North West Ambulance Service NHS Trust

REPORT TO BOARD OF DIRECTORS

DATE:	27 July 2022				
SUBJECT:	Learning from Deaths summary report and dashboard Q4 2021/22				
PRESENTED BY:	C Grant, Medical Director				
LINK TO BOARD ASSURANCE FRAMEWORK:	**SR01**	**SR02**	**SR03**	**SR04**	**SR05**
	☒	☐	☐	☐	☐
	SR06	**SR07**	**SR08**	**SR09**	**SR10**
	☐	☐	☐	☐	☐
PURPOSE OF PAPER:	For Assurance				
EXECUTIVE SUMMARY:	The Trust is required to publish on its public accounts a quarterly and then an annual summary of learning. The Q4 dashboard (appendix A) describes the opportunities to learn from deaths. In summary the contributory factors to patient deaths, where identified, were attributed to problems in EOC procedures, specifically calls being incorrectly categorised and lack of available resources. The peer review process identified most patients received appropriate care, but where failings occurred these included the failure to record observations/assessment/investigations, MTS being used inappropriately, absence of ECGs attached to EPRs, lack of escalation for decision making, no narrative regarding GP discussion, poor handover to AVS involving a sepsis patient, and failure to recognise differential symptoms and red flags. The peer review identified areas of good practice such as discussions around best interests and their wishes documented; supportive to family, condolences offered and signposted to bereavement care; and family provided with incontinence sheets and body wipes. A commitment to disseminating and promoting good practice has been made by the Consultant Paramedic (Medical) through the area learning forums and individual frontline staff. The form design within the DCIQ Mortality Module has been improved and work is ongoing to improve the reporting outputs.				
RECOMMENDATIONS:	The Trust Board is recommended to:				

<table>
<tr><td></td><td colspan="4">Agree the quarterly dashboard (appendix A) as the report to be published on the Trust public account as evidence of the Trust's developing engagement with a formal process of learning from deaths.
Note the risks associated with the development of the Learning from Deaths process notably the continued absence of the call handling/dispatch and triage review.
Acknowledge the impact of the SJR process in identifying opportunities for improving care and identification of serious incidents previously unknown to the trust.
Acknowledge the good practice identified including:
Crew recognised end of life and specialist pathway used
Discussion around best interests and their wishes documented
Crew supportive to family, condolences offered and signposted to bereavement care, and extended family members contacted for emotional support
Family provided with incontinence sheets and body wipes
Acknowledge the dissemination process as described in 3.4</td></tr>
<tr><td>CONSIDERATION TO RISK APPETITE STATEMENT
(DECISION PAPERS ONLY)</td><td colspan="4">The Trust's Risk Appetite Statement has been considered as part of the paper decision making process:

☐ Financial/ VfM
☐ Compliance/ Regulatory
☐ Quality Outcomes
☐ Innovation
☐ Reputation</td></tr>
<tr><td>ARE THERE ANY IMPACTS RELATING TO:
(Refer to Section 4 for detail)</td><td>Equality:</td><td>☐</td><td>Sustainability</td><td>☐</td></tr>
<tr><td rowspan="3">PREVIOUSLY CONSIDERED BY:</td><td colspan="4">Clinical Effectiveness Sub-Committee
Quality and Performance Committee</td></tr>
<tr><td>Date:</td><td colspan="3">05/07/2022 and 25/07/2022</td></tr>
<tr><td>Outcome:</td><td colspan="3">CESC: Recommendations approved
Q&PC: Unknown at time of writing</td></tr>
</table>

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1. PURPOSE

1.1 The purpose of this report is to meet the requirements of the National guidance for ambulance trusts on Learning from Deaths: A framework for NHS ambulance trusts in England on identifying, reporting, reviewing and learning from deaths in care' as referenced in the trust Learning from Deaths policy.

Appendix A is a summary dashboard of the Q4 2021/22 Learning from Deaths review; and it is proposed this document is published on the Trust's public accounts by 31st July 2022 in accordance with the national framework and trust policy. The Q4 dashboard includes output from moderation panels held following the structured judgement reviews (SJRs), for Q4. The learning from the panels is discussed later in this paper.

The next phase of dashboard development will require dedicated EOC subject experts to undertake the dispatch and triage review.

It is acknowledged the attached document remains an iterative reporting process which will continue to become more sophisticated and informative as 2022/23 progresses.

