NWAS Learning From Deaths Dashboard Annual 2020-2021 (April - March)

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
Q1	80	39	48.8%	19
Q2	77	43	55.8%	22
Q3	77	59	76.6%	33
Q4	**90**	44	48.9%	12
This Financial Year	324	187	57.7%	85

** 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 patient died under the care of the ambulance service (from call to handover), after handover or within 24 hours of initial contact where the decision was to not convey the patient. The sample must contain incidents across the categories outlined in the document.*

Table 1.

Learning from Deaths: Data over time

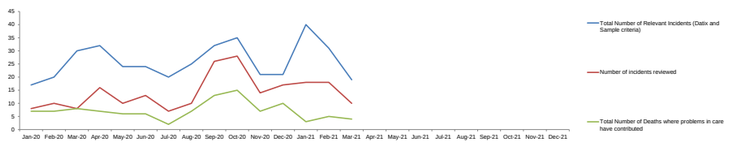

Figure 1.

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.

Data source:An amalgamation of both the Datix cohort and the Sample cohort data sources detailed below. Last accessed 11/06/2021.

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
Q1	22	6	4	12
Q2	24	2	3	19
Q3	16	1	5	10
Q4	18	3	7	8
Total	**62**	**12**	**19**	**49**

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
Q1	21	11	4
Q2	21	15	7
Q3	16	10	4
Q4	10	1	1
Total	**58**	**36**	**15**

Table 3.

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

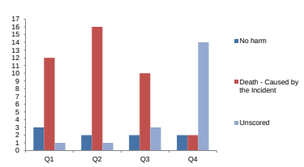

Figure 2.

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

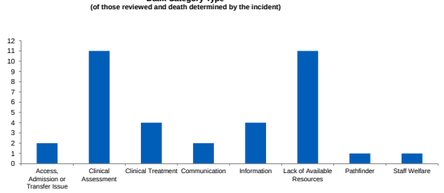

Figure 3.

Data source: Datix Incidents query 'Inc: LfD (DoH Expected Death or Death) Listing Report - Incident Date @laststquarter' and 'Inc: Wild Card Search (death/dead/deceased/died) Incident Date @laststquarter. Last extracted 21/04/2021. Last accessed 11/06/2021

Patient Experience Module only

Month	Relevant Patient Experience module incidents	Incidents Closed on Pat. Exp.	Number closed and death considered caused by the incident
Q1	13	13	3
Q2	6	5	2
Q3	6	4	3
Q4	4	0	0
Total	**25**	**22**	**8**

Table 4.

(Note- This represents 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 @laststquarter, last extracted using PE Listing report on 21/04/2021. Last accesed 11/06/2021.

Learning theme

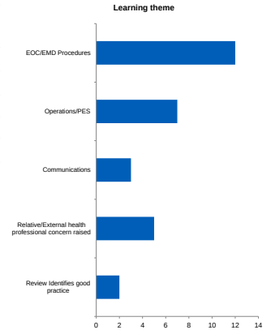

Figure 4.

Learning Theme	Learning Detail	Frequency	Action Themes (may have multiple)
EOC/EMD Procedures	Procedure not adhered to	4	Reflection and/or feedback; re-training/re-reading procedures; staff to attend EOC learning forum
	Incorrect call categorisation	3	Reflection and/or feedback; re-training/re-reading procedures;
	Extensive delay in emergency response for vulnerable patients	2	Reflection and/or feedback; re-training/re-reading procedures; staff to attend EOC learning forum
	EMD ineffective breathing recognition	2	Reflection and/or feedback; re-training/re-reading procedures;
Operations/PES	Lack of sufficient documentation	3	Reflection and/or feedback; improve documentation skills; emphasis of using CSH
	Concerns raised around delayed extrication of bariatric patient	1	Reflection and/or feedback
	Concerns raised around treatment of paediatric patient	1	Reflection and/or feedback; re-training/re-reading procedures
	Incorrect application of MTS/Pathfinder	1	Reflection and/or feedback; re-training/re-reading procedures
	Staff behaviour/attitude	1	Reflection and/or feedback
Communications	Internal communication messages	2	Reflection and/or feedbacl; re-training/re-reading procedures; new system configuration to avoid re-occurance
Relative/external health provider raised concern	Patient safety concern	6	Reflection and/or feedback; re-training/re-reading procedures
Review identifiied good practice	Reviewed as safe outcome	2	Reflection and/or feedback; commendation to EMD
	Good recognition of condition, treatment and interventions	1	Reflection and/or feedback

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
Q1	5	5	5
Q2	6	4	2
Q3	2	1	1
Q4	1	0	0
Total	**13**	**10**	**8**

Table 6.

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

Learning theme

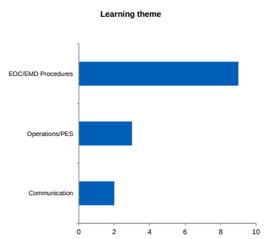

Figure 5.

