South Central Ambulance Service
NHS Foundation Trust

LEARNING FROM DEATHS POLICY

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DOCUMENT INFORMATION

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1. INTRODUCTION

1.1 This policy sets out the Trust's Learning from Deaths policy. It provides the standardised approach recommended for all ambulance trusts to adopt. It is based on National Guidance.

1.2 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.

1.3 Its introduction is in line with National Guidance for Ambulance Trusts on Learning from Deaths issued July 2019. It encompasses (but does not replace) reference to the Serious Incident Framework, the introductory Patient Safety Incident Response Framework (PSIRF), the statutory Duty of Candour and NQB's Learning from Deaths: Guidance for NHS trusts on working with bereaved families and carers. This guidance is also aligned with the new NHS Patient Safety Strategy.

1.4 The focus of this policy is routine case record reviews of deaths. 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, will 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.

2. PURPOSE

2.1 The Trust will implement the requirements outlined in the Learning from Deaths framework as part of the organisation's existing procedures to learn and continually improve the quality of care provided to all patients.

2.2 This policy sets out the procedures for identifying, recording, reviewing and investigating the deaths of people in the care of the Trust.

2.3 It describes how the Trust will support people who have been bereaved by a death at the trust, and also how those people should expect to be informed about and involved in any further action taken to review and/or investigate the death. It also describes how the trust supports staff who may be affected by the death of someone in the trust's care.

2.4 It sets out how the trust will seek to learn from the care provided to patients who die, as part of its work to continually improve the quality of care it provides to all its patients.

2.5 This policy should be read in conjunction with other Trust policies which relate to Clinical and Patient Safety.

3. SCOPE OF THE POLICY

3.1 This policy applies to all staff whether they are employed by the trust permanently, temporarily, through an agency or bank arrangement, are students on placement, are party to joint working arrangements or are contractors delivering services on the trust's behalf.

4. ROLES AND RESPONSIBILITIES

4.1 Board of Directors

The Trust Board takes the strategic overview. They receive assurance from the Quality & Safety bi-monthly board report, The Quality & Safety Committee receives upward reports from the Clinical Review Group and Patient Safety Group.

4.2 Chief Executive (CEO)

Is the Accountable Officer for all patient related contact with the Trust and will be responsible for ensuring that a specified executive director oversees the policy. The CEO also ensures that management fulfil their responsibility to implement this policy. The CEO will consider all reports to Board and act appropriately on any recommendations made.

4.3 Medical Director

Has the responsibility for the implementation of the policy and is the Board level lead for the policy.

4.4 Executive Director of Patient Care and Service Transformation

Has responsibility for overseeing any Patient Safety issues arising out of the policy.

4.5 Directors of all Areas of the Trust - 999, 111, Clinical Coordination Centre (CCC), Non-Emergency Patient Transport Service (NEPTS), Corporate Services

Are responsible for ensuring that any enquiries relating to the policy of actions required are dealt with in a timely manner.

5. APPROACH TO LEARNING FROM DEATHS

5.1 The Trust is committed to providing the highest standard of care to patients. The Learning from Deaths policy represents a proactive process for identifying areas where care can be improved from individual care given to patients, through to overall system processes. The involvement of relatives and staff in this process is an integral part of the process.

5.2 The Learning from Deaths policy will be led by the Learning from Deaths Group (LfDG) which integrates with, but does not replace other parts of the system such as Serious Incident Reviews and Patient Safety processes.

The membership of the LfDG is –

a) Assistant Medical Director (Chair)
b) Clinical Governance Leads 999
c) Consultant Pre-Hospital Care Practitioner (Deputy Chair of the Group)
d) Business Intelligence (BI) representative
e) Demand Management representative
f) Clinical Coordination Centre Lead
g) Clinical Directorate Representative, as required i.e. Safeguarding Lead
h) Legal Services Manager
i) Clinical Governance Leads 111

5.3 The LfDG reports to both the Patient Safety Group (PSG) and Clinical Review Group (CRG)

5.4 An integral part of the process is two way communication with external organisations such as receiving hospitals, Mental Health Trusts and Community and Primary Care services.

6. DETERMINING DEATHS IN SCOPE FOR CASE RECORD REVIEW

6.1 Deaths in scope for review are:

a) Any patient who dies 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.

A patient is considered under the care of the ambulance service:

i. while the 999 call is being handled;

ii. in the time between the 999 call being handled and the ambulance or subcontracted alternative patient transport arriving at the scene;

iii. at the scene;

iv. while the patient is being transported; and,

v. before handover concludes.

b) Any patient who dies after handover. 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. Contact includes 'hear and treat' and 111 calls 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.

7. DETERMINING WHICH DEATHS SHOULD BE SUBJECT TO CASE RECORD REVIEW

7.1 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;

A sample of 40-50 records per quarter relating to :

- Deaths of patients assessed as requiring category 1 and category 2 responses where the ambulance response was delayed;

- Deaths of patients assessed as requiring category 3 and category 4 responses;

- 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;

- 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.

8. ADDITIONAL REPORTING REQUIREMENTS

8.1 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. All deaths of those aged over four with a known learning disability must be reported to the Learning Disabilities Mortality Review (LeDeR) Programme. The Trust will contribute to this programme's review processes when approached and share its review findings with LeDeR when relevant.

b) Deaths of patients with severe mental illnesses. These deaths will be reported to the relevant mental health trust and/or management team where the person was known to be under their care, and trust will contribute to their review processes when approached.

