NHS
North West
Ambulance Service
NHS Trust

REPORT TO BOARD OF DIRECTORS

DATE:	26th January 2022
SUBJECT:	Learning from Deaths summary report and dashboard Q2 2021/22
PRESENTED BY:	Dr C Grant, Medical Director

LINK TO BOARD ASSURANCE FRAMEWORK:

SR01	SR02	SR03	SR04
☒	☐	☐	☐
SR05	**SR06**	**SR07**	**SR08**
☐	☐	☐	☐

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 Q2 dashboard (appendix A) describes the opportunities to learn from deaths. In summary, the contributory factors to patient deaths, where identified, were attributed to problems with 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, Manchester Triage System (MTS) being used inappropriately, and/or lack of a comprehensive PRF.

The peer review identified areas of good practice. This included recognition of patients approaching end of life where no End of Life Care package or DNACPR was in place. Another example was organising and engaging with MDTs comprised of carers/GP/family members and external providers to ensure best interests of the patient were met. A further area of good practice was exemplary behaviour when treating a patient who had self-harmed, ensuring they were thoroughly safety-netted with safeguarding, the police, the patient's GP and the Emergency Duty Team.

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.

DCIQ Mortality module completed testing in Q2 with the module going live in November 2021. The subsequent

	reports for this year will use data and findings from the new module.

RECOMMENDATIONS:	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:
	  ○ Recognising when a patient is approaching end of life and liaising with the patient, family and GP to ensure their best interests are met
	  ○ Showing exemplary behaviour, emotional and informational support to a patient approaching End of Life, ensuring the patient did so with dignity by going above and beyond what we expect from our clinicians.
	
	• Support the dissemination process as described in 3.4
	
	• Note the progress of the DCIQ Mortality module going live.

ARE THERE ANY IMPACTS RELATING TO: **(Refer to Section 4 for detail)**	Equality:	☐	Sustainability	☐

PREVIOUSLY CONSIDERED BY:	Quality and Performance Committee Clinical Effectiveness Sub Committee	
	Date:	24th January 2022 18th January 2022
	Outcome:	Received assurance

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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”.

Appendix A is a summary dashboard of the Q2 2021/22 Learning from Deaths review; and it is proposed this document is published on the Trust’s public accounts by 31st January 2022 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. 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 Q2 2021/22: APPENDIX A

3.1 The number of patients whose deaths were identified as in scope for review was 100 (58 Datix incidents and 42 sampled - *table 1, Fig.1*).

3.2 ***Datix Cohort Discussion***

Of the 58 patient deaths;

- 42 patients were identified through the Incidents module
- Ten (10) patients were identified through the Patient Experience module
- six (6) patients were 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 42 patients, 18 were reviewed and closed. In eight (8) 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 ten (10) patients reported, six (6) 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 four (4) cases that have been closed, all of those deaths were 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 falls patient, resulting in cardiac arrest
    - Significant delay in responding to a chest pain patient, resulting in cardiac arrest
- 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 handlers
    - HCP concerned delay in conveying a patient for emergency neurosurgery resulted in that patient's death
    - HCP concerned delay in conveying a renal patient by PTS resulted in death due to lack of resus status and lack of CPR

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

Six (6) 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:
    - ECH did not recall Sudden Silence Procedure, resulting in incorrect call categorisation for the incident
    - EMD did not send caller for a public access defibrillator when one was available due to no defibrillator icon appearing on the call system
    - Calls incorrectly categorised with missed opportunities to manually upgrade the incidents
    - ECH did not recall the Ineffective Breathing Procedure, resulting in an incorrect category for the incident

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

Of the 42 patient deaths:

