North East Ambulance Service NHS
NHS Foundation Trust

Learning from Deaths

Document Control Sheet

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This policy supersedes all previous issues.

Version Control - Table of Revisions

All changes to the document must be recorded within the 'Table of Revisions'.

Version number	Document section/ page number	Description of change and reason (e.g. initial review by author/ requested at approval group	Author/ Reviewer	Date revised
2	All	Policy renamed from 'Respond to Deaths' and updated in it's entirety to reflect the 'National Guidance for Ambulance Trusts Learning from Deaths' July 2019 publication.	Shane Woodhouse	27 June 2019

This page should not be longer than one single page.

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1. Introduction

The National Quality Board published the first edition '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' in June 2019. This requires all ambulance trusts to have implemented Learning from Deaths policy and to publicly report on the work outlined within the policy at board level from Quarter 1 2020/21.

The North East Ambulance NHS Foundation Trust implemented the National Quality Boards 'National Guidance on Learning from Deaths: a framework for NHS Trust and NHS Foundation Trust on identifying, reporting, investigating and learning from deaths' via the Responding to Deaths policy and local Learning from Deaths group in July 2018. NEAS contributed to the ambulance specific guidance by sharing the feedback and lessons learnt from implementing the NHS acute trust guidance. This policy has been updated to reflect the ambulance specific guidance.

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 builds on the Care Quality Commission (CQC) 2016 report 'Learning, Candour and Accountability: A review of the way NHS trusts review and investigate the deaths of patients in England' which highlights that valuable opportunities to learn from the care being provided to patients was being missed across the system and families did not experience the NHS as being open and transparent. It was recognised that there was not a consistent approach to reviewing and learning from the care provided to those who die.

The guidance seeks to ensure ambulance services are identifying and reviewing deaths consistently across all trusts. That mechanism exists to identify issues and compassionately support both staff and families when patients die. For many people who die whilst under the care of the NHS it is an inevitable outcome and they experience excellent care from the NHS leading up to their death. On occasions, some patients experience poor quality of care from a range of contributory factors. When mistakes happen or opportunities are missed providers are required to identify, understand, investigate and learn to ensure improvements are made for future patients.

2. Purpose

The purpose of the Learning from Deaths policy is to outline how NEAS will respond to deaths, identifying and consistently reviewing, then supporting staff and families whilst striving for continuous improvement in the clinical care provided.

3. Scope

This policy applies to all staff, volunteers and contractors who are providing clinical care to any patient, at any stage of their contact with NEAS and subsequently die.

4. Duties - Roles & Responsibilities

4.1 Trust Board

The Trust Board is responsible for gaining assurance that this policy is complied with.

4.2 Chief Executive

The Chief Executive has overall responsibility for ensuring the production and safe storage and destruction of clinical records. However, this has been devolved within the Trust board to a Medical Director (section 4.3).

4.3 Medical Director

The Medical Director has board level responsibility for ensuring that the Learning from Deaths work is undertaken in line with the national policy requirements.

4.4 The Chief Operating Officer

The Chief Operating Officer has operational responsibility to ensure that all operational staff adhere to this policy and the procedures outlined within this document.

4.5 Director of People and Development

The Director of People and Development is responsible for ensuring that the training recommendations are implemented (as per the training needs analysis and training program) and ensuring any refresher training is provided (including ensuring the earliest possible resolution for those who missed scheduled training).

4.6 Clinical Audit and Effectiveness Manager

The Clinical Audit and Effectiveness Manager has responsibility for coordinating the Learning from Deaths work.

4.7 Operational Management

The Operational Management Team have responsibility for ensuring operational staff abide by the requirements of this policy.

4.8 Quality Committee

The Quality Committee is responsible for receiving assurance that this policy is complied with through the bi annual data quality audit.

4.9 Learning from Deaths Group

The Learning from Deaths Group is responsible for reviewing the cases review, agreeing, implementing and monitoring actions.

4.10 Information Governance Working Group

The Information Governance Working Group is responsible for reviewing Trust wide implementation of the Information Governance Policy and recommending action as appropriate and ensuring all staff have information governance training.

4.11 Employees, Volunteers and Contractors

All Employees, Volunteers and Contractors of the Trust have a duty to ensure they comply with this policy.

