North West Ambulance Service NHS Trust

REPORT TO BOARD OF DIRECTORS

DATE:	25 January 2023					
SUBJECT:	Learning from Deaths. Summary Report and Dashboard Q2 2022/23					
PRESENTED BY:	Dr Chris Grant – Executive Medical Director					
LINK TO BOARD ASSURANCE FRAMEWORK:	**SR01**	**SR02**	**SR03**	**SR04**	**SR05**	**SR06**
	☒	☐	☐	☐	☐	
	SR07	**SR08**	**SR09**	**SR10**	**SR11**	**SR12**
	☐	☐	☐	☐	☐	☐
PURPOSE OF PAPER:	For Assurance					
EXECUTIVE SUMMARY:	The Trust is required to publish on its public accounts a quarterly and then an annual summary of Learning From Deaths. The Q2 dashboard (Appendix A) describes the opportunities to learn. The main contributory factor to patient deaths, identified in Datix, were attributed to delays in the emergency response. The peer review process identified that 76.2% of patients received appropriate care. The key areas for improvement identified were: • using a medical model when documenting a patient's assessment • correct use of Manchester Triage System • completing capacity to consent fully • detailing specific worsening advice • sub-optimal quality of patient records documentation The peer review also identified areas of good practice. This included: • holistic decision not to resuscitate • safety net and hand over to OOH GP • organising care for end of life. The panel continues to welcome observers to help raise awareness of the process and embed learning from the peer reviews. The DCIQ Mortality Module has undergone refinements and work is still ongoing. DCIQ listing reports have been created to allow the team to report on concerns logged in DCIQ for Q3.					

RECOMMENDATIONS:	The Board is recommended to: • Support the quarterly dashboard (Appendix A) as the report to be published on the Trust public account • Acknowledge the impact of the Structured Judgment Reviews in identifying opportunities for improving care and identification of Serious Incidents previously unknown to the trust. • Note key areas for improvement identified • Note areas of good practice.
CONSIDERATION OF THE TRUST'S RISK APPETITE STATEMENT (DECISION PAPERS ONLY)	The Trust's Risk Appetite Statement has been considered as part of the paper decision making process: ☐ Financial/ VfM ☐ Compliance/ Regulatory ☐ Quality Outcomes ☐ Innovation ☐ Reputation

INCLUDE CONSIDERATION OF RISK APPETITE STATEMENT AT SECTION 3 OF REPORT

ARE THERE ANY IMPACTS RELATING TO: **(Refer to Section 4 for detail)**	Equality:	☐	Sustainability	☐
PREVIOUSLY CONSIDERED BY:	Clinical Effectiveness Sub-Committee			
	Date:	17 January 2023		
	Outcome:	Approved		

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1. PURPOSE

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.

Appendix A is a summary dashboard of the Q2 2022/23 Learning from Deaths Review. It is proposed this document is published on the Trust's public accounts by 31st January 2023 in accordance with the national framework and trust policy. The Q2 dashboard includes output from moderation panels held following the structured judgement reviews (SJRs) for Q2. Learning from the panels is discussed later in this paper.

It is acknowledged that the attached document remains an iterative reporting process which will continue to become more sophisticated and informative as 2022/23 progresses.

2. BACKGROUND

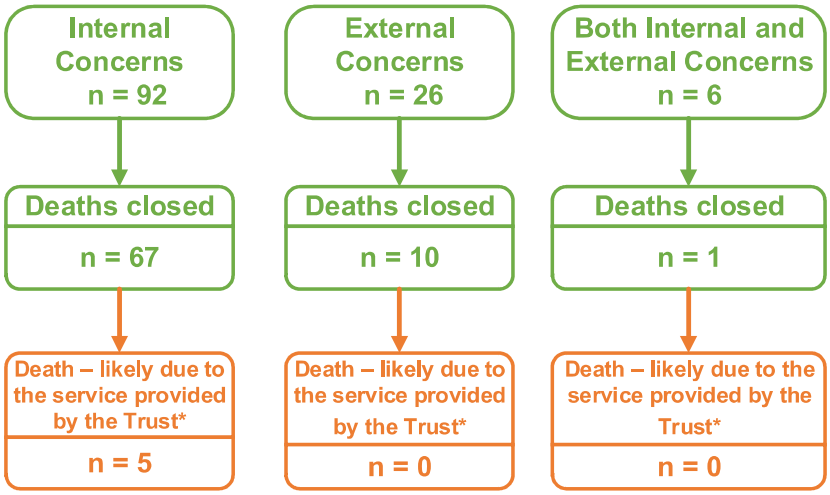
Learning from Deaths is an integral part of informing and developing the safest possible systems for the delivery of care to our patients. NWAS must identify suboptimal care and support the identification of areas for improvement. The methodology is available on request from the Clinical Audit Team at Learning.FromDeaths@nwas.nhs.uk

3.0 LEARNING FROM DEATHS DASHBOARD Q2 2022/23: APPENDIX A

3.1 Of the 124 patient deaths:

- 92 internal concerns were raised through the Incidents module
- 26 external concerns were raised through the Patient Experience module
- And a further 6 concerns were raised both internally and externally.