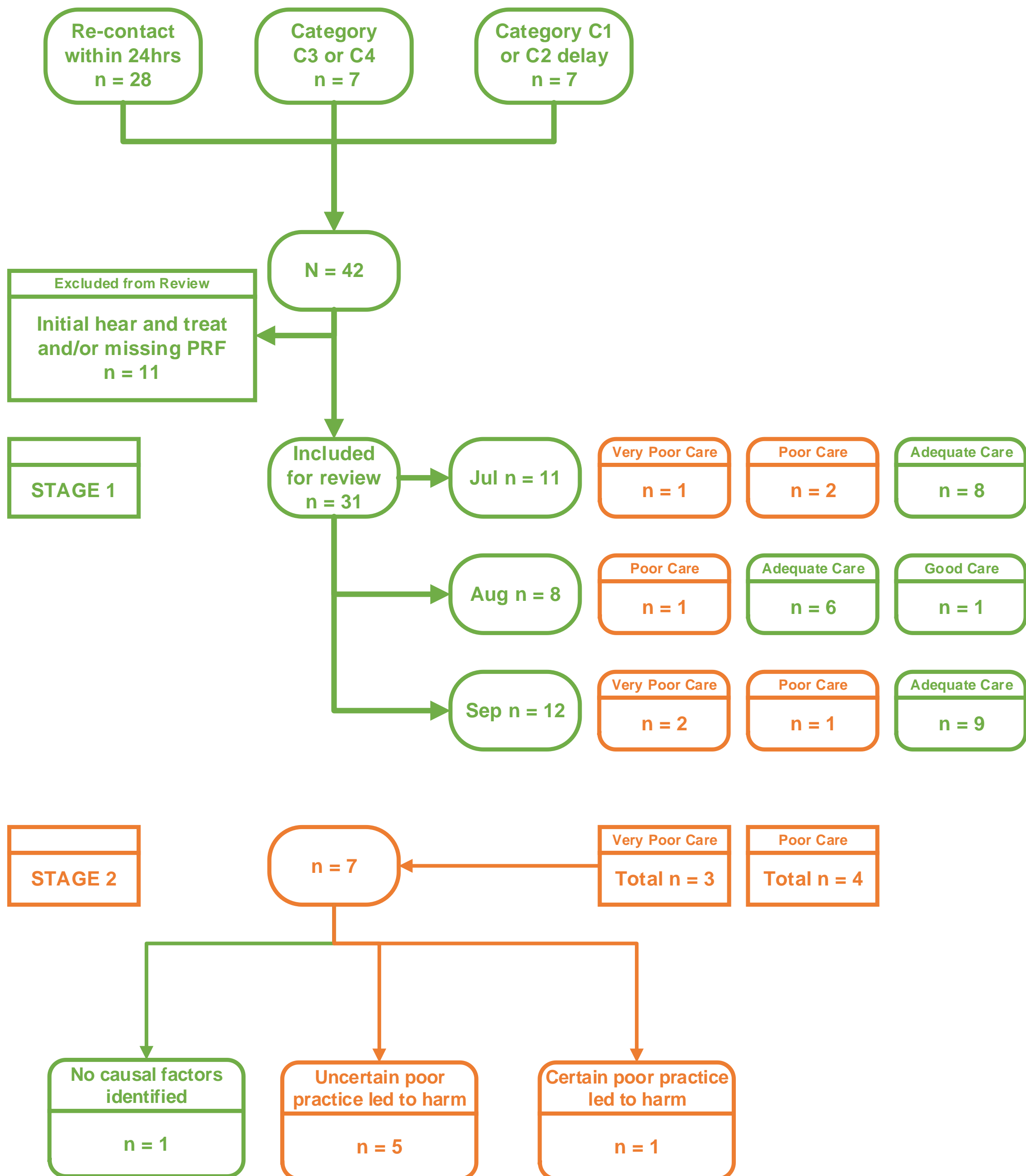
- 28 patient deaths occurred where patients were not initially conveyed and the service was re-contacted within 24 hours*
- Seven (7) patient deaths occurred where the incident was coded as Cat 3 or Cat 4
- Seven (7) deaths occurred where they were initially coded as Cat 1 or Cat 2, and were subjected 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 Q2 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



Flow chart to describe sample cohort attrition and treatment Q2 2021/22

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) 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 in 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
July 21	1	2	8		
Aug 21		1	6	1	
Sept 21	2	1	9		

Moderation Panels held on 14/09/2021, 12/10/2021, & 16/11/2021

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.***

Seven (7) cases were identified as needing second stage review following Stage 1. It was identified that in one (1) case 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.

In one (1) case it was identified that the factors identified did contribute to the death. The second stage review for the five (5) 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 the patient is appropriately safety-netted
- Ensure SOS/red flag/worsening advice is given and recorded
- Make appropriate referrals to AVS, primary care or alternative providers when appropriate to do so.
- Ensure Mental Health Assessments are carried out on patients when appropriate to do so
- Ensure when dealing with high-intensity users that unconscious bias does not enter decision making

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
Five (5) 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

- Recognising when a patient was approaching end of life and liaising with the patient and their family to ensure their best interests were met
- PES staff showing exemplary behaviour to a patient approaching End of Life by attending a local Hospice to provide the patient with bed pans as well as providing emotional and informational support to the spouse above and beyond what is expected
- PES Staff performing additional investigations and assessments beyond expected practice.