5. Glossary of Terms

This policy uses the following terms:

Term	Description
ePCR/PRF	Electronic patient care record or patient report – the documentation where all ambulance staff record patient contacts
Cleric	The system used within the emergency operations centre that records the triage, dispatch and notes passed between either of these functions and operational staff.
SJR	Structured judgement review – the methodology used to review individual cases
Ulysses	The Trusts incident reporting system
ROLE	Recognition of life extinct – the process of ambulance crews recognizing the death of a patient

6. Policy Content

6.1 Identifying cases

Cases will predominantly be identified through the cardiac arrest work and internal reports. The clinical audit team will liaise with patient safety, safeguarding, risk and patient experience to identify other cases.

6.2 Case review methodology

Royal College of Physicians Structured Judgement Review (SJR) methodology will be used to review all cases. This will consist of a two-stage review process with the first stage being undertaken by paramedic clinical auditors and the second stage a multiple disciplinary team within NEAS.

All cases identified will be recorded on the Learning from Deaths module hosted by Ulysses, the trust internal incident reporting system.

6.2.1 Stage 1 Review

Stage 1 reviews will be undertaken by paramedics that have been trained in the use of SJR methodology and who have not been involved in the care of the patient. Stage 1 will predominantly involve a case review of the ePCR of PRF and any cleric notes. Call audit and dispatch reports will be requested if potential issues are identified for either of these areas respectively.

Any patient that fulfils the inclusion criteria will have an individual incident generated on the Learning from Deaths module currently hosted by Ulysses.

Phases of care will be reviewed with explicit judgements about the quality of care recorded as free text and score for each phase of care. Not all phases of care will require review and it is the discretion of the reviewer to decide this.

Explicit judgements will refer to the quality of care the patient received and cannot comment on or describe the extent to which the care administered contributed to the death of the patient.

Reviews should be undertaken within 42 days of the death of the patient.

6.2.2 Cases requiring further review

The following cases will be referred for stage 2 review:

- Any patient who receives a score of 1 (very poor) or 2 (poor) for an individual phase of care
- Any patient who experienced a problem in more than one phase of care
- Concerns raised after reviewer undertaken stage 1

6.2.3 Stage 2 reviews

Stage 2 reviews will be attended by cross-organisational representatives at a monthly meeting. Cases will be presented by the stage 1 reviewer and then discussed until a decision and actions have been agreed. Outcomes will be updated on the Ulysses system and the minutes of the meeting will provide an account of the discussion.

6.3 Inclusion criteria

All patients that fulfill the inclusion criteria will undergo a stage 1 review. For the purpose of this document death/dies refers to any patient who experienced a cardiac arrest after initial contact with the ambulance service and ROLE was completed by NEAS or death confirmed after handover.

Inclusion criteria	Definition
Any patient who dies whilst under the care of NEAS	• While the 999 call is being handled • Before the ambulance response arrives • At the scene • Whilst the patient is being transported • Before handover has concluded
Any patient who dies following handover to an acute NHS, community, mental health or primary care provider when this information is known	
Any patient who dies within 24 hours after contact with the ambulance service	• Any patient non-conveyed by the ambulance service • Any 'hear and treat' patients
Any death where ambulance staff, other health and care staff, families or carers have raised concerns	
Any patient requiring a category 1 or category 2 ambulance response that experienced a delay	• Category 1 calls that exceed ARP 90th centile 18 minutes • Category 2 calls that exceed ARP 90th centile of 40 minutes

Any patient who dies having been triaged as requiring a category 3 or category 4 ambulance response	

6.4 Specific patient groups

NEAS will engage with all relevant organisations involved in the case review of specific patient group deaths as outlined below.

NEAS will identify these cases and refer to the appropriate agencies. NEAS will only undertake a SJR for specific patient groups outlined below if they fulfil additional criteria for review or at the request of the lead organization undertaking the death review.

6.4.1 Patients with learning disabilities

All patients with aged over 4 years with a Learning Disability should be reported to the Learning Disabilities Mortality Review programme (LeDeR).

Only patients that have ROLE completed by NEAS will be notified to LeDeR, it will be the responsibility for the receiving hospital to refer to LeDeR if the patient subsequently dies after handover.

6.4.2 Patients with severe mental health illness

All patients with a severe mental health illness will be notified to the trust Mental Health Lead so that the relevant organisation is notified.

6.4.3 Maternal and neonatal deaths

All these cases should be transported to hospital as per national guidelines and it is the hospital lead clinician to determine if the death fulfils the criteria for investigation and action this as required.

Any maternal or neonatal deaths identified will be passed to Safeguarding who represent the organisation at case reviews.

