance of power and have regard to the need to promote equality, in line with the Public Sector Equality Duty (Equality Act 2010). They should ensure that family involvement focuses on inclusivity, representation, non-discrimination and empowerment.

Where this information is provided in other policies, trusts can link to these rather than duplicating the full information.

Some best practice examples are included below:

"We will provide you with a named contact at the trust. Your named contact is committed to co-ordinating any meetings between yourself and the trust as well as ensuring that anything you wish to add to the investigation is passed onto the lead investigator to be considered." (Yorkshire Ambulance Service)

"Our Family Liaison Officer has been in post since January 2019. Her role includes: providing a platform from which patients and families can voice any concerns or provide positive feedback to crews, seeking patient and family views about their experiences of care and providing details of support agencies that may be available, as well as acting as a conduit into any investigation that may be taking place.

The introduction of the Family Liaison Officer has significantly improved our level of service to both members of the public and colleagues within the organisation, including: improved family communication, transparency of organisational procedures, and enhanced safeguarding processes which has led to identification of vulnerable people. Taken together, the impact is a

reduction of organisational risk and an increase in public confidence." (South Western Ambulance Service)

2.8 Supporting staff affected by the death of a patient

The death of a patient, whatever the circumstances, can have a considerable impact on staff involved. In this section, trusts should describe how they support staff following the death of a patient and how staff can seek help.

The policy should describe how the trust encourages and enables staff to identify issues and express concerns and demonstrate how the organisation is developing a culture of fairness, openness and learning.

Trusts should also describe the role of chaplaincy services in providing spiritual, emotional and practical support to staff affected by the death of a patient.

Trusts can link to existing HR policies detailing the support available for staff, rather than duplicating the full information.

2.9 Learning from case record reviews and investigations

In this section, trust policies should describe how learning from case record reviews and safety investigations is incorporated into quality improvement work. This should include how the outcomes of this work are recorded, measured and evaluated.

Since the process of undertaking case record reviews requires additional resources, the trust needs to be able to demonstrate how this work enhances information, advice and support for bereaved families and carers, as well as improving the service.

Intelligence and insights gained should be shared across ambulance trusts to identify common themes and opportunities for further joined up work to prevent future deaths and improve end of life care. This learning can be shared through relevant channels including the National Ambulance Service Medical Directors' group (NASMeD) and through the National Ambulance Service Quality, Governance and Risk Directors' group (QGARD). Ambulance trusts should also share learning with relevant local, regional and national bodies.

3. Reporting requirements

3.1 Publishing policies

Ambulance trusts should publish their Learning from Deaths policies by 1 December 2019.

3.2 Quarterly reporting

Ambulance trusts should publish their first set of data in Quarter 1 of 2020/2021. This will consist of data extracted from consideration of deaths that occurred in Quarter 4 of 2019/2020. In this and then every subsequent quarter, ambulance trusts should publish the following information in their public board papers:

- A summary of the learning from case record reviews and investigations completed in the previous quarter. (Examples of good quality care should be recognised within this);
- A summary of the resulting recommendations and actions to be taken and how the trust will evaluate the impact of these actions on patient safety;
- Number of completed case record reviews;
- Number of deaths for which a problem in care received was identified and this was considered more likely than not to have contributed to the death. This judgement should be made from the findings of further analysis undertaken following the initial case record review. More detail can be found in Annex C; and,
- A consolidated number of completed case record reviews and completed investigations for that financial year (from Quarter 2 2020/21 onwards).

Where ambulance trusts already report this information to their boards but in a different format, they are not required to duplicate this information in a separate 'Learning from Deaths' paper. However, they should assure themselves that they can meet the following tests:

- Does the way the information is presented enable the board to have a meaningful discussion in the context of its wider clinical governance and quality improvement responsibilities?
- Is the information easy to find on the trust's public website and does the way it is presented make it easy for an interested member of the public (eg a Healthwatch member) to understand?[31]

3.3 Annual reporting

From June 2021, ambulance trusts should provide a summary of their learning from deaths activity in the previous year. Subject to agreement, its inclusion is likely to become a requirement in annual quality accounts.

