NWAS Learning From Deaths Dashboard Quarter 2 2020-2021 (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	20	5	25.0%	2
August	25	7	28.0%	4
September	32	21	65.6%	10
This Quarter	77	**33**	**42.9%**	**16**
This Financial Year	157	44	28.0%	24

** 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 02/12/2020.

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
July	4	1	0	3
August	8	1	1	6
September	12	0	2	10
Total	24	2	3	19

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	4	2	1
August	7	4	1
September	8	7	1
Total	19	13	3

Table 3.

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

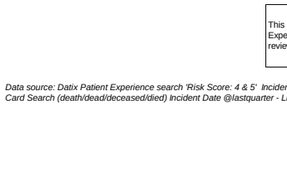

Figure 2.

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 30/11/2020.

Patient Experience Module only

Month	Relevant Patient Experience module incidents	Incidents Closed on Pat. Exp.	Number closed and death considered caused by the incident
July	2	1	0
August	1	0	0
September	3	0	0
Total	6	1	0

Table 4.

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

Learning theme

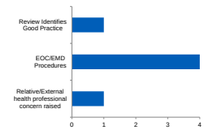

Figure 4.

Learning Theme	Learning Detail	Frequency	Action Themes (may have multiple)
Review identifies good practice	Reviewed as safe outcome	1	Commendation to the dispatcher for good incident management during high activity
EOC/EMD procedures	Procedure not adhered to	2	Reflection and/or feedback; staff to attend EOC learning forum; staff to receive increased coaching
	EMD Ineffective breathing recognition	1	Reflection and/or feedback; refresher training to be undertaken
	Incorrect call categorisation	1	Reflection and/or feedback; re-training/re-reading procedures
Relative/External health professional concern raised	Patient safety concern	1	None yet, 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 30/11/2020. Last accessed 15/12/2020

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
July	1	0	0
August	2	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)

Learning theme

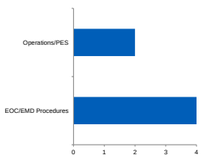

Figure 5.

Learning Theme	Learning Detail	Frequency	Action Themes
Operations/PES	Lack of sufficient documentation	1	Reflection and/or feedback; individual crew learning on Mental Health Act
	End of Life recognition	1	Reflection and/or feedback; staff to attend learning forum with EoLC lead
EOC/EMD Procedures	Procedure not adhered to	2	Reflection and/or feedback; re-training/re-reading procedures; staff to attend EOC learning forum
	EMD Ineffective breathing recognition	1	Reflection and/or feedback; staff to attend EOC learning forum; notable practice feedback to EMDs
	EMD MPDS Aspirin Diagnostic Instruction	1	Reflection and/or feedback; re-training/re-reading procedures; staff to attend EOC learning forum

Table 7.

This is a summary of the deaths recorded on the Incidents module and/or Patient Experience module that meet the cohort criteria. 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 30/11/2020. Information recorded on these incidents: last accessed 15/12/2020. 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': last extracted on 30/11/2020.

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	13	0	0
August	14	0	0
September	14	13	3
Total	41	**13**	**3**

Table 8.

SJR Stage 1 Overall Care Assessment

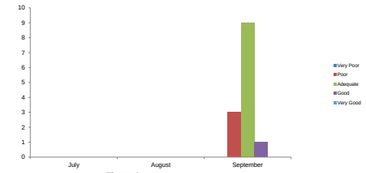

Figure 6

Quarter 2 2020-2021 Sample Data Breakdown			
Month	**C1 and C2 Long waits**	**C3 and C4 Deaths**	**24 hr Re-contact Deaths**
July	2	3	8
August	1	7	6
September	**1**	**1**	**12**
Total	4	11	26

Table 9.

	SJR Element	1 or 2 - Poor or Very Poor	3 - Adequate†	4 or 5 - Good or Very Good	Patients SJR where elements of Adequate or Good Care was identified by the Panel.	
Right Time	Call Handling/Resource Allocation‡	N/A	N/A	N/A	**N/A**	
Right Care	Patient Assessment Rating	2	8	3	**11 patients out of 13 patient cohort**	**85%**
	Management Plan/Procedure Rating	2	8	3		
Right Place	Patient Disposition Rating	1	11	1	**12 patients out of 13 patient cohort**	**92%**

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 trequired to undertake the call handling/resource allocation element of the SJR.

Structured Judgement Review Highlighted Learning Themes from Stage 1 (Review of 13 patients)

Evidence of Poor/Very Poor Practice

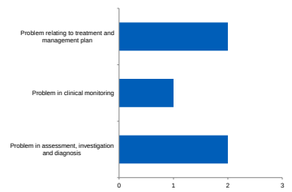

Figure 7.

Learning Theme	Learning Detail	Frequency (N= 5 Patients)
Problem relating to treatment and management plan	No safeguarding referral made when appropriate to do so	1
	No referral to primary care or mental health services made when appropriate to do so	1
Problem in clinical monitoring	Lack of clinical observations undertaken or documented	1
Problem in assessment, investigation and diagnosis	No assessment of patient's social and domestic history recorded	1
	No capacity, communication or consent assessments undertaken	1

Table 11.

Evidence of Good/Very Good Practice

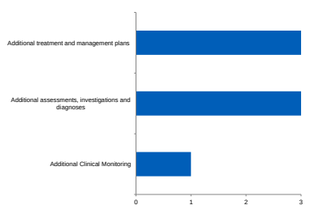

Figure 8.

Learning Theme	Learning Detail	Frequency (N= 7 Patients)
Additional treatment and management plans	Appropriate application of the ReSPECT process in lieu of formal DNACPR being in place	1
	Thorough knowledge of local community agencies with referrals made in addition to usual routes	1
	Long-term safety netting of both patients and carers/relations were considered and applied	1
Additional assessments, investigations and diagnoses	Assessment of patient with additional investigations and assessments beyond expected practice	3
Additional Clinical Monitoring	NEWS2 monitoring in a non-septic patient to assess if patient deteriorating	1

Table 12.

The SJR Completion is an iterative process. One month (September) has been successfully reviewed across three elements of the Stage 1 review process. It is fully expected Q3 will be complete for all months across three of the four Stage 1 review elements.

Data source: Informatics queries 912009 run on 02/10/2020. SJR data souce: Learning from Deaths SJR Database, last accessed on 02/12/2020.