The flow chart below provides a summary:



Flow chart to describe the Datix deaths Q2 2022/23

3.2 **Internal Concerns: Tables 2 and 3, Figures 2 and 3**

Of the 92 patients, 67 were reviewed and closed. In five cases the investigation concluded the Trust had contributed in some way to that patient death. A lack of available resources was cited as the main contributing factor to the deaths.

3.3 **External Concerns: Tables 4 and 5 and Figure 4**

Of the 26 external concerns that have been reported, 16 are still in the early stages of review and so it is unknown at the time of writing if the care given was in line with best practice. Ten concerns have been closed and no causal factors were identified. The content of the reviews so far suggests the learning themes and therefore opportunities for improvement are:

- Significant delay in responding to a chest pain patient
- Significant delay in responding to patients with Difficulty In Breathing , Falls, End Of Life Care and Inter Facility Transfers.
- Problems related to treatment and management planning
- Problems with capacity to consent recording

3.4 **Concerns raised internally and externally: Tables 6 and 7 and Figure 5.**

Six patient deaths were raised internally and externally – note these are different concerns from those referenced above. One investigation has been closed and no causal factors were identified. The remaining five investigations are all still open and the learning themes are:

- Significant delay in responding to a patient (Chest Pain, Falls)
- Problem with communication of handover

3.5 Structured Judgement Review (SJR): Cohort Discussion: Tables 8, 9 and Figure 6.

The process requires frontline staff to review and make explicit statements on the practice under review using the 'Sequence of Events' (SoE) and 'Patient Report Form' (PRF or electronic patient record) as the data source.

The explicit statements of care can be one of five categories ranging from very good to very poor and it is possible to use each of the statement's multiple times in a single review.

The review comprises of Stage 1: review of clinical practice and call handling/ resource allocation. Where less than adequate overall care is identified a Stage 2 review of the patient death to identify if any causal factors (systemic) problems in care have led to harm.

21 patient deaths were presented by reviewers and following the moderation panels the outcomes of the reviews were determined. 16 patients (76.2%) received adequate care.

The mid-range statement of 'adequate' practice is defined as the expected practices and procedures in compliance with guidance. Any practice identified as beyond expected practice is defined as 'good'. Any practice identified as not reaching expected practice is defined as 'poor'.

The Patient and Public Panel (PPP) representatives continue to support the panels and their contribution, and perspectives are greatly appreciated by the panel members.

3.6 Quality of Patient Records

The quality of patient records improved slightly from 67.0% to 71.4% during this quarter. Whilst the EPR is undergoing development from a hardware and software perspective, general feedback and support should be offered to improve the quality.

3.7 Structured Judgment Review - Learning Outcomes: Tables 11 -12

The key areas for improvement identified were:

- using a medical model when documenting a patient's assessment,
- incorrect use of Manchester Triage System
- completing capacity to consent fully
- detailing specific worsening advice
- sub-optimal quality of patient record documentation

The peer review also identified areas of good practice. This included:

- holistic decision not to resuscitate
- safety net and hand over to OOH GP
- organising care for end of life.

3.8 Learning Dissemination

Lessons identified will be shared through the area learning forums (ALFs) and with individual frontline staff. The Q2 Learning from Deaths infographic (Appendix B) will be shared with the clinical leadership teams. This is a new development aimed at embedding improvement identified in this paper.

The opportunities for improvement identified as general themes from the Datix review and more specifically from the SJR review will be taken to ALFs by the Consultant Paramedic, Medical on a bi-annual basis.

Good practice letters have been circulated to commend 10 clinicians, who through their care and professionalism, have supported families and patients to experience a good death during Q2.

4. LEGAL, GOVERNANCE AND/OR RISK IMPLICATIONS *(including consideration of the Trust's Risk Appetite Statement)*

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

5. EQUALITY OR SUSTAINABILITY IMPACTS

No equality or sustainability implications have been raised as a concern from this report.

