North West Ambulance Service NHS Trust

REPORT TO BOARD OF DIRECTORS					
DATE:	30th March 2022				
SUBJECT:	Learning from Deaths summary report and dashboard Q3 2021/22				
PRESENTED BY:	Dr C Grant, Medical Director				
LINK TO BOARD ASSURANCE FRAMEWORK:	**SR01**	**SR02**	**SR03**	**SR04**	
	☒	☐	☐	☐	
	SR05	**SR06**	**SR07**	**SR08**	**SR09**
	☐	☒	☐	☐	☐
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; this is the fourth quarterly report to be published. The Q3 dashboard (appendix A) describes the opportunities to learn from deaths. In summary the contributory factors to patient deaths, where identified, were attributed to problems in EOC procedures, specifically calls being incorrectly categorised and lack of available resources. The peer review process identified most patients received appropriate care, but where failings occurred these included the failure to record observations/assessment/investigations, MTS being used inappropriately, absence of ECGs attached to EPRs and misunderstanding of DNACPR/futile arrest. The peer review identified areas of good practice such as shared decision making and safety netting between crew, SPTL, AP and GP whilst respecting the patient's wishes to remain at home (re-contact death), crews showing care and compassion by allowing a natural death and supporting the family/caregivers in the process; and providing a detailed management plan to a patient within the community who is at risk of dying and refusing conveyance (re-contact death). A commitment to disseminating and promoting good practice has been made by the Consultant Paramedic (Medical) through the area learning forums and individual frontline staff. The DCIQ Mortality Module is now business as usual and four (4) SJR panels have been completed meaning the Q3 SJR data was pulled using the DCIQ Mortality dashboard. Elements of the dashboard need improvement to ensure robust data capture and analysis.				

<table>
<tr><td>RECOMMENDATIONS:</td><td colspan="4">The Board Of Directors are recommended to:

• Support the quarterly dashboard (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.
• Note the risks associated with the development of the Learning from Deaths process notably the continued absence of the call handling/dispatch and triage review.
• Acknowledge the impact of the SJR process in identifying opportunities for improving care and identification of serious incidents previously unknown to the trust.
• Acknowledge the good practice identified including:
  ○ Collective decision making and safety netting between crew, SPTL, AP and GP whilst respecting the patient's wishes to remain at home
  ○ Crew demonstrated care and compassion by allowing a natural death and supporting the family/caregivers in the process
  ○ Detailed management plan to support the patient in the community who is at risk of dying and refusing conveyance
• Support the dissemination process as described in 3.4
• Note the DCIQ Mortality module is now business as usual.</td></tr>
<tr><td>CONSIDERATION TO RISK APPETITE STATEMENT
(DECISION PAPERS ONLY)</td><td colspan="4">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</td></tr>
<tr><td>ARE THERE ANY IMPACTS RELATING TO:
(Refer to Section 4 for detail)</td><td>Equality:</td><td>☐</td><td>Sustainability</td><td>☐</td></tr>
<tr><td rowspan="3">PREVIOUSLY CONSIDERED BY:</td><td colspan="4">Quality and Performance Committee
Clinical Effectiveness Sub Committee</td></tr>
<tr><td>Date:</td><td colspan="3">28th March 2022
1st March 2022</td></tr>
<tr><td>Outcome:</td><td colspan="3">Assurance received</td></tr>
</table>

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1. PURPOSE

1.1 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 Q3 2021/22 Learning from Deaths review; and it is proposed this document is published on the Trust's public accounts by 31st March 2022 in accordance with the national framework and trust policy. The Q3 dashboard includes output from moderation panels held following the structured judgement reviews (SJRs), for Q3. The learning from the panels is discussed later in this paper.

The next phase of dashboard development will require dedicated EOC subject experts to undertake the dispatch and triage review.

It is acknowledged the attached document remains an iterative reporting process which will continue to become more sophisticated and informative as 2021/22 progresses.