6.4.4 Paediatric deaths

All these cases should be transported to hospital as per national guidelines and it is the hospital lead clinician to determine if the death fulfils the criteria for investigation and action this as required.

Any paediatric deaths identified will be passed to Safeguarding who represent the organisation at case reviews.

6.4.5 Safeguarding concerns

There is an established process for raising safeguarding concerns for adults and children, see the safeguarding adult and children policy/procedures on Q Pulse.

All patients were safeguarding concerns are identified through case review will be passed to Safeguarding for cross referencing and appropriate action.

6.4.6 Deaths in custody

Police officers have a statutory obligation to notify the Independent Office of Policy Conduct when a death occurs in custody. This includes police and prison suites, youth offender institutions, immigration removal centres and patients under Section 135 or 136 of the Mental Health Act.

Safeguarding will be notified of all patients identified that fulfil these criteria.

6.5 Patient safety incidents

When an incident is identified at any stage or the review process and it is believed that the ambulance service was more likely than not to have contributed to the death of a patient then patient safety will be notified.

This policy will adhere to the Trusts Reporting and Management of Serious Incident policy and Reporting and Investigation of Adverse Event policy.

6.6 Investigations

On occasion further information will be required to complete the stage 1 of the SJR. Requests for additional information will be made by the line manager of the staff member involved and be requested via the Ulysses system.

6.7 Duty of Candour

Families will be supported in line with the Trusts Reporting and Management of Serious Incident policy section 6.4 Being Open – Duty of Candour.

6.8 Reporting

Learning from death activity will be published quarterly in board level papers which will be available to the public.

7. Training Required for Compliance with this Policy

All staff involved in the process will require training in:

- SJR methodology
- Ulysses system
- Investigation training or supervised by a staff member that have received investigation training

Compliance with the policy will be monitored by the Clinical Audit & Effectiveness Manager. All staff involved will receive annual training and any identified training

needs will be actioned as they arise.

8. Equality and Diversity

This policy has had an equality and diversity assessment.

9. Monitoring Compliance with and Effectiveness of this Policy

9.1 Compliance and Effectiveness Monitoring

Arrangements for the monitoring of compliance with this policy and of the effectiveness of the policy are detailed below.

9.2 Compliance and Effectiveness Monitoring Table for this policy

Process in the policy	Monitoring and audit					
	Key Performance Indicators (KPI)/ Criteria	Method	Who By	Committee	Frequency	Learning/ Action Plan
Stage 1 reviews undertaken	The % of stage 1 reviews being undertaken	Report to LFD group	Clinical Audit & Effectiveness Manager	Learning from Deaths	Quarterly	
Stage 2 reviews undertaken	The % of stage 3 reviews being undertaken	Report to LFD group	Clinical Audit & Effectiveness Manager	Learning from Deaths	Quarterly	

10. Consultation and Review of this Policy

This policy has been reviewed in consultation with the Learning from Deaths group.

11. Implementation of this Policy

This policy will supersede the previous version and should be implemented in full by 1 October 2019.

12. References

This document refers to the following guidance, including national and international standards:

- National Quality Board, (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.

13. Associated Documentation

This policy refers to the following Trust documents:

- Trusts Reporting and Management of Serious Incident policy
- Reporting and Investigation of Adverse Event policy.