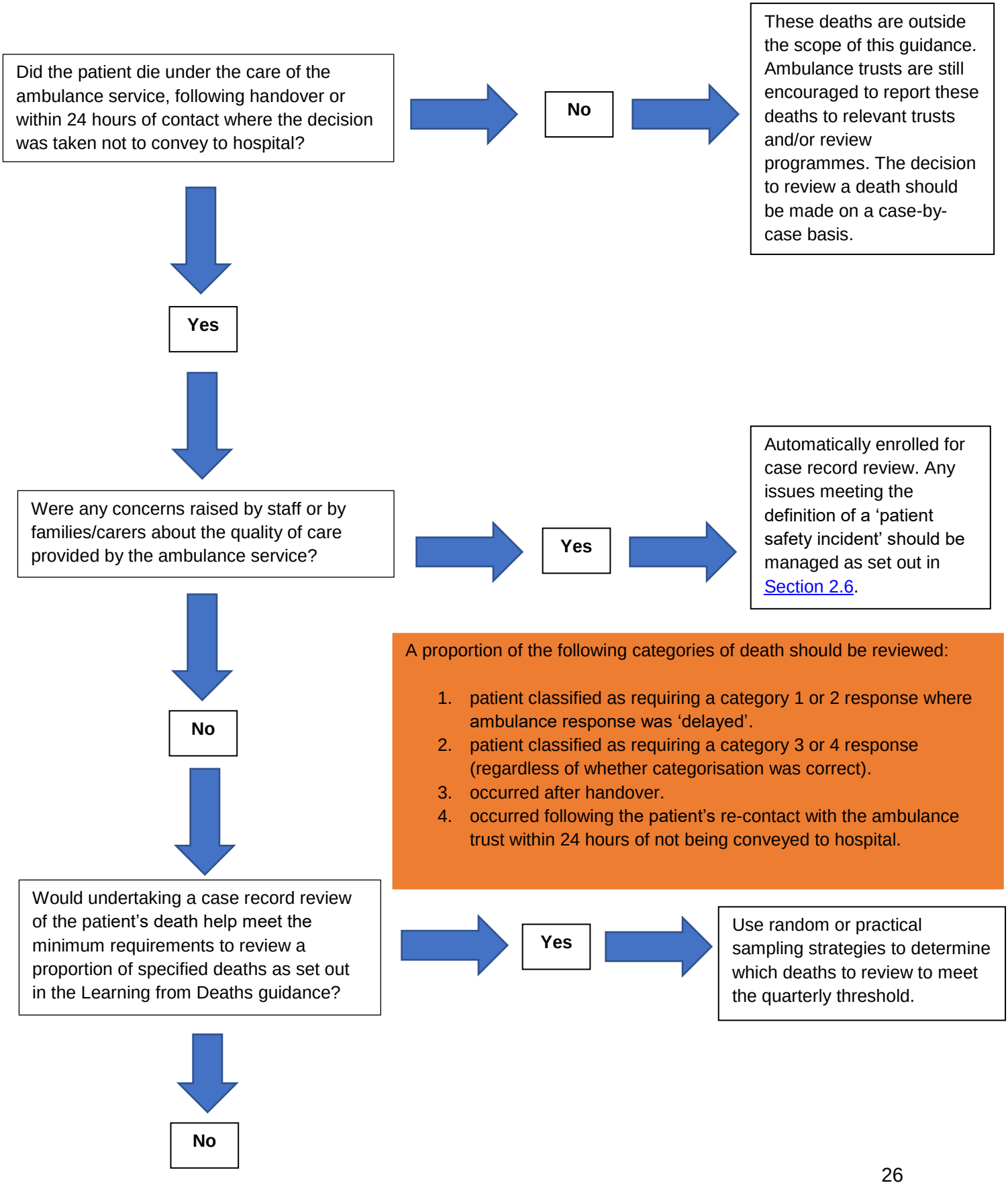
The exact information that ambulance trusts will be asked to provide will be clarified by December 2019. However, it is likely to consist of consolidated quarterly reporting information together with a narrative analysis of learning and resulting key themes, actions taken and the outcomes of these, reflecting the requirements for acute, community and mental health trusts.[32]