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.

There is an intention to commend individuals who through their care and professionalism have supported families and patients to experience a good death, and this will be a key element of the Learning from Deaths communication plan.

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. As of November 2021 the DCIQ Mortality Module is live. The LfD SJR process is now held on the DCIQ system with two full cycles of SJR review having taken place as of time of writing. This now means all of our LfD data and findings are now hosted on one secure platform allowing for a more efficient process of review and reporting.

4. LEGAL, GOVERNANCE AND/OR RISK IMPLICATIONS

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.

4.1 ***Risks***
Two on-going risks have been identified regarding the LFD project and they remain:

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. EQUALITY OR SUSTAINABILITY IMPLICATIONS

No equality or sustainability implications (other than those identified as risks) have been raised as a concern from this report.

6. RECOMMENDATIONS

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 developing 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:
    - Recognising when a patient is approaching end of life and liaising with the patient and family to ensure their best interests are met
    - Thorough safety-netting of mental health self-harm patients through multiple agencies
    - Thorough safety-netting of patients at risk of dying who refuse conveyance and/or are violent to our clinicians
- Support the dissemination process as described in 3.4
- Note the progress in developing the DCIQ Mortality module.

NWAS Learning From Deaths Dashboard Quarter 2 2021-2022 (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
July	31	18	58.1%	7
August	36	19	52.8%	7
September	33	16	48.5%	5
This Quarter	**100**	**53**	**53.0%**	**19**
This Financial Year	168	99	58.9%	38

** Criteria as specified in the 'National guidance for ambulance trusts on Learning from Deaths' (2019) - Where concern raised on quaily of care provieded where the patient died under the care of the ambulance service (from call to handover), after handover or within 24 hours of inital contact where the decision was to not convey the patient. The sample must contain incidents across the categories outlined in the document.*

Table 1.

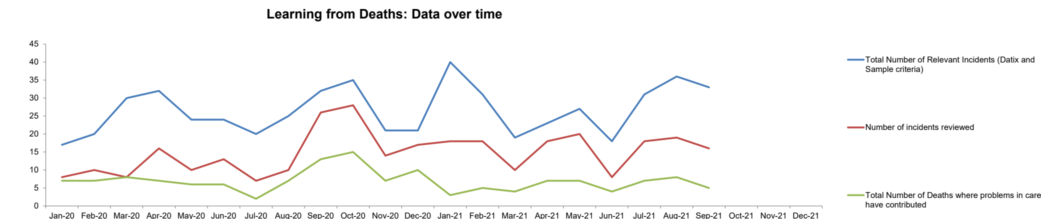


Figure 1.

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.

Data source:An amalgamation of both the Datix cohort and the Sample cohort data sources detailed below. Last accessed 15/12/2021.

Datix Cohort Breakdown

Datix Cohort Description: The 'must review' category includes incidents raised to the organisation and recorded via Datix as 'deaths that occured 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 occured; 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'.

Incidents Module

Total Datix Death incidents in scope		Risk grading		
		1 or 2	3	4 or 5
July	13	0	4	9
August	17	2	4	11
September	12	0	1	11
Total	**42**	**2**	**9**	**31**

Table 2.

Month	Number of Deaths Closed on Datix	Of those closed, Number of Deaths considered as caused by the incident	Lessons Learned complete for those closed and considered caused by the incident
July	5	2	1
August	9	4	2
September	4	2	1
Total	**18**	**8**	**4**

Table 3.

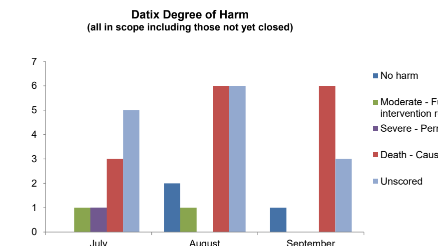


Figure 2.

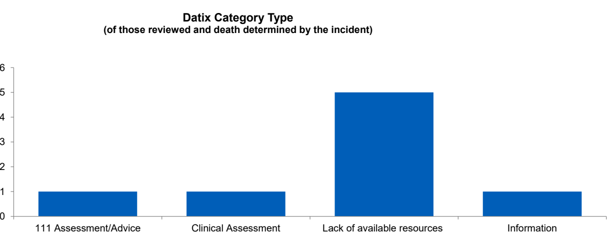


Figure 3.

