NHS
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NHS Trust

Learning from Deaths Policy

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Staff Summary

Death is inevitable and a natural event for all of us, and not all deaths will represent a medical failing or problem in the way the person has been supported during their life. However, like any other human system, the NHS is fallible. It does not always respond when needed, its healthcare staff sometimes makes mistakes and the component parts of the system do not always work together well.
This Policy will provide the framework in which the Trust provides consistently effective, meaningful engagement and compassionate support between families, carers and staff that is open and transparent to allow them to raise questions about the care provided to their loved one.
Dealing respectfully, sensitively and compassionately with families and carers when someone has died is crucially important. At times families may have questions, and/or concerns they would like answers to in relation to the care and treatment their loved one received but don't always want to make a complaint.
The Learning from Deaths process enhances and does not replace the Patient Safety Incident Response Framework, Safeguarding Policy, Courts & Evidence Policy, Disclosure Policy or the Compliment, Comments, Concerns and Complaints Management Policy.
The Trust operates within a 'just culture', recognising that mistakes can happen within healthcare and that there are often system and process improvements required to support staff to do their job effectively. YAS recognises that when staff are involved in a patient death, and or when a patient safety incident occurs, this can be a very stressful experience, sometimes becoming a 'second victim' to the incident and they will need support through a number of mechanisms.

1.0 Introduction

1.1 Death is inevitable and a natural event for all of us, and not all deaths will represent a medical failing or problem in the way the person has been supported during their life. However, like any other human system, the NHS is fallible. It does not always respond when needed, its healthcare staff sometimes makes mistakes and the component parts of the system do not always work together well. This means that, when things go wrong, the cost can be a death that may have been prevented, and investigations need to be carried out to learn, explain to families and carers what went wrong or make sure accountability is clear when failure is found. Two of the behaviours that underpin the vision and purpose of the NHS in England – openness and learning in order to improve – are never needed more than when a patient dies whose care may have been delivered differently and whose death might have been prevented.

1.2 This Policy will provide the framework in which the Trust provides consistently effective, meaningful engagement and compassionate support between families, carers and staff that is open and transparent to allow them to raise questions about the care provided to their loved one and ensure the Trust engages with other stakeholders (Acute Trusts, Primary Care, and Mental Health Trusts) to work collaboratively, sharing relevant information and expertise to maximise learning from deaths.

1.3 This policy will include:

- The Trust's approach to learning from deaths
- Which deaths the Trust considers to be in scope for case reviews, and which of these deaths in scope we will systematically review.
- The Trust's method for reviewing deaths, including the methodology that will be used for conduct case note reviews.
- The Trust's Patient Safety Incident Response Framework.

- The Trust's approach to involving and engaging with bereaved families and carers during these processes.
- The Trust's processes for supporting staff following the death of a patient which has had an impact on them, and the mechanisms and resources available for staff to access help.
- How the Trust will record learning from reviews and investigations and how this will be integrated into quality improvement work, including measuring the impact and results of this work.

2.0 Approach to Learning from Deaths

2.1 Investigations form a vital part of informal learning and improvement across Yorkshire Ambulance Service NHS Trust. Understanding why things go wrong and learning from these cases influences the safety and quality of care provision across the Trust. Identifying and sharing appropriate learning across the Trust enables improvement to be made. It is important that investigations identify good practice and areas for improvement, both of which can be shared Trust wide within a culture of openness and transparency to ensure lessons are learned.

3.0 Determining Deaths in Scope for Review

3.1 The following deaths will be in scope for the review process:

3.1.1 Any patient who dies whilst under the care of the Trust. (This is defined as the patient dying between the 999 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.)

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

- while the 999/NHS 111 call is being handled
- in the time between the 999 call being handled and the ambulance or subcontracted alternative patient transport arriving at the scene, including any welfare calls made to the patient
- at the scene
- while the patient is being transported
- before handover has concluded

3.1.3 Any patient who dies after handover, including paediatric patients transported as per the SUDICA process or where ROLE cannot be invoked. (Only applicable when notified by the Acute Trust.)

