Appendix A: Quarter 1 2020-2021 Learning from Deaths Report Dashboard

NWAS Learning From Deaths Dashboard Quarter 1 2020-2021 (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 both described in more detail in the data-split breakdowns below.

Total Number of Deaths in scope (Sample cohort and Datix incidents [Incidents and Patient Experience module])*		Total Number of Deaths Reviewed	% Deaths Reviewed	Total Number of Deaths where problems in care have contributed
April	32	8	25.0%	3
May	24	5	20.8%	2
June	24	4	16.7%	3
This Quarter	80	**17**	**21.3%**	**8**
This Financial Year	80	17	21.3%	8

*** 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.**

Figure 1.

Data source:An amalgamation of both the Datix cohort and the Sample cohort data sources detailed below. Last accessed 03/08/2020.

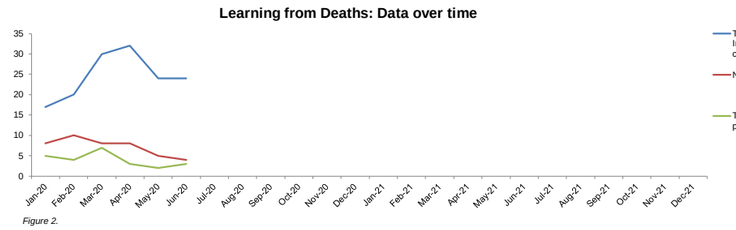

Figure 2.

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.

Number of Learning from Death requests by other trusts	
April	0
May	1
June	0

Figure 3.

Number of patients NWAS informed of by other Trusts who died after handover		Number of these deaths reviewed
April	0	N/A
May	0	N/A
June	0	N/A

Figure 4.

Datix Cohort Breakdown

Datix Cohort Description: This Dashboard describes those outlined in the guidance as 'must review'. The 'must review' category includes those that have been raised to the organisation and recorded via Datix as being deaths that occured in our care where there has been concern has been raised about the quality of care provided. This has been broken down into those where an incident has been raised with concern for care (Incidents module), those that have been escalated to the Patient Experience Module and where an incident appears on both modules. For the Patient experience incidents these are included where they are Risk scored 4/5 and death has occured. For Datix, the reviews are considered as complete when the incident is closed. For the incidents module data, it is considered as death caused by the incident when 'Degree of harm' is 'Death- Caused by the incident'. For the incidents module data, it is considered as death caused by the incident when the incident is closed and 'Reason for SI: Unexpected /Potentially avoidable death'.

Incidents Module only

Total Incident module Deaths in scope		Incident Grade		
		1 or 2	3	4 or 5
April	11	2	2	7
May	4	1	2	1
June	7	3	0	4
Total	22	6	4	12

Figure 5.

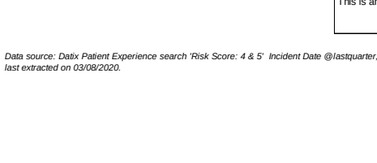

Figure 6.

Month	Number of Deaths Closed on Incidents module	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	8	3	2
May	4	2	0
June	4	3	1
Total	16	8	3

Figure 7.

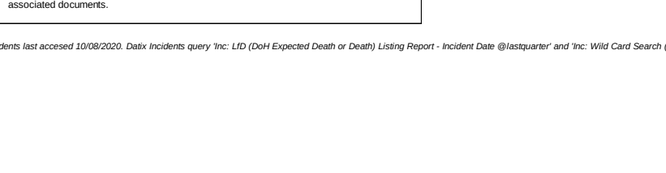

Figure 8.

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 - Listing Report' both last extracted on 03/08/2020. Information recorded on these incidents last accesed 11/08/2020.

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	4	0	0
May	3	0	0
June	6	0	0
Total	13	0	0

Figure 9. (Note- This is the month the incident occured, not when the notification of raised concern for care was received)

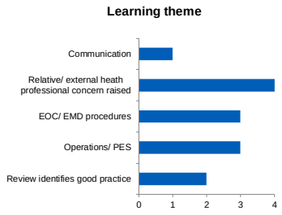

Figure 10.

Learning Theme	Learning Detail	Action Themes (may have multiple)
Review identifies good practice	Reviewed as safe outcome (1)	· Reflection and/or feedback
	Good recognition of condition, treatment and clinical interventions (1)	· Reflection and/or feedback
Operations/ PES	Correct outcome but lacked pre-alert (1)	· None yet, still under review
	Lack of sufficient documentation (2)	· Reflection and/or feedback · Improve documentation skills · Emphasis of using Clincal Hub
EOC/ EMD procedures	Procedure not adhered to (2)	· Reflection and/or feedback · Re-training / re-reading procedures
	Resource monitoring/ management (1)	· Reflection and/or feedback · Re-training / re-reading procedures
Relative/ External heath professional concern raised	Patient safety concern (2)	· None yet, still under review
	No Learning yet (2)	· None yet, still under review
Communication	Internal Communication Messages (1)	· New system configuration to avoid reoccurance (to commence September 2020)

Figure 11.

Data source:Datix Patient Experience search 'Risk Score: 4 & 5' Incident Date @lastquarter, last extracted on 04/08/2020. Information recorded on these incidents last accesed 11/08/2020.

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	0	0
May	3	1	0
June	1	0	0
Total	5	1	0

Figure 12. (Note- This is the month the incident occured, not when the notification of raised concern for care was received)

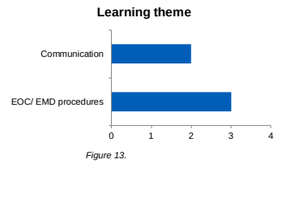

Figure 13.

Learning Theme	Learning Detail	Action Themes
EOC/ EMD procedures	EMD Ineffective breathing recognition (2)	· Reflection and/or feedback · Re-training / re-reading procedures · Review EOC enviroment · Change in Code categorisation · Review Equipment (headsets)
	Procedure not adhered to (1)	· Re-review process · Re-training / re-reading procedures
Communication	Communication with other services (1)	· Development of new SOP around Police cancellations
	Technonology/ Communication (CPAD) (1)	· None yet, still under review

Figure 14.

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 on 04/08/2020. Information recorded on these incidents last accesed 10/08/2020. 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' both last extracted on 03/08/2020.

Sample Cohort Breakdown

Sample Data Description: A random sample of 40 incidents using the specified criteria from the national guidance. This includes deaths that were 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. For the sample, when the incident has had a structured judgement review (SJR) it is considered as reviewed.

Incidents used for the Sample criteria	Number of Deaths Reviewed	Total Number of Deaths where problems in care have contributed
April 16	0	0
May 14	0	0
June 10	0	0
Total 40	0	0

Figure 15.

Quarter 1 2020-2021 Sample Data Breakdown			
Month	**C1 and C2**	**C3 and C4**	**24 hr Re-contact Deaths**
April	1	8	7
May	0	7	7
June	2	2	6

Figure 16.

Currently, there have been no reviews of the sample cohort due to a lack of dedicated staff resource. Therefore we have no completed reviews for Quarter 1.

Data source: Informatics queries 874893 (April and May) run on 16/06/2020, and 854372 run on 03/07/2020.