Data source: Datix Incidents query 'Inc: LfD (DoH Expected Death or Death) Listing Report - Incident Date @lastquarter' and 'Inc: Wild Card Search (death/dead/deceased/died) Incident Date @lastquarter. Last extracted 02/12/2021. Last accessed 15/12/2021

Patient Experience Module only

Month	Relevant Patient Experience module incidents	Incidents Closed on Pat. Exp.	Number closed and death considered caused by the incident
July	2	2	2
August	5	2	2
September	3	0	0
Total	**10**	**4**	**4**

Table 4.

(Note- This is the month the incident occured, not when the notification of raised concern for care was received)

Data source: Datix Patient Experience search 'Risk Score: 4 & 5' Incident Date @lastquarter, last extracted using PE Listing report on 02/12/2021. Last accesed 15/12/2021.

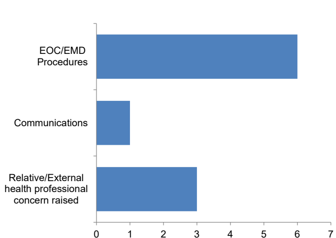


Figure 4.

Learning Theme	Learning Detail	Frequency	Action Themes (may have multiple)
EOC/EMD procedures	Call incorrectly categorised, opportunity to manually upgrade was missed	4	Reflection and/or feedback; refresher training to be undertaken for sudden silences/sudden arrest
	Significant delay in responding to a falls patient leading to cardiac arrest	1	Demand outstripped resources; guidance issued on principles of dispatch; HART to be included in review of Trust Meal & Rest Break policy
	Significant delay in responding to a chest pain patient	1	Demand outstripped resources; resourcing levels were not appropriate anywhere across the Trust on night of incident; commendation to dispatcher for effective monitoring of incident
Communication	111 did not convey sufficient information to EOC/EMD	1	Reflection and/or feedback; refresher training to be undertaken; still under review
Relative/external health professional concern raised	Relative concerned patient was not prioritised by call handlers	1	Complaint not upheld; Call handled correctly; Incident monitored safely
	HCP concern delay in conveying patient for emergency neurosurgery resulted in death	1	Complaint not upheld; demand outstripped resources;
	HCP concern delay in conveying renal patient by PTS resulted in death due to lack of resus status and lack of CPR	1	Complaint not upheld; no mismanagment from NWAS perspective; concern from NWAS as to suitability of patient for transfer

Table 5.

Incidents on both Patient Experience Module and Incidents Module

Month	Relevant incidents on both modules	Incidents Closed on both modules	Number closed and death considered caused by the incident
July	2	0	0
August	1	0	0
September	3	0	0
Total	**6**	**0**	**0**

Table 6.

(Note- This is the month the incident occured, not when the notification of raised concern for care was received)

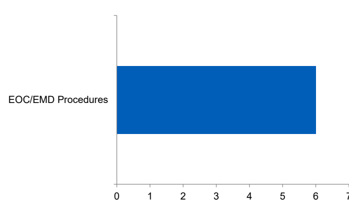


Figure 5.

Learning Theme	Learning Detail	Frequency	Action Themes
EOC/EMD Procedures	ECH did not recall Sudden Silence Procedure, resulting in incorrect category for incident	1	Reflection and/or feedback; re-training/re-reading procedures; conduct an incident learning review; refresher training to be undertaken for sudden silences/sudden arrest
	EMD did not send caller for Defibrillator as no defibrillator icon appeared	1	Reflection and/or feedback; re-training/re-reading procedures; instruction to send someone for defib should still have been given as per IAED
	Call incorrectly categorised, opportunity to manually upgrade was missed	3	Reflection and/or feedback; re-training/re-reading procedures; review of Patient Safety Plan; escalate incident to EOC learning forum
	ECH did not recall Ineffective Breathing Procedure, resulting in incorrect category for incident	1	Reflection and/or feedback; re-training/re-reading procedures; raise issue of ineffective breathing at EOC Learning Forum

Table 7.

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

Data source: Datix Patient Experience search 'Risk Score: 4 & 5' Incident Date @lastquarter: last extracted 02/12/2021. Information recorded on these incidents: last accessed 15/12/2021. Datix Incidents query 'Inc: LfD (DoH Expected Death or Death) Listing Report - Incident Date @lastquarter' and 'Inc: Wild Card Search (death/dead/deceased/died) Incident Date @lastquarter - Listing Report': last extracted on 02/12/2021. Last accessed 15/12/2021

Sample Cohort Breakdown

Sample Data Description: A random sample of 40 incidents minimum using the specified criteria from the national guidance reviewed using the SJR process.
This includes deaths classified as requiring a Category 1 or Category 2 response, Category 3 and Category 4 incidents that resulted in deaths and deaths of patients that were not initally conveyed and the ambulance service was re-contacted within 24 hours.