3.1.4 Any patient who dies within 24 hours of contact with the ambulance service where a decision was taken not to convey to hospital or where another HCP has seen the patients within 24 hours. This contact includes "hear and treat" patients as well as patients who were visited by ambulance personnel. This criterion should exclude 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.

3.1.5 This does not mean that all these deaths must be reviewed, only that they are eligible for consideration for review and should be reviewed if it is considered appropriate as described below.

4.0 Determining which Deaths Should be Reviewed

4.1 The Trust will review between 40 and 50 cases per quarter comprising of:

- 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
- 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

4.2 Where these deaths are already encompassed under national mortality review programmes the Trust will consider, in discussion with the relevant review programme, whether there are still merits in undertaking their own review or whether there is more value in them contributing to a wider or external review. These include:

a. Deaths of patients with learning disabilities
All deaths of those aged 18 and over 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. The ACGL performing the LfD review is responsible for reporting onto the NHS website and as of 1st January 2022 this referral now includes those patients who have a diagnosis of Autism.

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 the Trusts 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 (Deaths of patients under 18 years old)
The Child Death Review Statutory and Operational Guidance outline ambulance trusts' statutory duties with regards to notification and information gathering. Neonatal deaths are also covered by this guidance. The Trusts will participate in child death review meetings or Child Death Overview Panel (CDOP) meetings when approached.

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

5.0 Process

5.1 All deaths notified by the use of the ePR ROLE option will be screened by the Clinical Informatics and Audit team (appendix 13.4) and referred into the stage 1 review if set criteria are met. Any deaths involving children and young adults 18 years and younger or any vulnerable adult deaths to be notified to the safeguarding team by the appropriate Quality Governance Assurance Manager (QGAM).

5.2 Stage 1 review will be performed by the QGAM or delegated appropriate clinician using the Royal College of Physicians Structured Judgment Review tool (appendix 8.2) and an AMPDS/NHS Pathways call audit performed on Category 2, 3 and 4 calls if concerns exist about the coding or response time. Any deaths with a care score of 1 or 2 in any section, a failed (one that would have impacted on the overall response category) AMPDS/NHS Pathways audit, will be referred to the area QGAM and presented to the Local Incident Review Group for a stage 2 review (Terms of Reference at Appendix 8.1)

5.3 The QGAM or delegated appropriate clinician will present the case to the Local Incident Review Group and a decision will be made to the next steps, which includes: no further action or referral into the patient safety incident process or clinical case review process. Incidents involving moderate or above harm will be presented to the next available Central Incident Review Group. Themes and trends will be collated by the Clinical Informatics and Audit team and presented to the Trust Patient Safety Learning Group. A case study will be chosen from the previous quarter to present at PSLG by the relevant area team. Themes and trends will be collated and published on a quarterly basis.

5.4 The Learning from Deaths process enhances and does not replace the Patient Safety Incident Response Framework,, Safeguarding Policy, Courts & Evidence Policy or the Compliment, Comments, Concerns and Complaints Management Policy. In some circumstances where the Trust was involved in the care of a person who has died, it will be immediately clear that this constitutes review under the patient safety response framework and an investigation should be undertaken to understand what happened and what can be learned from the incident. 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 LfD reviews.

5.5 All other deaths identified by Safeguarding, Patient Relations, Legal Services and Patient Safety team will be managed as per existing processes. The Datix system will be interrogated for an existing SJR and the QGAM or delegated appropriate clinician contacted to provide a clinical review if required. If SJR is used to review the incident, a care score of 1 or 2 in any category should prompt review at the Local Incident Review Group.

5.6 All inbound Learning from Death review requests and Medical Examiner requests from Primary, Secondary and Community Services will be logged by the Patient Relations or Patient Safety team and passed to the relevant QGAM to make review as per stage 1 and 2 criteria and feedback directly. (13.5 SOP Medical Examiners)

5.7 Any LFD reviews which involve external organisations and would benefit from wider review will be initiated by the QGAM and reviewed at the Learning from Deaths panel. The external reporting decision tree should be used to support this decision. An End to End review may be recommended if complex.

6.0 Bereaved Families and Carers

6.1 Dealing respectfully, sensitively and compassionately with families and carers when someone has died is crucially important. At times families may have questions, and/or concerns they would like answers to in relation to the care and treatment their loved one received but don't always want to make a complaint.