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. The methodology is available on request from the Clinical Audit Team at Learning.FromDeaths@nwas.nhs.uk

3. LEARNING FROM DEATHS DASHBOARD Q3 2021/22: APPENDIX A

3.1 The number of patients whose deaths were identified as in scope for review was 162 (101 Datix incidents and 61 sampled - *table 1, Fig.1*).

3.2 ***Datix Cohort Discussion***

Of the 101 patient deaths;

- 67 patients were identified through the Incidents module
- 27 patients were identified through the Patient Experience module
- And a further seven (7) patient was identified as having records on both the Incidents and the Patient Experience module.

3.2.1 ***Incident Module: Tables 2 and 3, figures 2 and 3***

Of the 67 patients, 33 were reviewed and closed. In 19 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 patient's death

3.2.2 ***Patient Experience Module: Tables 4 and 5 and figure 4***

Of the 27 patients reported, 26 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. For the one (1) case that has been closed, death was not considered to have been caused by the incident. The content of the reviews so far suggest the learning themes and therefore opportunities for improvement are:

- EOC and EMD procedures
    - Call incorrectly categorised with a missed opportunity to manually upgrade the call
    - Significant delay in responding to a difficulty in breathing patient, resulting in cardiac arrest
    - Significant delay in responding to a chest pain patient, resulting in cardiac arrest
- PES/Operations
    - Lack of safety-netting, incorrect MTS application in a chest pain patient
    - Lack of safety-netting, incorrect MTS application in an anticoagulant patient with a haemorrhage
- Communication
    - 111 did not convey sufficient information to EOC/EMD
- Relative/external health professional concern raised
    - Relative concerned that patient was not prioritised by call handler

3.2.3 ***Investigation and Patient Experience Modules: Tables 6 and 7 and figure 5.***

Seven (7) patient deaths were recorded on both modules – note this is a different incident from those referenced separately in the incident and patient experience modules. None of the incident investigations have been closed though themes emerging from the investigations include:

- EOC and EMD procedures:
    - Calls incorrectly categorised with missed opportunities to manually upgrade the incidents
    - Significant delay responding to a patient with breathing difficulties
- Relative/external health professional concern raised:
    - Relative concerned patient was not prioritised by call handlers

