NHS
North West
Ambulance Service
NHS Trust

Policy on

Learning from Deaths

Safe, Effective and Patient Centred Care, Every Time

Recommended by	Quality & Performance Committee
Approved by	Board of Directors
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Responsible Director	Executive Medical Director
Responsible Manager (Sponsor)	Consultant Paramedic (Medical Directorate)
For use by	All Trust employees and volunteers

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Change record form

Version	Date of change	Date of release	Changed by	Reason for change
0.1	September 2019	November 2019	Consultant Paramedic (Medical Directorate)	Document creation
0.2	November 2019	November 2019	Consultant Paramedic (Medical Directorate)	Amends following review by Clinical Effectiveness Management Group (CEMG); Sections 8, 9 & 10.
0.3	November 2019	November 2019	Consultant Paramedic (Medical Directorate)	Addition of Section 11 following Head of Legal Services review
1.0	November 2019	December 2019	Consultant Paramedic (Medical Directorate)	Policy finalisation following Committee review. No significant change
1.1	December 2021	January 2022	Consultant Paramedic (Medical Directorate)	Scheduled review. Minor amends and updates reflecting changes to Corporate Governance Structure and process
1.2	December 2023	February 2024	Consultant Paramedic (Medical Directorate)	Scheduled review. Changes to align to PSIRF introduction. Minor changes to reflect Trust strategies update.

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1. Introduction

In 2016 the Care Quality Commission (CQC) published their report 'Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England'. It found that learning from deaths was not being given sufficient priority in many NHS organisations and consequently valuable opportunities for improvement were being missed. The report highlighted NHS organisations could do more to engage families and carers with recognition that their insights are a vital learning source. In 2017, the National Quality Board's (NQB) 'Learning from Deaths framework' applicable to all NHS acute, mental health and community trusts was published.

In 2018, the Department of Health and Social Care announced its intent to extend the principles of the learning from death process to ambulances trusts. Under the auspices of the Association of Ambulance Chief Executives (AACE), the National Ambulance Service Medical Directors (NASMeD) committed to a formal process with the NQB to produce a national framework for the sector.

The NQB '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' was published in 2019. It sets the national standards and requirements for ambulance trusts to undertake a process of learning from deaths and makes a requirement that all ambulance trusts formally develop and publish a Policy on Learning from Deaths. The North West Ambulance Service Policy on Learning from Deaths commits the organisation to a process of learning in order to improve the care delivered to our patients and reducing avoidable harm and deaths.

2. Executive Summary

The North West Ambulance Service (NWAS) has a vision to deliver the right care, at the right time, in the right place. These commitments are underpinned by a promise to provide high-quality, inclusive care and to use learning to continuously improve the safety of our systems, processes, and practices whereby the care we deliver is informed by a constant process of review.

This Policy on Learning from Deaths sets out the practices that will be used within NWAS to review and learn from the deaths of patients who had been under our care. This learning will ensure we are able to protect future patients from avoidable harm, reduce unwarranted variation and provide truly patient-centred care. This Policy is consistent with the national guidance for ambulance trusts on learning from deaths and formally establishes the implementation of a standardised and transparent approach to learning.

This policy goes far beyond a process of simply counting, classifying, and reporting deaths; it is a commitment to supporting our journey towards providing an outstanding service to patients, their families and carers.

3. Scope

This policy applies to all Trust staff, including volunteers.

4. Duties and Responsibilities

Board of Directors

The Board of Directors has the accountability for the ownership of Learning from Deaths via the approval of this policy and the commitment to ensuring sufficient resource is available to facilitate learning across the organisation.

Chief Executive

The Chief Executive has overall responsibility for ensuring a Learning from Deaths process in place within the trust and for meeting all internal and external reporting requirements. The Chief Executive will delegate this responsibility to the Executive Medical Director.

Executive Medical Director

The Executive Medical Director has ownership of the policy on behalf of the Chief Executive. They will ensure that any changes in legislation or national guidance relating to Learning from Deaths are made known to the Executive Leadership Committee and the Board of Directors via the Quality & Performance Committee.

Executive Directors

It is the responsibility of Executive Directors to ensure compliance with this policy within their area of control, to monitor all relevant learning resulting from the learning from deaths process and ensuring that any recommendations regarding actions are implemented.