Learning Theme	Learning Detail	Frequency	Action Themes
EOC/EMD Procedures	EMD ineffective breathing recognition	3	Reflection and/or feedback; re-training/re-reading procedures; staff to attend EOC learning forum
	Procedure not adhered to	3	Reflection and/or feedback; re-training/re-reading procedures; staff to attend EOC learning forum
	Resource monitoring/management	2	Reflection and/or feedback; re-training/re-reading procedures; staff to attend EOC learning forum
	EMD MPDS aspirin diagnostic instruction tool	1	Reflection and/or feedback; re-training/re-reading procedures; conduct an incident learning review
Operations/PES	Lack of sufficient documentation	1	Reflection and/or feedback; re-training/re-reading procedures
	End of Life recognition	1	Reflection and/or feedback; re-training/re-reading procedures; staff to attend learning forum with EoLC Lead
	Incorrect application of MTS/Pathfinder	1	Reflection and/or feedback; re-training/re-reading procedures
Communications	Communication with other services	2	Development of new SOP around Police cancellations

Table 6.

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 @laststquarter: last extracted 21/04/2021. Information recorded on these incidents: last accessed 11/06/2021. Datix Incidents query 'Inc: LfD (DoH Expected Death or Death) Listing Report - Incident Date @laststquarter' and 'Inc: Wild Card Search (death/dead/deceased/died) Incident Date @laststquarter - Listing Report': last extracted on 21/04/2021. Last accessed 11/06/2021

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
Q1	40	0	0
Q2	41	13	3
Q3	53	38	19
Q4	67	34	11
Total	**134**	**85**	**33**

Table 8.

Total 2020-2021 Sample Data Breakdown			
Month	**C1 and C2 Long waits**	**C3 and C4 Deaths**	**24 hr Re-contact Deaths**
Q1	3	17	20
Q2	4	11	26
Q3	9	16	28
Q4	4	16	47
Total	16	44	74

Table 9.

SJR Stage 1 Overall Care Assessment

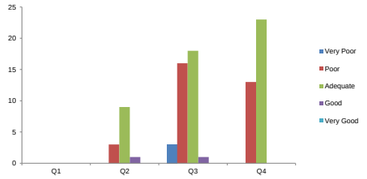

Figure 6.

	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	23	58	4	**62 patients out of 85 patient cohort**	**73%**
	Management Plan/Procedure Rating	22	53	10	**63 patients out of 85 patient cohort**	**74%**
Right Place	Patient Disposition Rating	17	65	3	**68 patients out of 85 patient cohort**	**80%**

Table 10.

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

† 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

Structured Judgement Review Highlighted Learning Themes from Stage 2 (Review of 85 patients)

Evidence of Poor/Very Poor Practice

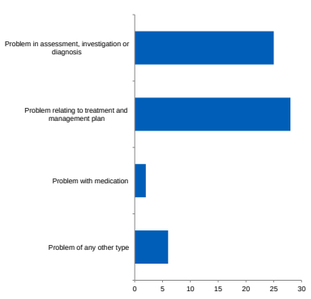

Figure 7.

Learning Theme	Learning Detail	Frequency (n=85 patients)
Problem in assessment, investigation or diagnosis	Lack of clinical observations and/or investigations performed	24
	No capacity, communication or consent assessments undertaken	1
Problem relating to treatment and management plan	No referral to AVS/GP/alternative providers when appropriate to do so	12
	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	2
	No discussion with family members regarding patient's condition/DNACPR/EoLC	1
Problem with medication	Incorrect use of medication	2
Problem of any other type	Incomprehensive PRF	2
	Distress caused to patient's family	2
	No LeDer referral made	1
	DoD procedure not followed correctly	1

Table 11.

Evidence of Good/Very Good Practice

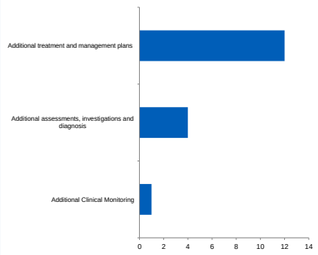

Figure 8.

Learning Theme	Learning Detail	Frequency (n=85 patients)
Additional assessments, investigations or diagnosis	Assessment of patient with additonal investigations and assessment beyond expected practice	4
Additional treatment and management plans	Additional referrals/management plans put in place for long-term safety-netting of both patients and dependents	4
	Crew built holistic picture of patient's condition for treatment and rapid placement of EoLC package/DNACPR in best interests of patient	3
	Crew decided not to resuscitate patient they recognised as EoL in absence of formal EoLC package/DNACPR in best interests of patient	2
	Appropriate application of the ReSPECT process in lieu of a formal DNACPR in place	1
	Crew engaged with MDT comprised of external providers, carers, GP and family to ensure best interests of patient were met	1
	Thorough knowledge of local community agencies with additional referrals made	1
Additonal clinical monitoring	NEWS2 monitoring in a non-septic patient to assess deteriorating status of patient	1

Table12.

Data source: Informatics queries 874893, 892664, 912009, 924638, 962543 & 988356 last run on 20/04/2021, SJR data source: Learning from Deaths SJR Database, last accessed on 11/06/2021.