North West Ambulance Service NHS Trust

REPORT

Board of Directors	
Date:	
Subject:	Learning from Deaths: Q4 2019/20 review
Presented by:	C Grant
Purpose of Paper:	For Assurance
Executive Summary:	Following publication of the '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' the Trust is required to publish on its public accounts a quarterly and then annual summary of learning. The first quarter to be published is Q4 2019/20. The dashboard contained within this report is the start of an iterative process of reporting and will develop into a more sophisticated reporting mechanism as the Trust receives further guidance and training to improve learning in this area. Findings from the initial Q4 dashboard attached at appendix A identifies there have been 16 incidents identified on Datix where the trust may consider to have contributed to the death of a patient; eight of which were due to the delay in ambulance availability. In performing the review it has not been possible to identify common learning themes as the 'learning from event/ lessons learned element' has not been completed. This is not a mandatory field on Datix. To date the combined impact of no national training for structured judgement reviews (SJRs) and redirection of clinical resource to the COVID-19 pandemic has meant the deep dive element of this dashboard is has not been fully explored for the Q4 report. This will improve over the next 12 months.
Recommendations, decisions or actions sought:	The Board of Directors are recommended to: • Accept the dashboard at Appendix A as the report to be published on the Trust public account as evidence of the Trust's developing engagement with a formal process of learning from deaths • Accept the limitations of the dashboard with the assurance this is an iterative process which will develop over time.

Link to Strategic Goals:	**Right Care**	☒		**Right Time**	☒
	Right Place	☒		**Every Time**	☒

Link to Board Assurance Framework (Strategic Risks):

SR01	SR02	SR03	SR04	SR05	SR06	SR07	SR08	SR09	SR10	SR11
☒	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Are there any Equality Related Impacts:	
Previously Submitted to:	**Quality & Performance Committee**
Date:	**15 June 2020**
Outcome:	**Supported**

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1. PURPOSE

The body of this report has previously been received by the Quality and Performance Committee on 15 June 2020.

The purpose of this report is to meet the requirements of the 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' as referenced in the trust Learning From Deaths policy.

The document attached at Appendix A is a summary dashboard of the 2019/20 Q4 Learning from deaths review; and it is proposed this document is published on the trust's public accounts by 30 June 2020 in accordance with the national framework and trust policy.

It is acknowledged the attached document is the beginning of an iterative reporting process which will become more sophisticated and informative as the year progresses. The content of the current dashboard has been affected due to the combined absence of a national training programme for structured judgement reviews and, the redirection of senior clinical resourcing towards the COVID-19 pandemic meaning the deep dive element has not been undertaken.

2. BACKGROUND

2.1 Learning from Deaths is an integral part of informing and developing the safest possible systems for the delivery of care to our patients. NWAS must identify suboptimal care and support the identification of areas for improvement.

2.2 The methodology to produce the information described in appendix A is as follows:

Phase 1.
Identify all deaths where a concern was raised be that by ambulance personnel, other health and care staff and / or families or carers about the care received.
A combination of data sources were used to identify these incidents and this included cases received by the Review of Serious Events (ROSE) panel and 'wild card' searches through Datix.

Phase 2.
A sample of between 40 and 50 from:

- *Deaths where Cat1 and Cat 2 responses with a delayed ambulance response*
- *Deaths of patients assessed as requiring Cat3 and Cat4 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 not initially conveyed to hospital and who then had re-contact with NWAS within 24 hrs*

A number of Health Informatics reports were requested and scrutinised to provide the sample. Given the numbers involved in the different categories it was determined that all deaths (Cat 1 and Cat2) where there was a delayed ambulance

response be included in the sample for review.

The information taken from each phase has been described as an overall position in appendix A and then broken down into its two phases as described above.

2.3 In future iterations the dashboard will develop to include the learning from structured judgement reviews (SJRs) – the deep dive - which is not available for the Q4 dashboard. The SJR is a validated research methodology which is able to create an overall care score.

The benefits of using the SJR methodology is that it provides a structured and replicable process to review deaths, which examines both interventions and holistic care giving reviewers a rich data set of information. The SJR methodology allows organisations to ask 'why' questions about things that happen to enable learning and actions where required. SJR allows the identification and feedback of good care in the same detail as 'problematic' care, which is integral as evidence suggests most care is of good or excellent quality and that there is much to be learned from the evaluation of high-quality care.

Whilst there exists a National Mortality Case Record Review (NMCRR) toolkit; this was developed for Acute Hospital Trusts and the toolkit to support ambulance services and the associated training is not yet published.

Moving forward it the deep dive case review will be undertaken by named senior clinicians to ensure a standardised audit methodology and in the continued absence of an ambulance NMCRR toolkit it is anticipated the case review will not be dissimilar to that undertaken at ROSE.

3. DISCUSSION

3.1 The patient cohort to be included in the review is clearly defined and is referenced briefly in section 2.2 and fully in the trust Learning from Death policy.

Appendix A: Learning from Deaths Dashboard Q4 2019/2020.
The number of patients whose deaths were identified as being in scope for this review was 67 (27 Datix incidents and 40 sampled).

3.2 *Datix Cohort Discussion*
Of the 27 patient deaths;

- 15 were considered incidents graded 4 (major) or 5 (catastrophic).
- 19 patient deaths had been reviewed and closed in Datix

Of the 19 patients, 16 patient deaths (84%) it was considered more likely than not the death was caused by the incident. In reviewing the 16 patient deaths by category type and then sub category the investigator has identified each incident is associated with ambulance availability. The lack of ambulance availability may be due to a number of reasons such as timeliness, staffing levels and allocation etc.

A thematic analysis of lessons and recommendations for change and improvement was rendered impossible due to the lessons learnt section in Datix not being

completed.

This is not currently a mandatory field in the document and therefore it is not possible to gather information for trust wide learning. Following the Quality and Performance Committee meeting steps have been taken to understand if this can be changed to support the learning from the process.

3.3 *Sample Cohort Discussion*

Of the 40 patients identified:

- 27 patients were deaths that occurred where patients were not initially conveyed and then the service was re-contacted within 24 hours*.
- Three patient deaths occurred where they were initially coded as Cat 1 or Cat 2, and were subjected to a long wait
- Ten patient deaths occurred where the incident was coded as Cat 3 or Cat 4.

It has not been possible to perform a SJR or deep dive review of these patient deaths due to the combined impact of a lack of available an Ambulance NMCRR and the availability of suitable qualified senior clinician(s) to perform a review.

**The results should not be correlated to the results of the Safe Care Closer to Home audit due to the significant differences in audit methodology.*

4. LEGAL and/or GOVERNANCE IMPLICATIONS

4.1 There are no legal implications associated with the content of this report and the data gathered to produce the dashboard has been managed with attention to the Data Protection Act 2018.

5. RECOMMENDATIONS

5.1 The Board of Directors are recommended to:

- Accept the dashboard at Appendix A as the report to be published on the Trust public account as evidence of the Trust's developing engagement with a formal process of learning from deaths
- Accept the limitations of the dashboard with the assurance this is an iterative process which will develop over time.