5. RECOMMENDATIONS

The Board is recommended to:

- Support the quarterly dashboard (Appendix A) as the report to be published on the Trust public account
- Acknowledge the impact of the Structured Judgment Reviews in identifying opportunities for improving care and identification of Serious Incidents previously unknown to the trust.
- Note key areas for improvement identified
- Note areas of good practice.

NWAS Learning From Deaths Dashboard Quarter 2 2022-2023 (July - September)

Overall Dashboard Description: This is a systematic dashboard that is a combination of those outlined in the guidance as 'must review' and those in the specified sample. These are described in more detail in the data-splits below.

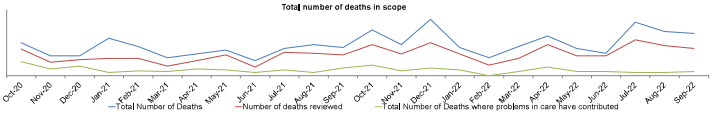
Total Number of Deaths in Scope (Sample Cohort and Datix Incidents)*		Total Number of Deaths Reviewed	% Deaths Reviewed	Total Number of Deaths where problems in care have contributed
Jul-22	57	38	66,7%	3
Aug-22	47	32	68,1%	3
Sep-22	45	29	64,4%	4
This Quarter	149	99	66,4%	10
This Financial Year	244	174	71,3%	27

** Criteria as specified in the 'National guidance for ambulance trusts on Learning from Deaths' (2019) - Where concern raised on quality of care provided where the*

Table 1

Data source: An amalgamation of both the Datix cohort and the Sample cohort data sources detailed below.

Total number of deaths in scope



Those in scope must have died under the care of the ambulance service (from call handling to before handover concludes), after handover (if notified by other trusts of these) or within 24 hours of contacting the service and the decision was not to be conveyed to hospital. This report draws on learning from the previous quarter and remains an iterative process.

Concerns raised in Datix Breakdown

Datix Cohort Description: The 'must review' category includes incidents raised to the organisation and recorded via Datix as 'deaths that occurred in our care where there has been concern has been raised about the quality of care provided'. Patient experience module, records are included where Risk score is 4/5 and death has occurred; the review is considered complete when the record is closed. Incidents module data, it is considered as a death in cohort where 'Degree of harm' is 'Death- Caused by the incident', Patient Experience module data, is included in the cohort where the incident is closed and 'Reason for SI: Unexpected /Potentially avoidable death',NB This is the month the incident occurred, not when the notification of raised concern for care was received.

Internal Concerns - Incidents (including SIs)

Total Datix Death Incidents in Scope		Risk grading		
		1 or 2	3	4 or 5
July	31	5	13	13
August	34	10	13	11
September	27	6	12	9
Total	92	21	38	33

Table 2

Number of Deaths Closed on Datix	Of those closed, Number of Deaths likely due to the service provided by the Trust	Lessons Learned complete for those closed and Deaths likely due to the service provided by the Trust
July	24	2	2
August	25	1	1
September	18	2	2
Total	67	5	5

Table 3

Datix Degree of Harm
(all in scope including those not yet closed)

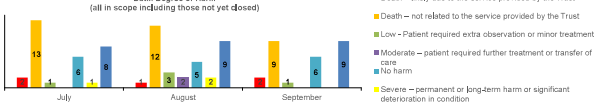


Figure 2

Datix Category Type
(of those reviewed and death determined by the incident)

Figure 3

External Concerns

Number of Complaints		Incidents Closed on Pat_Exp.	Number closed and Deaths likely due to the service
July	13	6	0
August	8	3	0
September	5	1	0
Total	26	10	0

Table 4

External concerns by service line

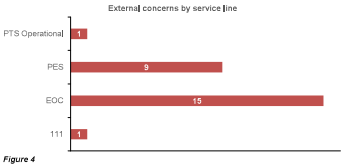


Figure 4

Department	Concern Raised	Cause and Actions	Total
EOC	Problem with call taking and response allocation	Demand outstripped resources; No actions	1
		No causal factors; No actions	1
		Still under review	1
	Problem with call taking and response allocation (DIB)	Demand outstripped resources; Incorrect coding of call; No actions	1
		No causal factors; No actions	1
	Problem with call taking and response allocation (chest pain)	Still under review	2
		Still under review	2
	Problem with call taking and response allocation (fall)	Demand outstripped resources; Hospital handover delays; No actions	1
	Problem with transporting EOLC patient back home	Still under review	3
	Problem with call taking and response allocation (baby with DIB)	Demand outstripped resources; Hospital handover delays; No actions	1
	Problem with call taking and response allocation (IFT)	Demand outstripped resources; Inappropriate resource levels across Trust at time of incident; Hospital handover delays; Incident shared with review panel/internal meeting/committee	1
	Problem related to treatment and management plan	Demand outstripped resources; Inappropriate resource levels across Trust at time of incident; Staff feedback and/or reflection	1
PES		Still under review	1
	Problem with capacity to consent	Still under review	1
	Problem with patient disposition	No causal factors; No actions	2
PTS Operational	Problem with mobilisation	Still under review	4
111	Problem with management of call	Still under review	1
		Incorrect reason of call logged in system; Staff feedback and/or reflection	1