3.3 ***Sample Cohort Discussion: tables 8, 9 and fig 6.***

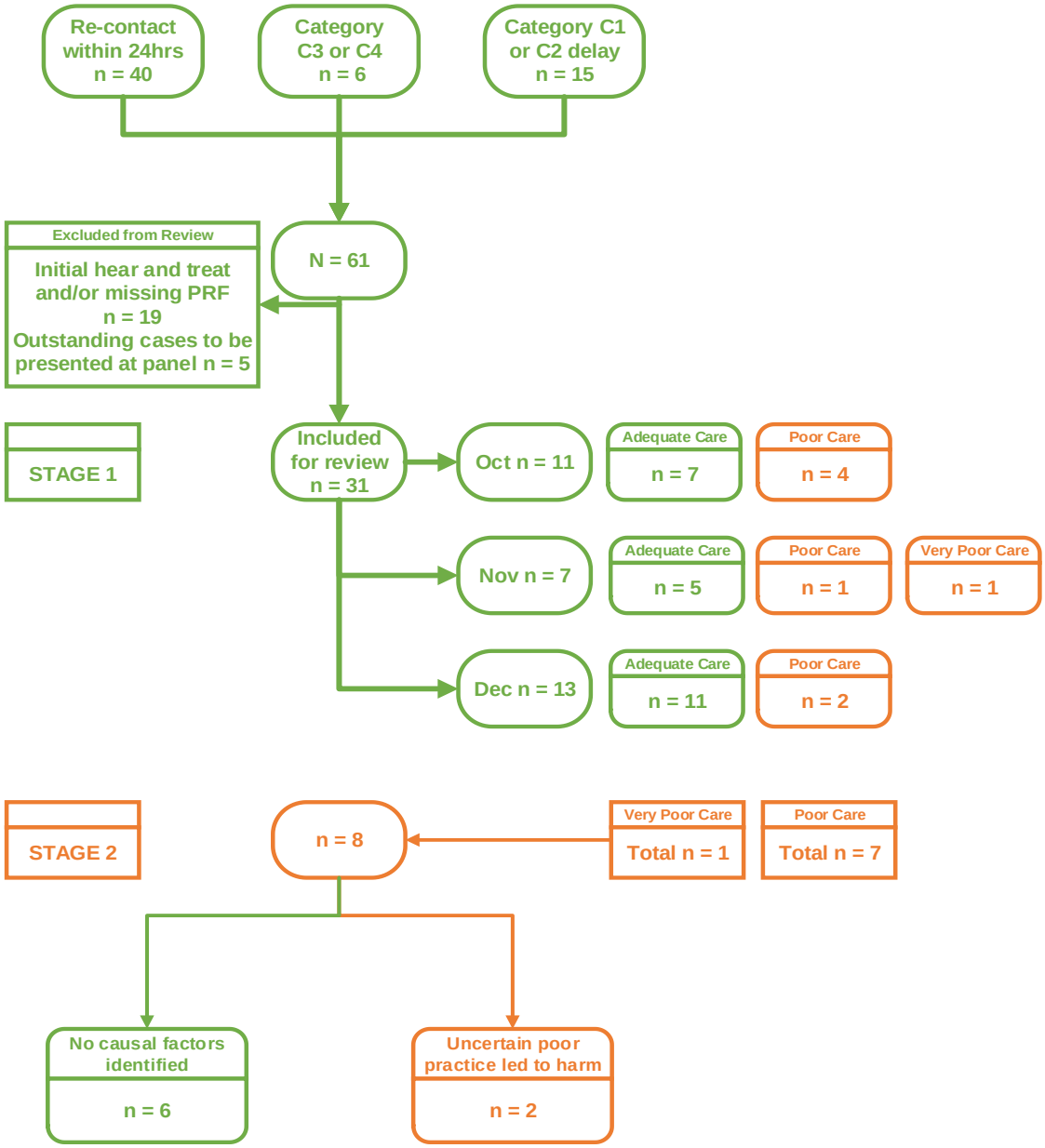
Of the 61 patient deaths:

- 40 patient deaths occurred where patients were not initially conveyed and the service was re-contacted within 24 hours*
- Six (6) patient deaths occurred where the incident was coded as Cat 3 or Cat 4
- 15 deaths occurred where they were initially coded as Cat 1 or Cat 2, and were subjected to a long wait.

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

The flow chart below provides a summary of which of the cases identified were reviewed and how the numbers referred to in tables 8 and 9 and fig 6 of the Q4 dashboard change. There are two reasons why the whole cohort identified are not reviewed:

1. Without a patient report form the review cannot be undertaken
2. Where a 24hr re-contact incident is initiated as a ‘hear and treat’ and subsequently as a see and treat; the ‘hear and treat’ element review cannot be undertaken without the EOC Clinical Hub specialist.



3.3.1 ***Structured judgement review methodology***

The process requires the reviewing frontline staff to make explicit statements upon 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 statements multiple times in a single review. The review comprises of Stage1: 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.

3.3.2 ***Outcome: Q2 Review: Stage 1.***

31 patient deaths were reviewed by reviewers and following the moderation panels the outcomes of the reviews were determined as described in the table below.

Month	Very Poor	Poor	Adequate	Good	Very Good
Oct 21		4	7		
Nov 21	1	1	5		
Dec 21		2	11		

Moderation Panels held on 14/12/2021, 11/01/2022, & 15/02/2022

It should be understood 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'.

3.3.3 ***Q2 Review: Stage 2.***

Eight (8) cases were identified as needing second stage review following Stage 1. It was identified that in six (6) cases no other causal factors were identified as contributing to harm and simply the care experienced by the patient in terms of assessment, management plan and disposition were below expected levels one might reasonably expect. The second stage review for the two (2) remaining patients remained as uncertain whether poor practice had led to harm.

3.3.4 ***Learning Outcomes: Tables 11 -12***

Poor Practice: Table 11 fig 7.