6.2 Patient carers/families/appointed advocate or representatives will be assigned a single point of contact following any review in which safety concerns have been raised. The single point of contact (or family liaison officer) will support the family in managing their bereavement, support the family through the investigation process, and if required through the coronial process.

6.3 Statutory Duty of Candour

6.3.1 In accordance with national guidance the Trust will be open with all persons involved in serious incidents (or incidents where moderate or above harm is confirmed) unless there is a specific reason to consider a different course of action, for example relating to the health or wellbeing of the patient or carer. The Trust has a statutory Duty of Candour to be open and honest with patients and carers and relatives when something has gone wrong. This is detailed in the Being Open (Duty of Candour) Policy. Early contact should be made with the next of kin to inform them of the investigation and to give them the opportunity to be involved if they wish to do so. The decision on communication with patients and/or carers should be made ultimately by the Executive Director of Quality and Chief Paramedic with advice and input from other specialist experts across the Trust.

6.4 Outside the statutory Duty of Candour

6.4.1 In addition to the Duty of Candour requirements, the Trust will offer a single point of contact with all relatives of patients when the family or carers have made a complaint following the death of a patient.

7.0 Supporting Staff Affected by the Death of a Patient

7.1 The Trust operates within a 'just culture', recognising that mistakes can happen within healthcare and that there are often system and process improvements required to support staff to do their job effectively. YAS recognises that when staff are involved in a patient death, and or when a patient safety incident occurs, this can be a very stressful experience, sometimes becoming a 'second victim' to the incident and they will need support through a number of mechanisms.

7.2 Staff can sometimes feel very isolated after an adverse event, particularly if they are absent from work or if they do not work within the team where the incident took place; agency staff or students can feel particularly isolated and excluded. Care should be taken to ensure that those staff who may be affected or traumatised by an incident are identified as soon as possible and every effort made to engage with them and offer appropriate support both immediately post incident and in the longer term through the Post Incident Care process.

7.3 Having an open reporting culture is key to the delivery of safe and compassionate care. For it to be effective, the raising of concerns must be embraced as a normal part of clinical care, where staff feel confident and safe to speak up without fear of any repercussion or reprisal. Staff must report any patient safety concerns through the Datix system, their line manager or as per the Freedom to Speak up Policy.

8.0 Learning from Reviews and Investigation

8.1 Reports will be produced to show theme and trend analysis and presented to the relevant committees and groups across the Trust throughout the year. The key reporting route will be through the Patient Safety Learning Group that informs Trust Executive Group, Quality Committee and Trust Board Group

9.0 Training expectations for staff

9.1 Training is delivered as specified within the Trust Training Needs Analysis (TNA).

9.2 Clinicians undertaking Structured Judgment Reviews – All clinicians undertaking SJR will receive training as per the NHS guidance.

9.3 Family Liaison Officer - all staff involved in providing support to families as part of investigation will receive training, delivered by the Investigations & Learning Team. This will be delivered as part of a 'family liaison' training package, ensuring a consistent approach is delivered regardless of how the Trust learns of the death and which process it falls within.

10.0 Implementation Plan

10.1 The latest approved version of this Policy will be posted on the Trust Intranet site for all members of staff to view. New members of staff will be signposted to how to find and access this guidance during Trust Induction.

11.0 Monitoring compliance with this Policy

11.1 Quarterly reporting through to the Quality Committee:

- A summary of the learning from reviews and investigations undertaken in the previous quarter and resulting actions taken.
- The number of deaths in the previous quarter in scope for review.
- The number of these deaths for which a review was indicated and, of these, the number of completed reviews.
- The number of deaths for which an investigation was indicated and, of these, the number of completed investigations.
- 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.
- A consolidated total of the number of live and completed reviews and investigations relating to that financial year (from quarter two 2020/21 onwards).