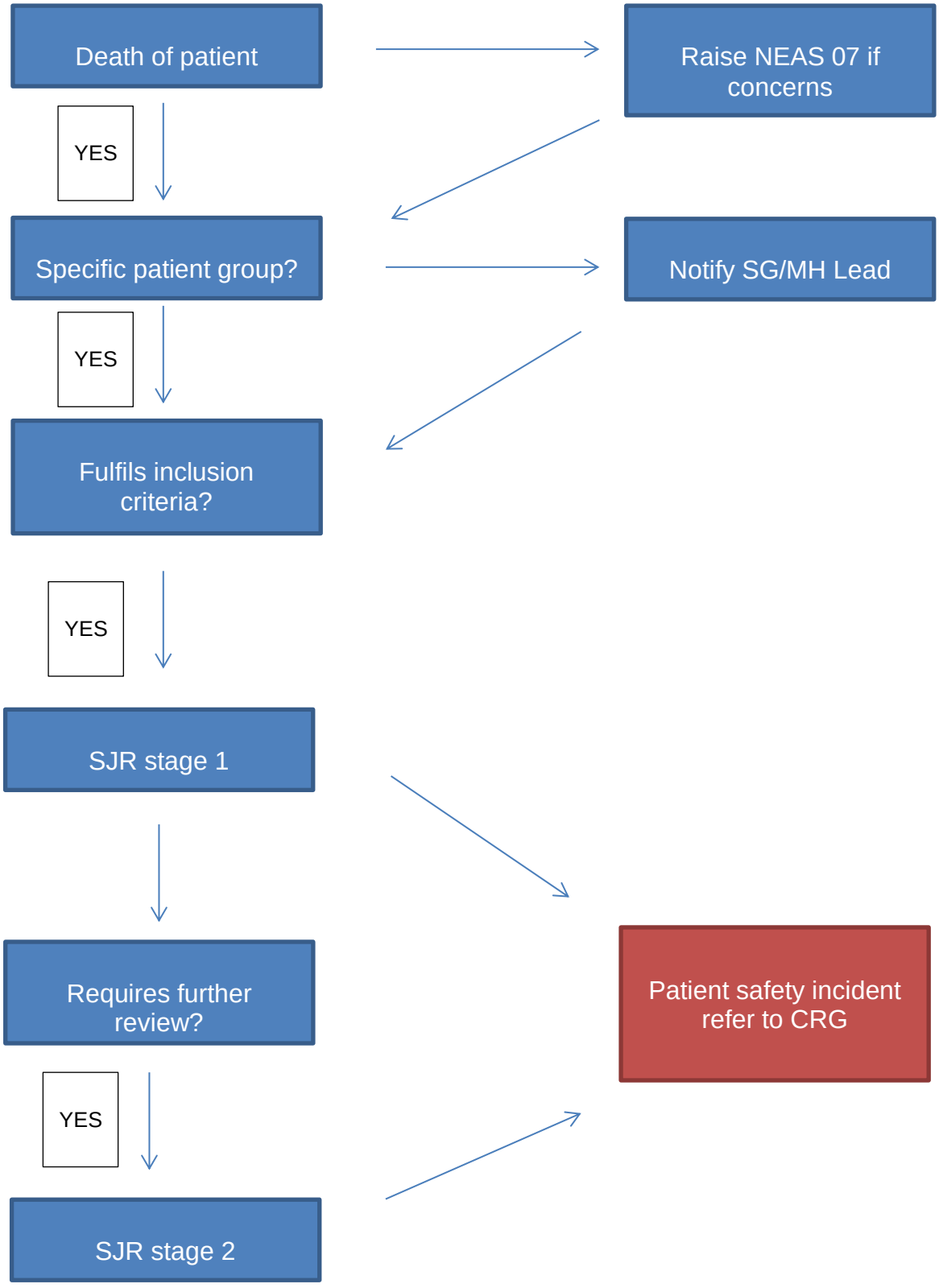
14. Appendices

Appendix A Process Flowchart

Appendix B SJR methodology

Appendix C Reporting

14.1 Appendix A Process Flowchart



14.2 Appendix B: Structured Judgement Review

Structured Judgement Review methodology will be used to review the phases of care as outlined in the guidance document. Documentation has been added as a local phase of care to reflect on-going work.

Structured Judgement Review: Stage 1		
Incident information	Reviewer Review date Inclusion criteria Incident number Incident date Incident time Sex Age Incident postcode Aetiology Crew names	
Phase 1: Pre-scene	Call handling issue? Dispatch or response issue?	Reviewer explicit judgement review Phase of care score
Phase 2: On-scene	Clinical Care issue?	Reviewer explicit judgement review Phase of care score
Phase 3: Transfer & Handover	Transfer issue? Handover issue?	Reviewer explicit judgement review Phase of care score
Phase 4: End of Life Care	End of life care issue?	Reviewer explicit judgement review

		Phase of care score
Phase 5: Documentation	Documentation issue?	Reviewer explicit judgement review Phase of care score
Structured Judgement Review: Stage 2		
Meeting date Summary Actions Outcome Patient safety incident?		

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

14.3 Appendix C Reporting

Learning from Deaths will be reported on quarterly and provide accounts of the Learning from Deaths activity for that quarter.

1. A summary of the learning themes from reviews and investigations with the resulting recommendations and actions taken. This will include examples of good quality care.
2. How NEAS are assessing whether their learning and actions are improving patient safety.
3. The number of completed reviews.
4. The number of deaths for which and investigation was indicated and, of these, the number of completed investigations.
5. 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.
6. A consolidated total of the number of live and completed reviews and investigations relating to that financial year.