Consultant Paramedic (Medical Directorate)

It is the responsibility of the Consultant Paramedic (Medical Directorate) to provide professional clinical advice and guidance with regard to the learning from deaths process and ensure reports are completed in order that learning is disseminated and actioned within the organisation.

All Senior Clinicians and Managers

It is the responsibility of senior clinicians and managers to ensure this policy and associated procedures are implemented within their areas of responsibility and to participate fully with the review process in a timely manner. All senior clinicians and manages will commit to providing feedback to their staff on the review process and subsequent learning. Senior clinicians and managers have the responsibility to provide assurance to their management team on the progression and quality of case reviews.

All Employees

It is the responsibility of all employees, and volunteers where necessary, to participate in the learning from deaths process promptly, openly and honestly.

5. Our Approach to Learning From Deaths

Our Policy on Learning from Deaths is an integral part of informing and developing the safest possible systems for the delivery of care to our patients. In establishing a robust methodology to learn from deaths, and in particular to determine whether harm has occurred during the final episodes of life, we have enabled the opportunity to evolve our systems of care to deliver against our core purpose to save lives and reduce harm. This policy challenges the organisation to scrutinise the care we deliver to patients who die within our care. NWAS must identify suboptimal care which reaches the patient because of something we should have done but didn't, or something we did do but shouldn't have; it challenges us to get better and supports the identification of areas for improvement.

We have adopted a process of structured judgement review in order to systematically and consistently scrutinise the care provided to patients and therefore use the opportunity to increase safety and reliability as well as promote the adoption of improvement methodology to make real changes to practice.

This policy contributes to the systems and processes already established within the Trust and whilst it formally commits the organisation to a process of learning from deaths which occur whilst patients are within our care, it serves to augment organisational learning and compliments the established clinical governance, patient safety and quality improvement procedures including those around the Patient Safety Incident Response Framework (PSIRF) and clinical audit.

This policy seeks to strengthen and develop our partnership approach to information sharing and joint learning. We recognise that opportunities for system-based learning should be actively sought and that working in isolation is detrimental to patients. We will work with our partners across the healthcare system in the North West to proactively share information and collaborate with the aim of supporting system level and cross-agency learning and improvement in accordance with the PSIRF principles. This is not a new commitment, but through the implementation of this policy we will seek to formalise the arrangements we currently have with

our partners and commit to a central role within the health system of the North West in learning from the deaths of patients in our care.

In the emotive period following bereavement, this Policy makes a commitment to family members, carers and loved ones that we will apply a genuinely empathetic approach to listening to concerns and communicating openly with them throughout.

6. Determining Deaths in Scope for Review

This Policy on Learning from Deaths aligns with the definitions and recommendations within the National Framework for NHS ambulance trusts in describing the scope for patients considered as appropriate for case record review. However, it is clear that this does not mean that all deaths in scope must be reviewed. Section 7 articulates how we will determine of those cases that are eligible for consideration, which ones will be subject to a review. Hence, the deaths that are initially in scope are as follows:

- Any patient who dies while under the care of NWAS. These are patients who die from the point of a 999 call being made and their care being transferred to another part of the system, or to the point they are discharged from NWAS after a decision is made not to convey them to hospital. This category includes patients who are transported using subcontracted alternative patient transport. This definition includes the periods of time where the 999 call is being handled, in the time between the 999 call being handled and a resource arriving at the scene, whilst at the scene, during transport or before the handover concludes.

- Any patient who dies after handover. As it is acknowledged that patient identification may be an issue; NWAS is only to consider these deaths in scope when they are notified of them by a partner agency.

- Any patient who dies within 24 hours of contact with NWAS where a decision was taken not to convey them to hospital. This includes ‘hear and treat’ as well as a visit by ambulance clinicians but excludes patients at the end of life and where a specific care plan or advanced directive is in existence.

7. Determining Which Deaths Should be Reviewed

In accordance with the national framework, not all deaths in scope must be or will be reviewed. A two-tier process of selection to determine which cases are selected for case record review will be utilised which is both recommended within the framework and appropriate to ensure maximum benefit for organisational learning within NWAS.