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

d) Paediatric deaths. The Child Death Review Statutory and Operational Guidance outlines Trust's statutory duties with regards to notification and information gathering. Neonatal deaths are also covered by this guidance. The Trust will participate in child death review meetings or Child Death Overview Panel (CDOP) meetings when approached.

e) Safeguarding concerns. These deaths should be referred to the Trust's named professional/safeguarding lead manager, in line with their statutory duties.

f) Deaths in custody. These deaths fall under the police forces' remit.

9. APPROACH TO CASE RECORD REVIEW

9.1 Cases will be identified by two main methods:

a) Search criteria on SCAS electronic patient record system to identify all deaths that occur whilst the patient is under the care of the ambulance service
b) Notifications of deaths from partner organisations

9.2 Each case will then be assessed using the methodology in Appendix A. The initial scoring will be done by a clinician who has undergone specific training for the role. Any case scoring 1 or 2 on the overall care will undergo further analysis which will include a review by senior clinicians. These cases will be reviewed by LfDG.

9.3 Learning points will be identified by LfDG and feedback will be given according to the nature of the learning which may include – individual feedback, additional training to individuals or all staff, review of systems and policies, feedback to external partners.

9.4 Upward reporting will be to both the Patient Safety Group and Clinical Review Group.

10. LINKS WITH OTHER INVESTIGATION PROCESSES

10.1 The Learning from Deaths policy does not replace other investigation processes such as Serious Incidents and Patient Complaints. The Learning from Deaths process will concentrate on identifying areas of learning at both an individual and system level. Other investigative processes will run in parallel with this.

10.2 Any problems or issues with care which meet the definition of a patient safety incident at whatever stage in the process these are identified, will 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.

11. BEREAVED FAMILIES AND CARERS

11.1 Where a patient dies whilst under the Trust's care, bereaved families and carers will initially be cared for as part of standard clinical care.

11.2 Any complaints or concerned raised by families or carers will be dealt with through the Patient Experience team.

11.3 In a situation where the Learning from Deaths process identifies 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, the statutory Duty of Candour process will be followed in line with the Adverse Incident policy.

12. SUPPORTING STAFF AFFECTED BY THE DEATH OF A PATIENT

12.1 The death of a patient, whatever the circumstances, can have a considerable impact on staff involved.

12.2 Support for staff is available in a number of ways including, support from Team Leaders, peer support, TRIM practitioners and external psychological support.

12.3 Staff are encouraged to identify issues and express concerns and the Trust has a culture of fairness, openness and learning.

12.4 Chaplaincy services can be engaged to providing spiritual, emotional and practical support to staff affected by the death of a patient.

13. LEARNING FROM CASE RECORD REVIEWS AND INVESTIGATIONS

13.1 When an area of learning is identified from the Learning from Deaths an assessment will be made on the appropriate method of dissemination to ensure

learning takes place. The process may include individual feedback via Mentors or Team Leaders, communication to all staff through publications such as SCASCADE and/or formal education programs.

13.2 In the case where system changes are required this will be fed through the relevant parts of the organisation which may include Clinical Coordination Centre, Operations or Quality Improvement.

13.3 Where partner organisations are involved a two way process of learning will be used using single point of contact for each partner organisation.

13.4 Feedback can also be given to local and national bodies such as National Ambulance Medical Directors (NASMeD) group or through the National Ambulance Service Quality, Governance and Risk Directors' group (QGARD). This will help identify common themes and opportunities for further joined up work to prevent future deaths and improve end of life care.

13.5 Where possible a further review will be undertaken to assess whether the actions taken have been effective.

14. RESOURCES

14.1 The Trust undertakes to provide adequate resources including workforce and IT infrastructure to support the Learning from Deaths policy.

15. REPORTS – QUARTERLY AND ANNUAL

15.1 The Trust will 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, the Trust will publish the following information in the public board papers:

- A summary of the learning from case record reviews and investigations completed in the previous quarter. (Examples of good quality care will be recognised within this);

- A summary of the resulting recommendations and actions 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 will be made from the findings of further analysis undertaken following the initial case record review.

- A consolidated number of completed case record reviews and completed investigations for that financial year (from Quarter 2 2020/21 onwards).

15.2 Annual reporting -

From June 2021, the Trust will provide a summary of the learning from deaths activity in the previous year. The content of the report will be in line with national guidance.

16. EQUALITY STATEMENT

16.1 The Trust is committed to promoting positive measures that eliminate all forms of unlawful or unfair discrimination on the grounds of age, marital status, disability, race, nationality, gender, religion, sexual orientation, gender reassignment, ethnic or national origin, beliefs, domestic circumstances, social and employment status, political affiliation or trade union membership, HIV status or any other basis not justified by law or relevant to the requirements of the post.

16.2 By committing to a policy encouraging equality of opportunity and diversity, the Trust values differences between members of the community and within its existing workforce, and actively seeks to benefit from their differing skills, knowledge, and experiences in order to provide an exemplary healthcare service. The Trust is committed to promoting equality and diversity best practice.

16.3 The Trust will therefore take every possible step to ensure that this procedure is applied fairly to all patients, advocates and employees regardless of race, ethnic or national origin, colour or nationality; gender (including marital status); age; disability; sexual orientation; religion or belief; length of service, whether full or part-time or employed under a permanent or a fixed-term contract or any other irrelevant factor.

16.4 Where there are barriers to understanding e.g. a patient, advocate or employee has difficulty in reading or writing or where English is not their first language additional support will be put in place wherever necessary to ensure that the process to be followed is understood and that each individual is not disadvantaged at any stage in the procedure.

APPENDIX A – Learning from Deaths (LfD) - Structured Judgement Review (SJR) Template

A Structured Judgement Review form is available for Internal use by SCAS Staff. It can be accessed internally via our Staff Intranet.