Yorkshire Ambulance Service NHS Trust

MEETING TITLE Trust Board in Public		**MEETING DATE** 28/11/2019	
TITLE of PAPER	Learning from Deaths Policy	**PAPER REF**	3.2
KEY PRIORITIES	Embed an ethos of continuous improvement and innovation, that has the voice of patients, communities and our people at its heart Create a safe and high performing organisation based on openess, ownership and accountability Choose an item.		
PURPOSE OF THE PAPER	This paper serves to assure Board that the Trust has developed a policy and procedure to ensure that Learning from Deaths takes place in accordance with NHSE/I requirements.		
For Approval	☐	**For Assurance**	☒
For Decision	☐	**Discussion/Information**	☐
AUTHOR / LEAD	Dr Steven Dykes, Deputy Medical Director	**ACCOUNTABLE DIRECTOR**	Dr Julian Mark, Executive Medical Director

DISCUSSED AT / INFORMED BY – include date(s) as appropriate [free text - please provide an audit trail of the development(s) / proposal(s) subject of this paper: see also guidance 3 overleaf]:

PREVIOUSLY AGREED AT:	**Committee/Group:** Trust Management Group Choose an item.	**Date:** 13/11/2019 Click to enter date
RECOMMENDATION(S)	It is recommended that the Clinical Governance Group:- Approve the Learning from Deaths policy	

RISK ASSESSMENT	**Yes**	**No**
Corporate Risk Register and/or Board Assurance Framework amended *If 'Yes' – expand in Section 4. / attached paper*	☐	☒
Equality Impact Assessment - *[New]* *If 'Yes' – expand in Section 2. / attached paper*	☐	☐
Resource Implications (Financial, Workforce, other - specify) *If 'Yes' – expand in Section 2. / attached paper*	☒	☐
Legal implications/Regulatory requirements If 'Yes' – expand in Section 2. / attached paper	☒	☐

ASSURANCE/COMPLIANCE	
Care Quality Commission **Choose a DOMAIN(s)**	1: Safe 5: Well led
NHSI Single Oversight Framework **Choose a THEME(s)**	2. Quality of Care (safe, effective, caring, responsive)

	Choose an item.

Learning from Deaths Policy

1. PURPOSE/AIM

1.1 This paper serves to assure Board that the Trust has developed a policy and procedure to ensure that Learning from Deaths takes place in accordance with NHSE/I requirements.

2. BACKGROUND/CONTEXT

2.1 In March 2017 the National Quality Board published the first national guidance on learning from deaths for NHS acute, mental health and community trusts in response to the Care Quality Commission's 2016 publication "Learning, candour and accountability: a review of the way NHS trusts review and investigate the deaths of patients in England" to address the inconsistent approach to reviewing and learning from deaths.

2.2 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. With input from the National Ambulance Services Medical Directors group (NASMeD) and the national ambulance Quality, Governance And Risk Directors group (QGARD), and recognising that the ambulance sector had already made considerable progress in establishing learning from death review processes, NHSI developed guidance for learning from deaths for ambulance services (Appendix A) in July 2019.

2.3 Two workshops have been held with representatives from the legal team, safeguarding, patient relations, investigations and learning, and clinical audit teams to review current process, design the new workflows and develop the attached policy.

2.4 The draft Learning from Deaths policy was agreed at Clinical Governance Group on 15 October and approved at Trust Management Group on 13 November 2019.

3. PROPOSALS/NEXT STEPS

3.1 To comply with national requirements a learning from deaths policy is being presented to Board prior to publication on our website. Datix will be used to gather incidents and the procedure will be tested during December, producing live data from Q4 2019/20.

4. RISK ASSESSMENT

4.1 Capacity to review the number of deaths in the detail required by the guidance may be challenging. A review of job roles is underway which will incorporate case review for this purpose, including training to be able to undertake the required structured judgement review, which will provide a degree of mitigation.

4.2 Incident management will be performed through the Datix platform. The module required for this isn't due to be incorporated until November 2019. Any

delay to the upgrade to the Datix platform may adversely affect our ability to review incidents and report learning.

5. RECOMMENDATIONS

It is recommended that the Board are assured that the Trust has adequate mechanisms in place to satisfy the NHSE/I requirements for Learning from Deaths.

6. APPENDICES/BACKGROUND INFORMATION


Learning from Deaths policy v0.3.dc


EIA Learning from Deaths.docx


Learning from deaths guidance for ambular