The national guidance stipulates that the Trust must review **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. This includes any concern raised that cannot be answered fully at the time or anything not answered to the satisfaction of the person raising the concern. These notifications, and the subsequent review, investigation, and management fall under the Trust's Patient Safety Incident Response (PSIRF) Policy as detailed in Section 10.

In addition, the Trust will review a sample of each of the four categories listed below.

- Deaths of patients assessed as requiring category 1 and category 2 responses where there has been a delayed ambulance response.

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

- Deaths that occur following handover to an NHS acute, community or mental health trust or to a primary care provider, when this information is known by way of notification to NWAS.

- Deaths of patients who were initially not conveyed to hospital and who then subsequently had re-contact with NWAS within 24 hours. The death should have occurred as part of that episode of care and not during a subsequent episode of care.

The Trust will determine a number across the four identified categories listed above which would equate to 40 to 50 case reviews per quarter; this sample size produces a rich source of information on care quality and on problems in care (Royal College of Physicians, 2016).

It is these reviews that this policy pertains to, with the Learning from Deaths methodology providing a bespoke and comprehensive review of the sample incidents.

Additional Reporting Requirements:

- **Deaths of Patients with Learning Disabilities**

The Trust must report all deaths of those aged over four with a known learning disability to the Learning Disabilities Mortality Review (LeDeR) Programme. The Trust will contribute to their review processes when approached and share its review findings with LeDeR when relevant. The Learning Disabilities Mortality Review programme is aimed at reviewing all cases of death of an adult or child with learning disabilities, to identify any factors associated with that death that may have been preventable, and to learn from them. Where it is known or suspected that that an adult or child has a learning disability and has undergone a diagnosis of death, or termination of resuscitation, then details of the learning disability must be recorded on the Diagnosis of Death form and reported to the Support Centre for formal reporting. The Trust commits to participating fully in LeDeR programme reviews when approached to do so.

- **Maternal and Neonatal Deaths**

Maternal deaths will be reported to the Healthcare Safety Investigations Branch (HSIB) and the Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE). The Trust's Resuscitation (Diagnosis of Death) Policy should be followed for all maternal deaths.

Neonatal deaths are managed in line with the guidance and processes detailed within the Trust's Sudden Unexpected Death in Infancy, Children and Adolescents (SUDICA) procedures which includes formal notification to partner agencies.

The Trust will contribute to HSIB, MBRRACE and SUDICA review processes through this information sharing process and will, when approached, contribute to reviews and investigations and share its review findings when relevant.

- **Paediatric Deaths**

The Child Death Review Statutory and Operational Guidance outlines the Trust's statutory duties with regards to notification and information gathering. The Trust will participate in child

death review meetings, including Child Death Overview Panel (CDOP) meetings, whenever notified. In the event of a sudden unexpected death in a patient under 18 years, the Trust's Sudden Unexpected Death in Infants, Childhood or Adolescents (SUDICA) procedures for the management of these incidents including the involvement of the police and partner agencies will be followed. Attendance at Child Death panels may be required, and this governance resides under the Trust's Safeguarding Team.

- **Safeguarding Concerns**

Any deaths where there are safeguarding concerns (either adult or child) should be referred to the Trust's Safeguarding Team or Head of Safeguarding (Head of Clinical Safety) in line with our statutory duties. The Safeguarding Team has the responsibility for the liaison with partner agencies and for facilitating Trust involvement in any subsequent review processes.

- **Deaths in Custody**

These deaths fall under the relevant police forces' remit; the Trust will participate and contribute to any formal reviews arising from deaths in custody whenever approached.

There may be cases, in addition to reporting provisions listed above, when the Trust will make the decision to conduct our own review of the death in addition to the formal, national process. This is likely only to be applicable if we identify at early stage that there are potential learning improvement actions which need to be taken in advance of the national review process to prevent reoccurrence or further harm. However, this is discretionary and will always be in addition to the Trust's requirements to notify and contribute to the national review programmes of the death.

The Trust will consider each case individually in order to determine whether it should also undertake a review in each circumstance and will consider its decision to undertake an independent review of these deaths in discussion with the relevant review programme, to minimise duplication.