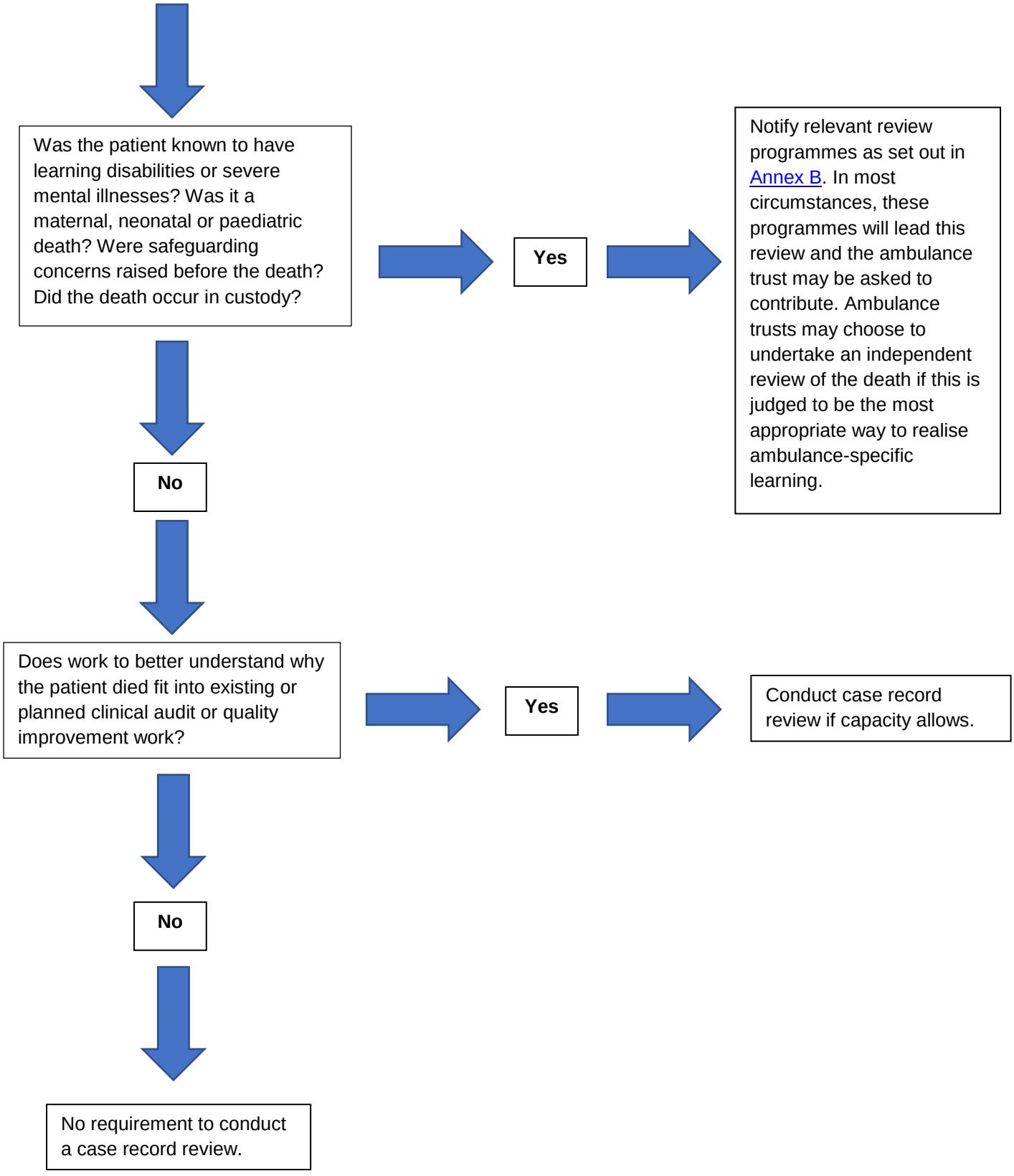
[31] Ambulance trusts should also consider how best to share this information with other interested parties such as Healthwatch and patient and family forums.
[32] The current requirements for acute, community and mental health trusts. Please see pages 14 and 15.

4. Revised versions

It is proposed that this guidance is reviewed at a suitable date to take account of simultaneous wider developments in learning from deaths and mortality reviews, as well as the impact of the introduction of the medical examiner system.

Annex A: Process for selecting deaths for review




Was the patient known to have learning disabilities or severe mental illnesses? Was it a maternal, neonatal or paediatric death? Were safeguarding concerns raised before the death? Did the death occur in custody?
Yes
Notify relevant review programmes as set out in Annex B. In most circumstances, these programmes will lead this review and the ambulance trust may be asked to contribute. Ambulance trusts may choose to undertake an independent review of the death if this is judged to be the most appropriate way to realise ambulance-specific learning.
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.

Annex B: 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 should be reported to the Learning Disabilities Mortality Review programme (LeDeR).[33]

When requested, trusts should 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 should also share the findings from their own review into the death with the LeDeR programme as soon as they can.[34]

Ambulance trusts may find LeDeR's e-learning tools help them to understand the LeDeR review process. [35]

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

[33] Notify deaths to LeDeR via http://www.bristol.ac.uk/sps/leder/notify-a-death/.
[34] Ambulance trusts can submit their findings as an attachment to the LeDeR notification web-based platform.
[35] Available at https://www.lederlearning.co.uk/login/index.php.

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[36] 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;[37]
- Report the maternal or neonatal death to MBRRACE-UK when deaths meet its criteria;[38]
- Report the neonatal death to Each Baby Counts[39] and NHS Resolution's Early Notification Scheme[40] where deaths meet their EBC criteria; and,

[36] Royal College of Psychiatrists' mortality review tool.
[37] HSIB's maternity investigation information.
[38] MBRRACE-UK's data collection system.
[39] Royal College of Obstetricians & Gynaecologist's Each Baby Counts quality improvement programme.
[40] NHS Resolution's Early Notification Scheme report.