11.2 Yearly reporting - Summary presented in the Trusts annual quality accounts.

12.0 References

- NMC & GMC (2015) 'Openness and Honesty When Things Go Wrong: The Professional Duty of Candour' - openness-and-honesty-professional-duty-of-candour.pdf
- National Quality Board (2018) 'Learning from Deaths: Guidance for NHS Trusts on Working with Bereaved Families and Carers'- NHS England » National Guidance on Learning from Deaths
- Patient Safety Incident Response Framework (PSIRF) (2019) - NHS England » Patient Safety Incident Response Framework

- Statutory and Regulatory Duty of Candour (2014) - Regulation 20: Duty of candour - Care Quality Commission
- Just Culture Guidance (2018) - NHS England » A just culture guide

13.0 Appendices

13.1 This Policy includes the following appendices:

Appendix A – Template for Structured Judgment Review
Appendix B – Flow diagram summarising process
Appendix C – Flow diagram: Process for selecting deaths for stage 1 review
Appendix D – Medical Examiners SOP
Appendix E– Roles and Responsibilities

Appendix A - Template for Structured Judgment Review

Phase of care	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	End of Life care	Appropriateness of clinical care and handover location, timeliness
	Other locally determined aspects of care	Quality and legibility of health care records
Assessment of overall care		

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

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. 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.

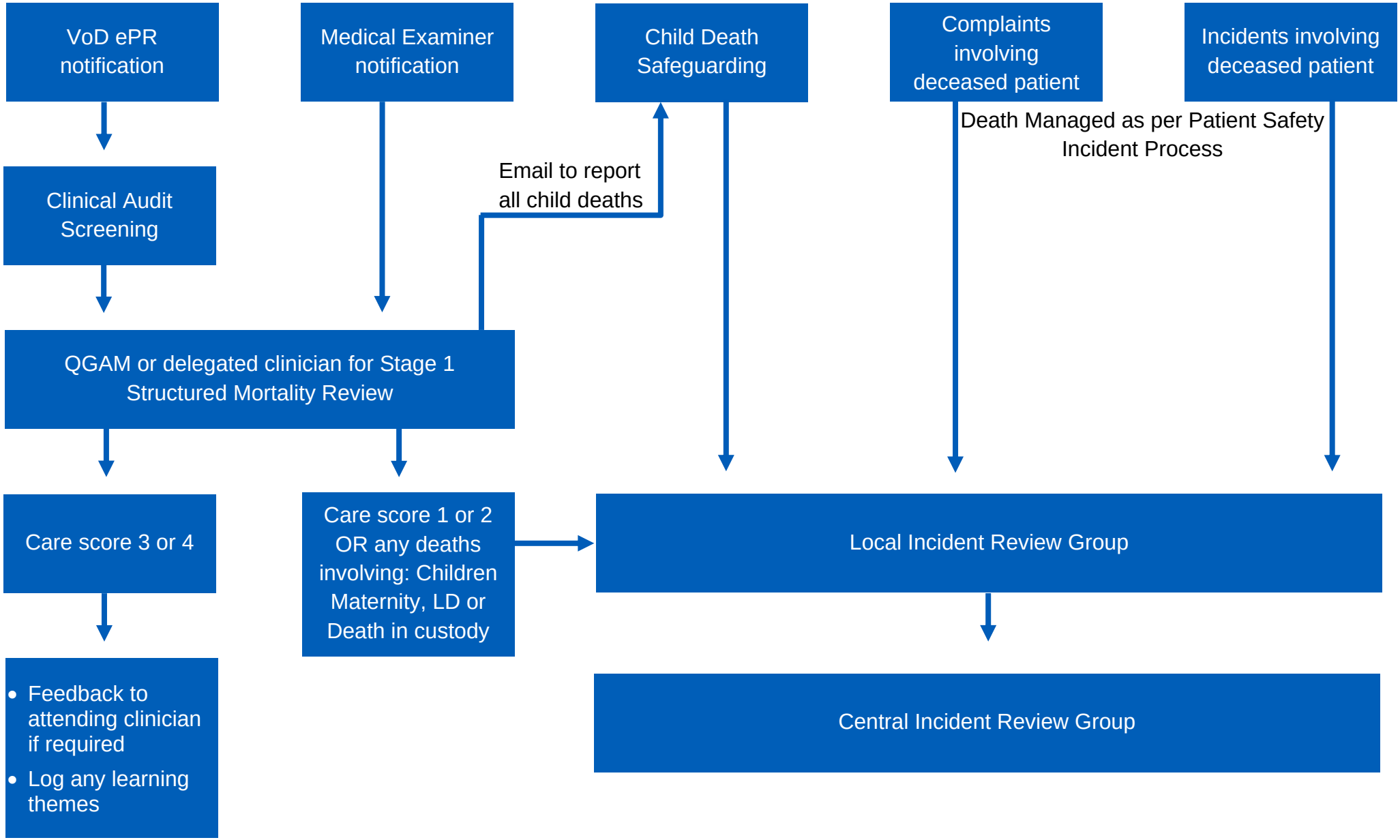
Reviewers are encouraged to identify actual and potential concerns to patient safety through answering. (Provide a brief written statement for each one.)