8. Case Record Reviews

NWAS utilises a structured method of case review for those deaths identified for inclusion utilising a standard methodology based upon an adaptation of the Royal College of Physicians' Structured Judgement Review process. The objective of the structured judgement review methodology is to look for strengths and weaknesses in the caring process, to provide information about what can be learnt about the systems and processes in use where care goes well and to identify points where there may be gaps, problems or difficulty in the care process. In order to identify the strengths and weaknesses of individual patient contact episodes there is a need to look at the full range of care provided to an individual; adopting this holistic care approach allows for the nuances of individual cases and the outcomes of interventions to be considered.

An important feature of this method is that the quality and safety of care is judged and recorded whatever the overall judgement of the case and good care is judged and recorded in the same detail as care that has been judged to be problematic; we commit to doing this. Evidence shows that most of the care provided within the NHS is of good or excellent quality; there is much to be learned from the consideration of high-quality care and these opportunities should not be overlooked. By supporting the implementation of this methodology, the knowledge and expertise gained will be transferable to other areas of reflection and review within the organisation. The methodology could, for example, be used to rigorously assess the care provided for people who have had a cardiac arrest and therefore enhance the organisational learning we can derived from such cases in addition to those identified by the learning from deaths process.

The structured judgement reviews for Learning from Deaths are undertaken by senior clinicians within our organisation and the appropriate subject matter experts depending on each individual case. We will commit to the necessary training for these individuals to provide a consistent and standardised approach across the organisation. Following implementation of the structured judgement reviews methodology and training there is the opportunity to use this acquired expertise in other areas of the Trust's investigation and learning processes; any decision for further adoption of the methodology lies with the responsible managers and directors for those processes.

9. Learning from Reviews

NWAS has a commitment to develop and work on our culture to become a learning organisation; this policy supports the aim of achieving this and contributes to our development as a learning organisation through the processes highlighted.

In accordance with the NQB Framework requirements we publish quarterly Learning from Deaths reports. These reports will draw upon learning from deaths data acquired in the previous quarter and will be submitted to the Clinical and Quality Group, Quality and Performance Committee and ultimately the Trust Board. Following approval Trust wide dissemination of the reports will take place together with associate briefing documents to ensure learning is accessible to all clinicians and staff. The Area Learning Forums will be utilised as key vehicles to present and share reports and key learning ensuring the dissemination is embedded within the formal sharing arrangements within the Trust.

The Trust will commit to share learning from reviews and investigations through the National Ambulance Risk and Safety Forum who will highlight trends to the National Ambulance Quality, Governance and Risk Directors Group (QGARD).

10. Patient Safety Incident Response Framework (PSIRF)

This Learning from Deaths Policy enhances and compliments the NWAS Patient Safety Incident Response Plan and Policy.

PSIRF supports organisations to use their incident response resources to maximise improvement, rather than repeatedly responding to patient safety incidents based on subjective thresholds and definitions of harm, from which new learning will be limited.

Some patient safety incidents, such as deaths though more likely than not due to problems in care (that is, those meeting the Learning from Deaths criteria for investigation) all require a Patient Safety Incident Investigation (PSII) to learn and improve.

Patient safety concerns identified at any stage of the Learning from Deaths process should be escalated by the Consultant Paramedic (Medical Directorate) to the PSIRF Team. The concern should be reported within the Events Module in the Datix Cloud IQ (DCIQ) system. All patient

safety concerns must be reported via the DCIQ system, this also allows the notification to the NHS England, Learning from Patient Safety Events (LFPSE) system.

All reported patient safety concerns will be triaged and reviewed against the NWAS Patient Safety Incident Response Plan and Policy to determine the level of learning response. Patient safety incidents that meet a National Requirement or a NWAS Local Priority will require the completion of a pro-forma and will be presented to the Patient Safety Event Cases (PSEC) Group. The PSEC group will determine if the incident meets a National Requirement or a NWAS Local Priority and if a Patient Safety Incident Investigation (PSII) is required.

NWAS will ensure that our people who are affected by the patient safety incident will be afforded the necessary support and given time to participate in a patient safety learning response, under PSIRF. All NWAS leaders will work within our just culture principles and utilise other teams to ensure our people are supported. NWAS service lines will ensure processes are adopted so leaders work within the PSIRF principles to ensure psychological safety.