The panel identified areas for improvement were to

- Increase observations and/or investigations recorded
- Apply MTS/Pathfinder appropriately and correctly, ensuring that decisions are recorded
- Ensure SOS/red flag/worsening advice is given and recorded
- Ensure bias does not impact clinical assessment and investigations
- Ensure ECGs are attached to the electronic patient record (EPR)
- Follow NWAS/JRCALC guidance on COVID 19 when appropriate to do so
- Ensure termination of resuscitation protocols are followed
- Ensure patients with breathing difficulties have 12-lead ECGs
- Encourage crews to escalate complex cases
- Improve clinical narrative within the EPR

Other learning which was identified through the review but not leading automatically to a stage 2 review was the variable quality of the patient record itself in terms of legibility, its comprehensiveness and use of appropriate language – leading to the more specific learning identified above.

Escalation and Learning

Nine (9) case have been escalated for a further review but unfortunately due to the current demands on EOC and local operational teams, these are delayed.

Good Practice: Table 12 fig 8.

The panel review identified numerous positive examples of practice over and above expected practice. This included

- PES Staff performing additional investigations and assessments beyond expected practice.

- Shared decision making for complex cases to ensure the patient is safety netted whilst respecting their wishes to remain at home.
- Care and compassion by allowing a natural death and supporting family and caregivers in the process.
- Detailed management plan to support the patient in the community and involved the patient in the decision making so that they could make a fully informed decision regarding their care and risks of dying.

3.4 ***Dissemination Process***

A commitment to disseminating and promoting good practice has been made by the Consultant Paramedic (Medical) through the area learning forums (ALFs) and individual frontline staff.

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 28 clinicians who through their care and professionalism have supported families and patients to experience a good death during September 2020 to September 2021.

3.5 ***Report Development***

DCIQ: Mortality Module

The project team for DCIQ has worked with the Clinical Audit Team and Consultant Paramedic (Medical) to develop the structured judgement review process in Datix. The DCIQ Mortality Module is now business as usual and four (4) SJR panels have been completed at the time of writing. This now means all of the Q3 LfD data and findings are now hosted on one secure platform allowing for a more efficient process of review and reporting. The DCIQ Mortality dashboard designed by project team helped compile the dashboard for this report. Minor improvements are needed to ensure data capture and analysis is more robust. The Clinical Audit Team will outline those development requests to the DCIQ team.

4. RISKS

4.1 ***DX3408:*** *(risk score 12)* There is a risk that the lack of resource will mean the competing priorities to perform additional high risk defined audits (such as the Learning from Deaths audit) will not be undertaken in their entirety and this will have a negative impact upon the annual clinical audit plan resulting in a failure to provide assurance to the trust and regulatory bodies.

It is not possible to complete the ‘call’ element of the review without a dedicated EOC subject expert. Until this is resolved, all SJRs can only be 75% complete. Findings from each of the SJR panels held have highlighted this element as crucial towards identifying potential risks in practice.

DX3477: *(risk score 12)* There is a continued risk that NWAS will cease to be able to deliver the nationally mandated co-ordinated Learning from Deaths programme because

of a failure to resource the co-ordinator position. Since 31st March 2021 cover has ceased and without a fully funded resource this will result in a failure to meet the national statutory requirement placed upon the trust going into 2021-2022.

5. LEGAL, GOVERNANCE AND/OR RISK IMPLICATIONS

5.1 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.

6. EQUALITY OR SUSTAINABILITY IMPLICATIONS

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

7. RECOMMENDATIONS

7.1 The Board of Directors is recommended to:

- Support the quarterly dashboard (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.
- Note the risks associated with the development of the Learning from Deaths process notably the continued absence of the call handling/dispatch and triage review.
- Acknowledge the impact of the SJR process in identifying opportunities for improving care and identification of serious incidents previously unknown to the trust.
- Acknowledge the good practice identified including:
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    - Detailed management plan to support the patient in the community who is at risk of dying and refusing conveyance
- Support the dissemination process as described in 3.4
- Note the DCIQ Mortality module is now business as usual.