NWAS Learning From Deaths Dashboard Quarter 3 2020-2021 (October - December)

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
October	35	23	65.7%	12
November	21	12	57.1%	6
December	21	14	66.7%	8
This Quarter	**77**	**49**	**63.6%**	**26**
This Financial Year	234	93	39.7%	50

** 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 12/02/2021.

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
October	11	1	2	8
November	2	0	2	0
December	3	0	1	2
Total	**16**	**1**	**5**	**10**

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
October	7	5	2
November	2	1	1
December	2	1	0
Total	**11**	**7**	**3**

Table 3.

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

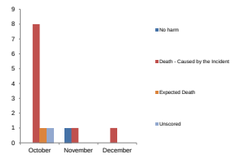

Figure 2.

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

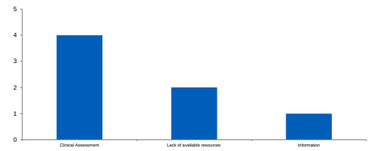

Figure 3.

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 01/02/2021.

Patient Experience Module only

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

Table 4.

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

Learning theme

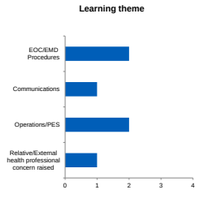

Figure 4.

Learning Theme	Learning Detail	Frequency	Action Themes (may have multiple)
EOC/EMD procedures	EMD ineffective breathing recognition	1	Reflection and/or feedback; refresher training to be undertaken; still under review
	Incorrect call categorisation	1	Reflection and/or feedback; refresher training to be undertaken; still under review
Communications	External/internal communication messages for IFTs	1	Reflection and/or feedback; invidicual and/or system learning with external HCPs
Operations/PES	Staff behaviour/attitude	1	Reflection and/or feedback; still under review
	Incorrect application of MTS	1	Reflection and/or feedback; re-training/re-reading procedures; still under review
Relative/External health professional concern raised	Patient safety concern	1	Reflection and/or feedback; re-training/re-reading procedures; still under review

Table 5.

Data source: Datix Patient Experience search 'Risk Score: 4 & 5' Incident Date @lastquarter, last extracted using PE Listing report on 01/02/2021. Last accesed 12/02/2021.

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
October	1	0	0
November	0	0	0
December	1	0	0
Total	**2**	**0**	**0**

Table 6.

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

Learning theme

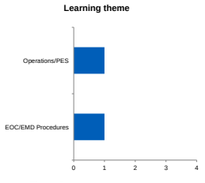

Figure 5.

Learning Theme	Learning Detail	Frequency	Action Themes
Operations/PES	Incorrect application of MTS	1	Reflection and/or feedback; re-training/re-reading procedures; still under review
EOC/EMD Procedures	Resource monitoring/management	1	Reflection and/or feedback; re-training/re-reading procedures; still under 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 01/02/2021. Information recorded on these incidents: last accessed 12/02/2021. 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 01/02/2021.

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
October	22	16	7
November	16	10	5
December	15	12	7
Total	**53**	**38**	**19**

Table 8.

SJR Stage 1 Overall Care Assessment

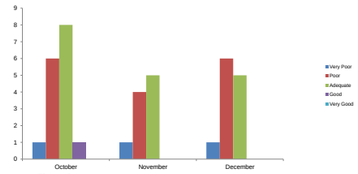

Figure 6.

Quarter 2 2020-2021 Sample Data Breakdown			
Month	**C1 and C2 Long waits**	**C3 and C4 Deaths**	**24 hr Re-contact Deaths**
October	7	7	8
November	1	4	11
December	1	5	9
Total	9	16	28

Table 9.

	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	12	25	1	**26 patients out of 38 patient cohort**	**68%**
	Management Plan/Procedure Rating	15	19	4	**23 patients out of 38 patient cohort**	**61%**
Right Place	Patient Disposition Rating	11	26	1	**27 patients out of 38 patient cohort**	**71%**

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 38 patients)

Evidence of Poor/Very Poor Practice

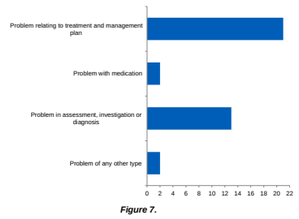

Figure 7.

Learning Theme	Learning Detail	Frequency (n=38 patients)
Problem in assessment, investigation or diagnosis	Lack of observations or investigations performed	13
Problem relating to treatment and management plan	No referral to AVS/GP/alternative providers when appropriate to do so	8
	No SOS/red flag/worsening advice given	5
	No senior clinical advice sought	3
	No resuscitation attempted	2
	Delay in upgrading incident	2
	MTS/Pathfinder not used	1
Problem with medication	Incorrect use of medication	2
Problem of any other type	Lack of clinician signature on paperwork	1
	No LeDer referral made	1

Table 11.

Evidence of Good/Very Good Practice

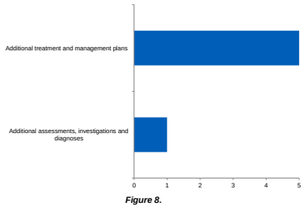

Figure 8.

Learning Theme	Learning Detail	Frequency (n=38 patients)
Additional treatment and management plans	Crew decided not to resuscitate patient they recognised as EOL in absence of formal EOLC package/DNACPR. Acted in best interest of patient.	2
	Additional referrals/management plans put in place for long-term safety netting of both patient and dependents	1
	Crew built holistic picture of patient's condition for treatment and rapid placement of EOLC package where one was absent	1
	Crew engaged with MDT comprised of external providers/carer/GP/family to ensure best interests of patient were met	1
Additional assessments, investigations and diagnoses	Crew recognised that patient was coming to the end of their life despite no EOLC/DNACPR being in place	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 staff absence/sickness 38 reviews took place, two less than the minimum random sample size of 40 required.

Data source: Informatics query 924638 last run on 07/01/2021, . SJR data souce: Learning from Deaths SJR Database, last accessed on 12/02/2021.