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?

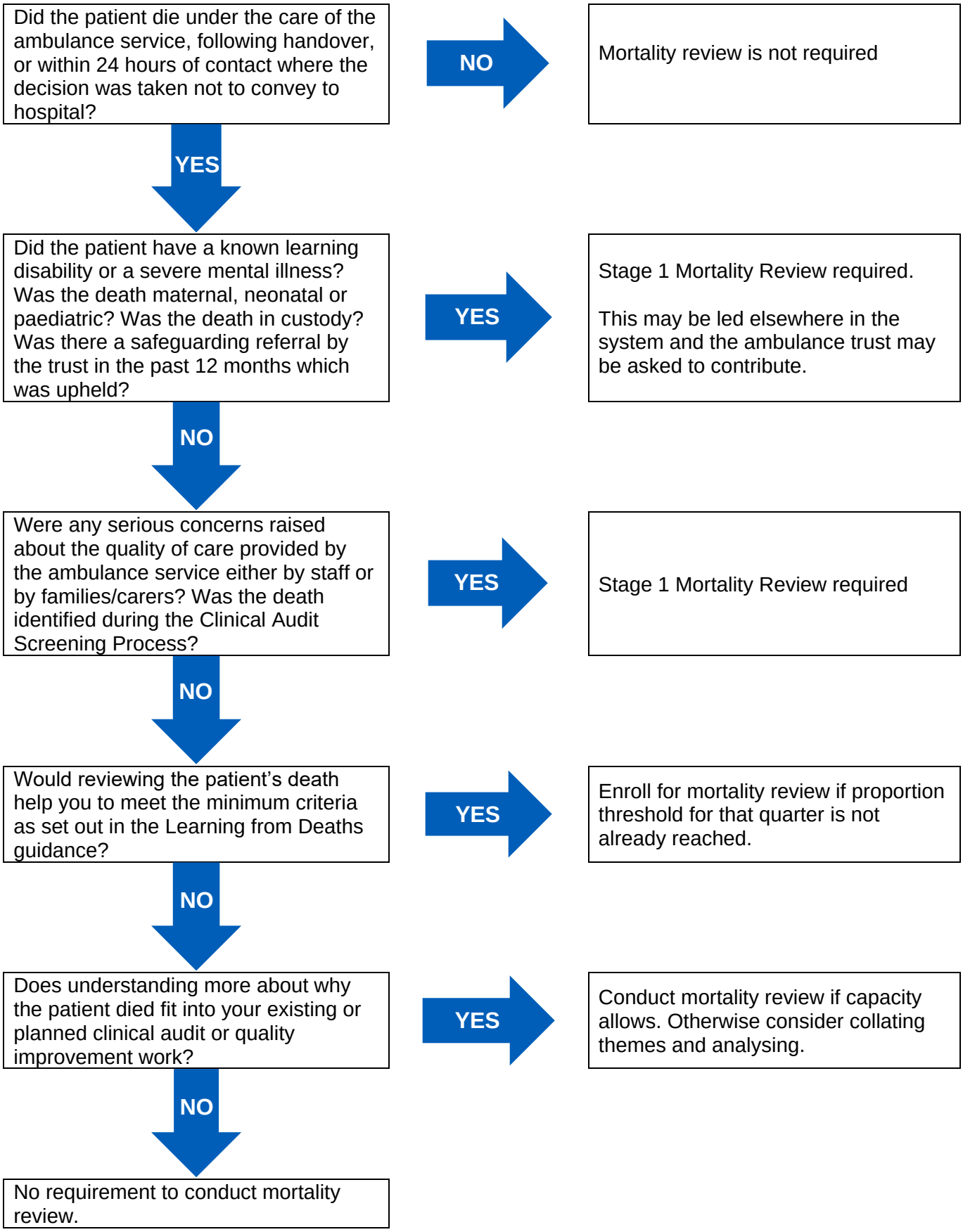
2. If yes, in which area(s) of the care phase did this problem(s) occur?

