NWAS Learning From Deaths Dashboard Quarter 1 2021-2022 (April - June)

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
April	23	16	69.6%	6
May	27	16	59.3%	6
June	18	6	33.3%	2
This Quarter	**68**	**38**	**55.9%**	**14**
This Financial Year	68	38	55.9%	15

** 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.

Data source:An amalgamation of both the Datix cohort and the Sample cohort data sources detailed below. Last accessed 24/08/2021.

Learning from Deaths: Data over time

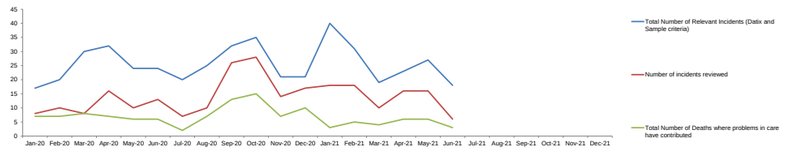

Figure 1.

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.

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
April	5	4	1	0
May	8	2	4	2
June	3	0	0	3
Total	**16**	**6**	**5**	**5**

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
April	3	0	0
May	3	0	0
June	1	1	1
Total	**7**	**1**	**1**

Table 3.

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

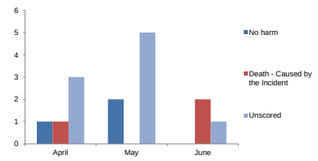

Figure 2.

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

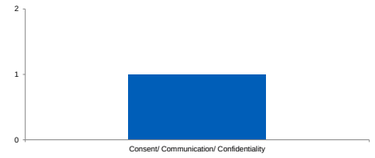

Figure 3.

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 28/07/2021. Last accessed 24/08/2021

Patient Experience Module only

Month	Relevant Patient Experience module incidents	Incidents Closed on Pat. Exp.	Number closed and death considered caused by the incident
April	1	2	0
May	1	0	0
June	4	1	0
Total	**6**	**3**	**0**

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 28/07/2021. Last accesed 24/08/2021.

Learning theme

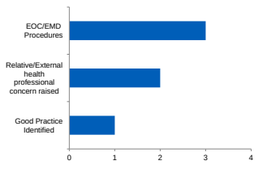

Figure 4.

Learning Theme	Learning Detail	Frequency	Action Themes (may have multiple)
EOC/EMD procedures	Call incorrectly categorised, opportunity to manually upgrade was missed	1	Reflection and/or feedback; refresher training to be undertaken; still under review
	Significant delay in responding to a suspected stroke patient	1	Reflection and/or feedback; demand outstripped resources; still under review
	Significant delay in responding to a chest pain patient	1	Reflection and/or feedback; demand outstripped resources; still under review
Relative/external health professional concern raised	Relative concerned clinicians lacked appropriate equipment (Defibrillator)	1	Still under review
	HCP concern patient was incorrectly conveyed to UCC instead of ED	1	Reflection and/or feedback; Crew acted appropriately as per GP instructions; still under review
Good Practice Identified	Diagnosis of potential C-Spine injury (later confirmed) in a patient presenting as medical cause not traumatic in nature	1	Positive feedback/commendation provided to crew; still under review

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
April	1	1	1
May	0	0	0
June	0	0	0
Total	**1**	**1**	**1**

Table 6.

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

Learning theme

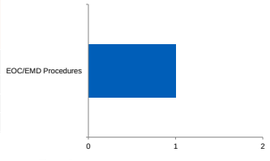

Figure 5.

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;

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 28/07/2021. Information recorded on these incidents: last accessed 24/08/2021. 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 28/07/2021. Last accessed 24/08/2021

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
April	16	10	5
May	18	13	6
June	11	4	1
Total	**45**	**27**	**12**

Table 8.

Quarter 2 2020-2021 Sample Data Breakdown			
Month	**C1 and C2 Long waits**	**C3 and C4 Deaths**	**24 hr Re-contact Deaths**
April	0	3	13
May	1	1	16
June	1	2	8
Total	2	6	37

Table 9.

SJR Stage 1 Overall Care Assessment

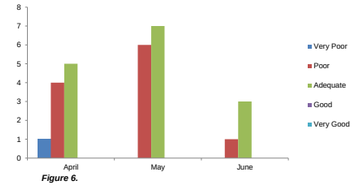

Figure 6.

	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	9	17	1	**18 patients out of 27 patient cohort**	**67%**
	Management Plan/Procedure Rating	9	15	3	**18 patients out of 27 patient cohort**	**67%**
Right Place	Patient Disposition Rating	7	20	0	**20 patients out of 27 patient cohort**	**74%**

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 27 patients)

Evidence of Poor/Very Poor Practice

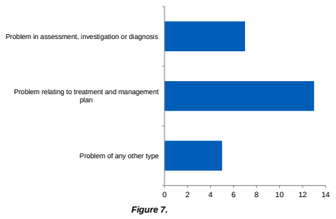

Figure 7.

Learning Theme	Learning Detail	Frequency (n=27 patients)
Problem in assessment, investigation or diagnosis	Lack of observations or investigations performed	7
Problem relating to treatment and management plan	MTS/Pathfinder incorrectly/not used	7
	No SOS/red flag/worsening advice given	3
	No discussion with family members regarding patient's condition/DNACPR/EoLC	1
	No Safeguarding referral made when appropriate to do so	1
	No referral to AVS/GP/alternative providers when approriate to do so	1
Problem of any other type	Incomprehensive PRF	4
	By not making contact, crew did not establish whether patient was alive or not	1

Table 11.

Evidence of Good/Very Good Practice

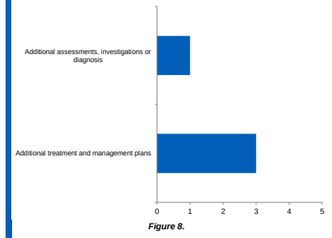

Figure 8.

Learning Theme	Learning Detail	Frequency (n=27 patients)
Additional assessments, investigations or diagnosis	Assessment of patient with additional investigations and assessments beyond expected practice	1
Additional treatment and management plans	Crew made multiple attempts to encourage a patient to be treated and conveyed for a life-threatening condition, despite being met with violence/aggression by patient	1
	Patient recognised to be approaching EoL; crew liaised with patient and family members to ensure best interests were met	1
	Crew showed exemplary behviour and treatment towards a mental health self-harm patient, ensuring thorough safety-netting of the patient took place through safeguarding referrals, police liaison, referral to the patient's GP, and the Emergency Duty Team (EDT)	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, 27 reviews took place, 13 less than the minimum random sample size of 40 required.

Data source: Informatics queries 994279, 1004018 & 1014348 last run on 05/07/2021, SJR data source: Learning from Deaths SJR Database, last accessed on 24/08/2021.