Table 5

Internal and External Concerns - Incidents and Complaints

Number of concerns that have been raised internally and externally		Incidents Closed on both modules	Number closed and Deaths likely due to the service
July	4	1	0
August	1	0	0
September	1	0	0
Total	6	1	0

Table 6

Department	Concern Raised	Cause and Actions	Total
EOC	Problem with call taking and response allocation	Demand outstripped resources; Staff feedback and/or reflection	1
	Problem with call taking and response allocation (chest pain)	Still under review	2
	Problem with call taking and response allocation (fall)	Still under review	2
	Problem with communication of handover	Insufficient information conveyed to ED; System/procedure review/update requested	1

Table 7

Concerns raised internally and externally by service

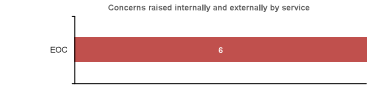


Figure 5

Data last exported 27/10/2022 and last updated 21/11/2022

This is an outline of the deaths recorded on the Incidents module and/or Patient Experience module that fit the cohort. The information is provided from the reviews and associated documents

Structured Judgement Review Sample (SJR) Breakdown

Sample Data Description: A random sample of 40 incidents minimum using the specified criteria from the national guidance reviewed using the SJR process.

Structured Judgement Review

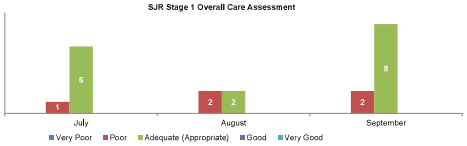
Incidents used for the Sample criteria		Number of Deaths Reviewed	Total Number of Deaths where problems in care have
July	9	7	1
August	4	4	2
September	12	10	2
Total	25	21	5

Table 8

SJR Category Type			
Month	C1 and C2 Long waits	C3 and C4 Deaths	24 hr Re-contact Deaths
July	2	2	5
August	0	0	4
September	3	2	7
Total	5	4	16

Table 9

SJR Stage 1 Overall Care Assessment



	SJR Element	1 or 2 - Poor or Very Poor	3 - Adequate (Appropriate)†	4 or 5 - Good or Very Good	% Patients receiving Adequate or Good Care	
Right Time	Call Handling/Resource Allocation‡	N/A	N/A	N/A	N/A	
Right Care	Patient Assessment Rating	4	17	0	17/21 patients	81%
	Management Plan/Procedure Rating	2	18	1	19/21 patients	90%
Right Place	Patient Disposition Rating	2	18	1	19/21 patients	90%

Table 10

† SJR Scoring Key:

Adequate: Care that is appropriate and meets expected standards;
Poor/Very Poor: Care that is lacking and/or does not meet expected standards;

Good/Very Good: Care that shows practice above and/or beyond expected standards

Definitions taken from the National Quality Board, "National Guidance for Ambulance Trusts on Learning from Deaths", July 2019

‡ EOC subject matter expert required to undertake the call handling/resource allocation element of the SJR.

Structured Judgement Review Highlighted Learning Themes from Stage 1 (Review of 21 patients)

Evidence of Poor/Very Poor Practice

Evidence of Poor/Very Poor Practice

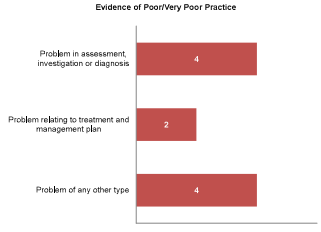


Figure 7

Department	Learning Theme	Learning Detail	Total
PES	Problem with assessment, investigation or diagnosis	Capacity to consent not assessed correctly	2
		Limited information recorded regarding clinical assessment, examination and outcome	1
		No indication of the status of the disease or the prognosis, no indication of current treatments, or plan	2
		No physical examination documented	2
		No systematic examination of respiratory, abdominal, urinary or MSK	2
		Normal oxygen saturations not recorded	1
	Problem related to treatment and management plan	Crew documented patient refusal but don't stay why - always good to document the wishes or reasons of the patient as gives / builds a picture as to why	1
		Details of the GP discussions not recorded	1
		Differential diagnosis and border line infection not considered	1
		MTS/Pathfinder not applied correctly	2
		No documented attempt to contact the GP to discuss the patient or the presence of a statement of intent given the nature of the history. No referral to AVS/GP/alternative providers when appropriate to do so	2 1
		No senior clinical advice sought No documentation of plan, worsening advice or SOS advice	1 1
	Problem of any other type	Possible Sepsis Red Flag missed	2
		Quality of EPR	4