It should be noted that SJR is a high level review of the documentation following the death of a patient and the initial scoring does not replace or reflect the findings of a full investigation of an incident.

Appendix B - Flow diagram summarising process



Appendix C - Flow diagram: process for selecting deaths for stage 1 review



Appendix D – Medical Examiners SOP

Introduction

All deaths in any health setting that are not investigated by a coroner will be reviewed by NHS medical examiners. Medical Examiners are senior doctors who are based at hospitals and their role is to agree the proposed cause of death and accuracy of the medical certificate with the doctor completing it, discuss the cause of death with relatives and establish if you have any questions or concerns with care before death.

The Medical Examiner can authorise the GP to issue a Medical Certificate for the Cause of Death (MCCD) or may refer the death to the coroner if there are any concerns about care before death. They do not replace the coronial system and HM Coroners still have a legal obligation to review deaths under The Coroners and Justice Act 2009 and Notification of Deaths Regulations 2019

The role of the Medical Examiner is to examine deaths to:

- agree the proposed cause of death and the overall accuracy of the medical certificate of cause of death (MCCD) with the doctor completing it
- discuss the cause of death with the next of kin/informant and establish if they have questions or any concerns with care before death
- act as a medical advice resource for the local coroner
- inform the selection of cases for further review under local mortality arrangements and contribute to other clinical governance procedures.

<u>Procedure</u>

1. Requests/notifications from Medical Examiners Officer to the Trust (Legal, Patient Relations, Clinical Directorate) passed to CBU Area Clinical Governance Lead
2. ACGL to enter Learning from Death (LfD) on Datix and escalate to Level 1
3. Structured Judgmental Review (SJR) undertaken
4. ACGL to follow LfD policy
5. ACGL to feed back to Medical Examiner

Appendix E – Roles & Responsibilities

Trust Board

The Trust Board is responsible for ensuring that effective systems are in place for the management of investigations and learning across the organisation including the Learning from Deaths process. The Trust Board will receive a yearly report as part of the Trust's Annual Quality Accounts

Quality Committee

The Quality Committee will undertake objective scrutiny of the Trust's clinical governance and quality plans, compliance with external quality regulations and standards and key functions associated with this, including processes to ensure effective learning from deaths. The Committee will receive quarterly reports providing evidence of compliance with the process and themes and trends of learning.

Trust Patient Safety Learning Group

The Trust Patient Safety Learning Group will monitor the themes and trends from the Learning from Deaths process and ensure implementation of learning.

Executive Medical Director

- Ensuring robust system are in place for recognising, reporting, reviewing or investigating deaths and learning from avoidable deaths that are contributed to by lapses in care across the Trust.
- Developing a framework of assurance for the Trust Board.
- Reviewing external mortality data sources and co-ordinate investigation into any issues unexplained by routine review processes.
- Presenting the quarterly National Data Set for learning from deaths to the Quality Committee.
- Linking with Learning from Death leads within our strategic partnerships to develop a consistent approach to learning from deaths of patients across our health economy.

Head of Investigations and Learning

- Leading on the Trust's processes in relation to incident management, Serious Incident management, the Duty of Candour and complaint/concern handling.
- Ensuring that training provision is in place for managers and staff who have duties to provide support to families as part of investigation.
- To work collaboratively with the relevant leads within other areas of the Trust where deaths may be reviewed and managed, to ensure a joint up approach.
- Developing processes to ensure lessons are shared across the organisation.

Deputy Medical Director

- Ensure effective process are in place through the Clinical Informatics and Audit Team to review all VOD forms, enter cases onto the Datix system and identify cases which require a Learning from Deaths review
- Ensure effective processes are in place to review cases using a Structured Judgement Review and refer appropriate cases to the LIRG.