11. Coronial Engagement

In addition to the statutory and legal requirements place upon us to contribute to and participate in coronial processes, through the implementation of this policy we commit to strengthening the relationships we have with Coroners across the north west region and proactively engage with Coroner's Offices in order to both share learning and enhance the opportunity for learning for us as an organisation.

Through this policy we will commit to embedding the learning and lessons learnt from Coroner's Hearings and conclusions and will implement a process of dissemination across the organisation utilising the Area Learning Forums as a key vehicle to share learning with clinicians and staff. Learning from Deaths reports will, where appropriate, contain significant learning from coronial processes as an included section and key messages will be disseminated within the associated briefing documents.

We recognise that proactive engagement with Coroners will strengthen professional relationships; selected and appropriate learning that the Trust derives because of the implementation of this policy will be shared with Coroner's Offices where the learning will be of interest from those incidents occurring within individual Coroner's jurisdictions.

12. Bereaved Families and Carers

A culture of openness, transparency and candour is essential to improving patient safety. The Trust's established Duty of Candour Procedure will be used to guide the processes for the interaction with bereaved families and carers during reviews of cases identified. NWAS is committed to engaging in a meaningful and compassionate way with bereaved families and carers. They will be provided with a primary point of contact and consulted on how they wish to receive feedback following the process. This will include cases where a joint review is being undertaken and where a death has been referred to the coroner and will be the subject of an inquest.

The Trust also has a statutory and contractual duty to meet the NHS standards of the Duty of Candour wherever there has been a notifiable patient safety incident. Where a case review identified through the Learning from Deaths process identifies concerns, the initiation of the Duty of Candour process will be rigorously applied.

A greater voice to the bereaved families and carers will be established through engagement with the Trust's Patient & Public Panel (PPP). The PPP have provided scrutiny of our learning from death processes and provided assurance that we are meeting the needs of the population we serve. Invited members of the PPP will contribute to the moderation of individual case reviews providing the vital family, carer and public perspective.

13. Supporting Our Staff

NWAS is committed in supporting our staff in the event of a death of family member, friend, colleague or patient. Occupational health provide staff with access to independent and confidential counselling and support to help them deal with work related and personal issues. Contact details can be found on the *Invest in Yourself* pages on the intranet.

The Trust also provides a safe and robust Trauma Risk Management (TRIM) assessment service for any member of staff to access. The TRIM system is a post traumatic peer led risk assessment tool which aims to keep staff functioning after a traumatic event, such as a death of a patient, and provides information about personal resilience to staff and managers as well as identifying staff that may need specialised help. The Trust also has an extensive network of peer support / Blue Light Champions who are also available to provide a listening ear and signpost to further services where necessary.

Our commitment to staff is to have a just culture. The basis for this is a shared set of values in which our staff trust that all case reviews, and where applicable investigations, will result in a timely, fair and comprehensive process. Staff are assured that any actions, omissions or decisions that reflect the conduct of a reasonable person under the same circumstances will not be subject to inappropriate or punitive sanctions.

14. Reporting and Monitoring Arrangements

The Trust will present quarterly reports on the outcomes of the Learning from Death reviews to the Clinical and Quality Group, the Quality and Performance Committee and ultimately to the Board of Directors. Scrutiny will be provided via this established governance process and serve to ensure that this Policy and the associated processes are fit for purpose and delivering upon their intended aims.

The Trust will produce an annual summary of learning from deaths within its Quality Account. This will provide a consolidation of the quarterly reporting information together with a narrative analysis of learning and resulting key themes, actions taken and the outcomes of these.

References

CQC (2016) ‘Learning, Candour and Accountability: A Review of the Way NHS Trusts Review and Investigate the Deaths of Patients in England’. London: CQC

NHS England (2022) Patient Safety Incident Response Framework (V1). London: NHS England

NHS Improvement (2018) ‘Just Culture Guide’. London: NHS Improvement

National Quality Board (2018) ‘Learning from Deaths: Guidance for NHS Trusts on Working with Bereaved Families and Carers’. London: National Quality Board

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’. London: National Quality Board

Royal College of Physicians (2016) ‘Using the Structured Judgement Review Method: A Guide for Reviewers (England)’. London: Royal College of Physicians