Table 11

Evidence of Good/Very Good Practice

Evidence of Good/Very Good Practice

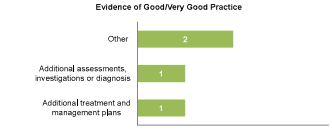


Figure 8

Data last accessed 01/12/2022

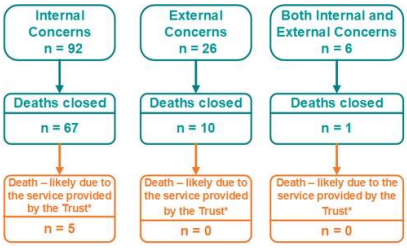
Department	Learning Theme	Learning Detail	Total
PES	Additional assessments, investigations or diagnosis	Holistic decision not to resuscitate.	1
	Additional treatment and management plans	Handover to OOHGP noted with reference to organising package of care for end of life	1
	Other	Documentation states involvement of those important to the patient, with holistic conversation noted	1
		Quality of EPR	2

Table 12

NWAS LEARNING FROM DEATHS (LFD)

Q2 2022/23 Report

DEATHS WITH CONCERNS RAISED IN DATIX



*as classified by the Datix investigator

94%

had no causal factors identified

KEY LEARNING THEMES FROM CONCERNS

Emergency Operations Centre (EOC)

- Significant delay responding to a patient with difficulty in breathing (x2)
- Significant delay in responding to a chest pain patient (x2)
- Significant delay in responding to a patient (x8)

Paramedic Emergency Service (PES)

- Problem related to treatment and management plan (x2)
- Problem with capacity to consent
- Problem with patient disposition (x6)

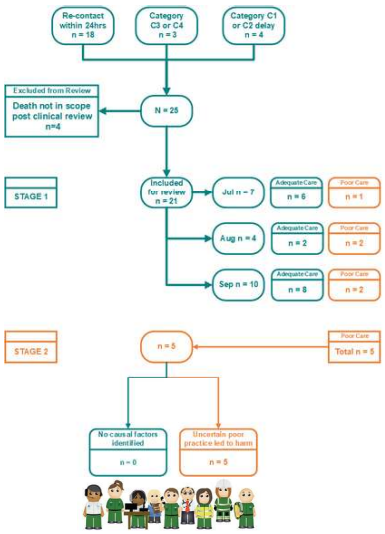
for more information on themes, full dashboard available on request

STRUCTURED JUDGEMENT REVIEW PHASES & OUTCOMES

- Call Handling/ Categorisation/ Resource Allocation **(not live)**
- Patient Assessment
- Management Plan/Procedure
- Patient Disposition

If any phase has a poor or very poor outcome, stage 2 is triggered to assess if it led to any harm in terms of assessment, medication, management plan, monitoring or resuscitation.

SJR DEATHS



STAGE 1 - SJR OUTCOMES

76.2% of patients received appropriate care

SJR STAGE 2 THEMES

Problem in assessment, investigation or diagnosis

- Lack of comprehensive documentation of the patient assessment
- No indication of the status of the disease or the prognosis, no indication of current treatments or plan
- Normal O2 saturation level not recorded
- Capacity to consent not assessed correctly

Problem relating to treatment and management plan

- Incorrect application of MTS/Pathfinder
- Lack of escalation for decision making
- No narrative regarding GP discussion
- No specific worsening advice
- No patient referral when appropriate to do so
- No documented attempt to contact the GP to discuss the patient or the presence of a statement of intent given the nature of the history
- No evidence of sepsis being considered

Problem of any other type

- Poor clinical documentation (x4)

EVIDENCE OF GOOD PRACTICE

Additional assessments, investigations or diagnosis

- Holistic decision not to resuscitate

Additional treatment and management plans

- Handover to OOHGP noted with reference to organising package of care for end of life

Other

- Documentation states involvement of those important to the patient, with holistic conversation noted
- Quality of EPR (x4)

Acknowledging good care and practice - **10 letters sent out**

well done!

SJR ACTIONS/ IMPROVEMENTS

- Case escalated for a local clinical review
- EOC specialists invited to November's panel (17/01/23)
- Regular observers in attendance

More information contact:
Learning.FromDeaths@nwas.nhs.uk