- 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)[41] is mandated to support standardised perinatal mortality reviews.

All paediatric deaths

In reviewing these deaths ambulance trusts should be guided by the Child Death Review Statutory and Operational Guidance.[42] 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 should 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.

[41] MBRRACE-UK's Perinatal mortality review tool.
[42] HM Government (2018) *Child death review statutory and operational guidance*.

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).[43] Ambulance trusts should contribute to its investigation process when approached.

Deaths where safeguarding concerns had been raised

Ambulance trusts have statutory obligations with regards to these deaths. Staff should 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 should also be referred for review by the Clinical Commissioning Group Accountable Officer.

[43] IOPC Statutory Guidance: https://www.policeconduct.gov.uk/complaints-and-appeals/statutory-guidance.

Annex C: Methodology

It is proposed that standard case record reviews are centred on analysing specific phases of care based on the Royal College of Physicians' structured judgement reviews.[44] This is a standardised methodology based on the principle that to allow judgement to made in a way that is reproducible but not overly rigid, trained clinicians should use explicit statements to comment on the quality and safety of care given.

Ambulance trusts are encouraged to use this approach because a more consistent approach to analysis makes it possible to compare findings for common themes.

Ambulance trust phases of care

Phase	Phase scope	Details
1	Initial management and/or pre-scene	Appropriateness of initial call handling and categorisation; response time, appropriateness of vehicle and staff dispatched
2	On-scene	Clinical care quality
3	Handover (transfer and handover)	Clinical care quality
4[45]	End-of-life care	Appropriateness of clinical care and handover location, timeliness
	Other locally determined aspects of care	Quality and legibility of note-taking[46]
Assessment of overall care		

Care score	Meaning
1	Very poor care
2	Poor care
3	Adequate care
4	Good care
5	Excellent care

[44] Royal College of Physicians (2019) *Implementing structured judgement reviews for improvement*.
[45] It is at the ambulance trust's discretion whether 'end-of-life care' is considered a separate category for review, or such cases are reviewed under an alternative phase of care instead.
[46] This is predominantly useful for training purposes.

The reviewer should write short and explicit judgement statements about the quality of care in each phase, using free text. They should then give a corresponding score for each phase (and the reviewer will need to judge which phases to include as it may not be appropriate to include all of them), from 1 to 5 (very poor care to excellent care).

The overall care score brings a focus to the review by asking for an explicit, clear judgement on what the reviewer thinks of the whole care episode, taking all aspects into consideration, and making it clear why the judgement was made. Overall care scores are vital to the review process; an overall score of 1 or 2 (very poor or poor) should trigger a further review.[47] It is important to note that the review cannot comment on or describe the extent to which the care administered contributed to the death of the patient.

Reviewers are encouraged to identify actual and potential concerns to patient safety through answering:

1. Were there one or more problems in care during the time the patient was under the care of the ambulance trust? Yes or no?
2. If yes, in which area(s) of the care phase did this problem(s) occur? Provide a brief written statement for each one.

It is recommended that reviews are undertaken by practising clinicians of paramedic level or above, who have been trained in using the methodology. Reviews must not be undertaken by any clinician who cared for the patient.

In some circumstances where more than one provider was involved in the last episode of care, it may make sense for the setting where the person died to lead the review because of its access to patient information. For example, where a patient

[47] Ambulance trusts may find a few further reviews useful periodically as a quality-assurance measure while the process embeds.

was conveyed to hospital by ambulance and subsequently died there, the hospital may lead the case record review and seek a contribution from the ambulance trust about its care provision if relevant.

Further review

If the first-stage reviewer judges care overall to be very poor or poor (scored 1 or 2), then the case should be subject to a second review process.

The second review process should be undertaken by a different reviewer. It is recommended that this reviewer is a senior medical practitioner such as the trust's medical director or similar. This reviewer's role should first be to verify the findings of the first-stage review and second to make an additional judgement about whether, in their view, any of the problems in care identified were more likely than not to have contributed to the death occurring at the time it did.

Following the second review process, the case should also be discussed at a relevant internal meeting.

At any point in the review process, any issues in care which meet the definition of a patient safety incident[48] should be reported via local risk management systems or directly to the National Reporting and Learning Systems (NRLS) and the Strategic Executive Information System (StEIS) if relevant.[49]

[48] A patient safety incident is any unintended or unexpected incident which could have or did lead to harm to one or more patients receiving NHS care.

[49] See NHS Improvement's advice on reporting a patient safety incident.

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© NHS Improvement 2019 Publication code: CG 45/19
Publications approval reference: 000687