Structured Judgement Review

Incidents used for the Sample criteria		Number of Deaths Reviewed	Total Number of Deaths where problems in care have contributed
July	14	11	3
August	13	8	1
September	15	12	3
Total	**42**	**31**	**7**

Table 8.

Quarter 2 2020-2021 Sample Data Breakdown			
Month	**C1 and C2 Long waits**	**C3 and C4 Deaths**	**24 hr Re-contact Deaths**
July	2	3	9
August	3	2	8
September	2	2	11
Total	7	7	28

Table 9.

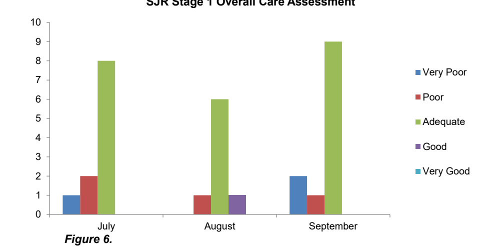


Figure 6.

	SJR Element	1 or 2 - Poor or Very Poor	3 - Adequate†	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	5	24	2	**26 patients out of 31 patient cohort**	**84%**
	Management Plan/Procedure Rating	6	23	2	**25 patients out of 31 patient cohort**	**81%**
Right Place	Patient Disposition Rating	6	24	1	**25 patients out of 31 patient cohort**	**81%**

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 31 patients)

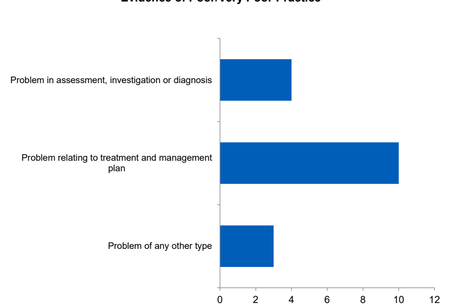


Figure 7.

Learning Theme	Learning Detail	Frequency (n=31 patients)
Problem in assessment, investigation or diagnosis	Lack of observations or investigations performed	4
Problem relating to treatment and management plan	MTS/Pathfinder incorrectly/not used	5
	Lack of patient safety-netting undertaken	2
	No SOS/red flag/worsening advice given	1
	No referral to AVS/GP/alternative providers when approriate to do so	1
	Lack of Mental Health Assessment	1
Problem of any other type	Incomprehensive PRF	2
	Unconscious clinician Bias when dealing with high intensity users	1

Table 11.

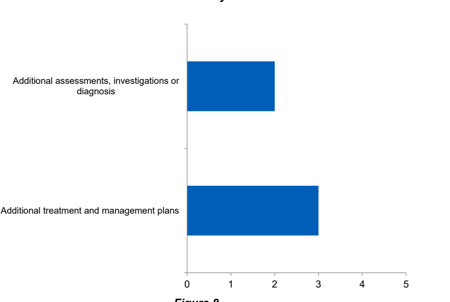


Figure 8.

Learning Theme	Learning Detail	Frequency (n=31
Additional assessments, investigations or diagnosis	Assessment of patient with additional investigations and assessments beyond expected practice	2
Additional treatment and management plans	Crew made multiple attempts to gain entry to a Mental Health Self Harm patient's property with excellent escalation before requesting permission to force entry when no answer from patient. Detailed description of recent police search & seize records as well as general scene.	1
	Patient recognised to be approaching EoL; crew liaised with patient, family members and GP to ensure best interests were met	1
	Crew showed exemplary behviour and treatment towards a patient approaching EoL. Crew attended local Hospice to obtain bed pans for patient and discuss supporting patient's spouse. Crew also provided emotional and informational support to patient, spouse and caregivers	1

Table 12.

The SJR Completion is an iterative process. All three months have been reviewed across three elements of the Stage 1 review process. Due to PRFs being unavailable and a lack of EOC subject experts for the SJR process, 31 reviews took place, 9 less than the minimum random sample size of 40 required.

Data source: Informatics Learning from Deaths SSRS Feed last run on 05/10/2021, SJR data source: Learning from Deaths SJR Database, last accessed on 15/12/2021.