2. BACKGROUND

2.1 Learning from Deaths is an integral part of informing and developing the safest possible systems for the delivery of care to our patients. NWAS must identify suboptimal care and support the identification of areas for improvement. The methodology is available on request from the Clinical Audit Team at Learning.FromDeaths@nwas.nhs.uk

3. LEARNING FROM DEATHS DASHBOARD Q4 2021/22: APPENDIX A

3.1 The number of patients whose deaths were identified as in scope for review was 76 (45 Datix incidents and 31 sampled - *table 1, Fig.1*).

3.2 ***Datix Cohort Discussion***

Of the 45 patient deaths.

- 29 patients were identified through the Incidents module
- 14 patients were identified through the Patient Experience module
- And a further two (2) patient was identified as having records on both the Incidents and the Patient Experience module.

3.2.1 ***Incident Module: Tables 2 and 3, figures 2 and 3***

Of the 29 patients, 12 were reviewed and closed. In six (6) cases the investigation concluded the Trust had contributed in some way to that patient death.

- Clinical treatment was cited as the main contributing factor to the patient's death

3.2.2 ***Patient Experience Module: Tables 4 and 5 and figure 4***

Of the 14 patients reported, 14 are still in the early stages of review and so it is unknown at the time of writing if the care given was in line with best practice. The content of the reviews so far suggests the learning themes and therefore opportunities for improvement are:

- EOC and EMD procedures
    - Call incorrectly categorised with a missed opportunity to manually upgrade the call
    - Significant delay in responding to a difficulty in breathing patient, resulting in cardiac arrest
    - Significant delay in responding to a patient who had collapsed, resulting in cardiac arrest
    - Significant delay in responding to a stroke
- PES/Operations
    - Lack of safety-netting, incorrect MTS application in a chest pain patient
- Communication
    - Concern raised about the use of terminology for a trauma incident
- Relative/external health professional concern raised
    - Delay in emergency transfer of patient with confirmed ruptured AAA
    - Family raised a concern around the mobilisation of a bariatric patient from upstairs to ambulance, patient went into cardiac arrest on stretcher
    - Social worker raised a concern about the management of the 111 call. Inappropriate outcome - too low
    - Concern raised around the mobilisation of a baby in cardiac arrest
    - Significant delay in responding to a sepsis patient
    - Delay in emergency transfer of patient with ST Elevation

3.2.3 ***Investigation and Patient Experience Modules: Tables 6 and 7 and figure 5.***

Two (2) patient deaths were recorded on both modules – note this is a different incident from those referenced separately in the incident and patient experience modules. Both of these investigations have been closed and concluded:

- EOC and EMD procedures:
    - Calls incorrectly categorised with missed opportunities to manually upgrade the incidents
    - Significant delay responding to a patient with breathing difficulties
- PES/Operations:
    - Concern raised around the management of a patient with abdominal pain

3.3 ***Structured Judgement Review (SJR): Cohort Discussion: tables 8, 9 and fig 6.***

Of the 60 patient deaths:

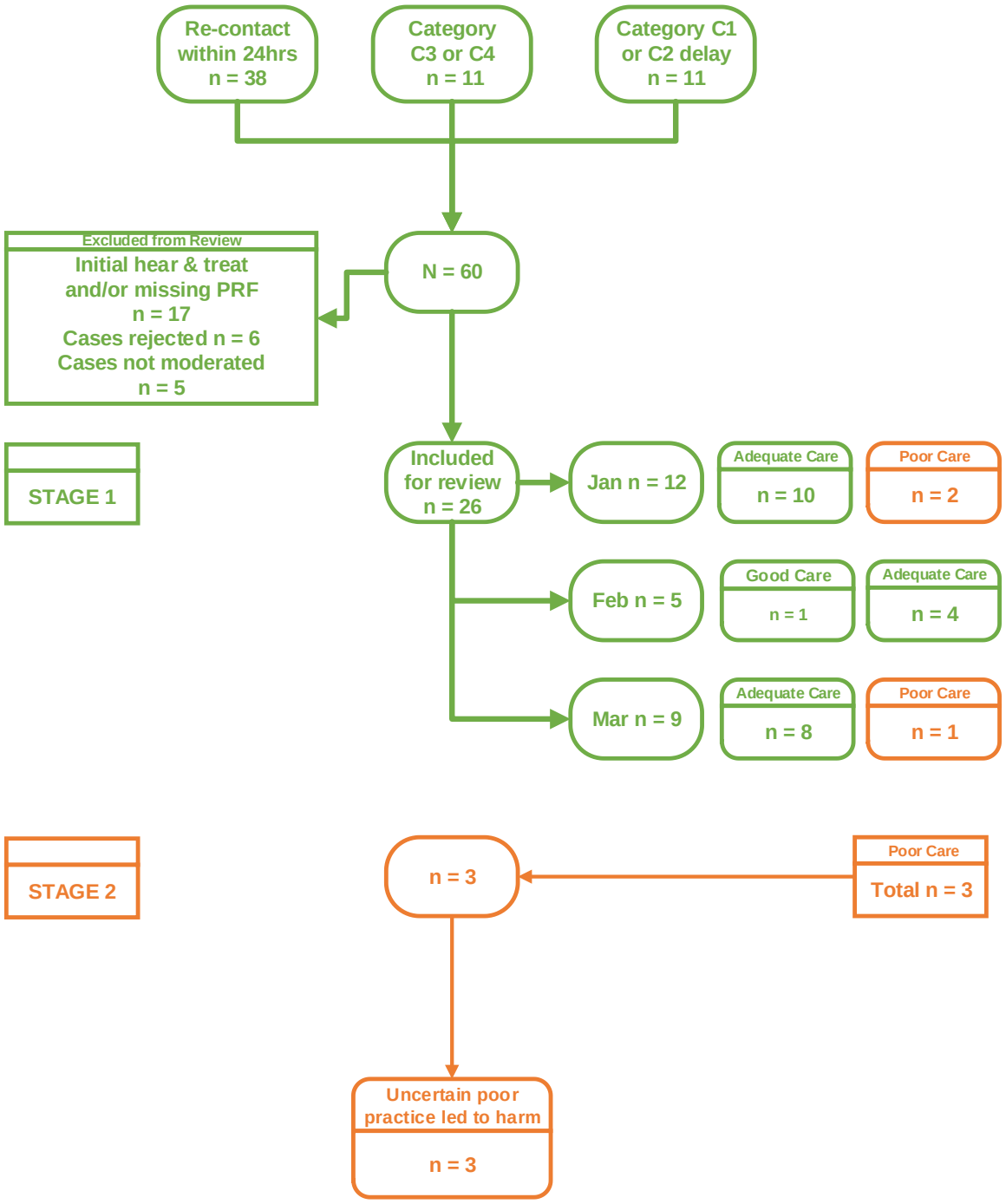
- 38 patient deaths occurred where patients were not initially conveyed, and the service was re-contacted within 24 hours*
- 11 patient deaths occurred where the incident was coded as Cat 3 or Cat 4
- 11 deaths occurred where they were initially coded as Cat 1 or Cat 2 and were subjected to a long wait.

**The results should not be correlated to the results of the Safe Care Closer to Home audit due to significant differences in audit methodology.*

The flow chart below provides a summary of which of the cases identified were reviewed and how the numbers referred to in tables 8 and 9 and fig 6 of the Q4 dashboard change. There are several reasons why the whole cohort identified are not reviewed:

1. Without a patient report form the review cannot be undertaken
2. Where a 24hr re-contact incident is initiated as a ‘hear and treat’ and subsequently as a see and treat; the ‘hear and treat’ element review cannot be undertaken without the EOC Clinical Hub specialist

3. Death not in scope post clinical review
4. SJR not moderated



Flow chart to describe sample cohort attrition and treatment Q4 2021/22

3.3.1 *Structured judgement review methodology*

The process requires the reviewing frontline staff to make explicit statements upon the practice under review using the 'Sequence of Events' (SoE) and 'Patient Report Form' (PRF or electronic patient record) as the data source.

The explicit statements of care can be one of five categories ranging from very good to very poor and it is possible to use each of the statement's multiple times in a single review.

The review comprises of Stage 1: review of clinical practice and call handling/ resource allocation. Where less than adequate overall care is identified a Stage 2 review of the patient death to identify if any causal factors (systemic) problems in care have led to harm.

3.3.2 ***SJR Stage 1 Outcomes:***

26 patient deaths were presented by reviewers and following the moderation panels the outcomes of the reviews were determined as described in the table below.

Month	Very Poor	Poor	Adequate	Good	Very Good
Jan 22		2	10		
Feb 22		0	4	1	
Mar 22		1	8		

Moderation Panels held on 15/03/2022, 12/04/2022, & 17/05/2022

It should be understood the mid-range statement of *'adequate'* practice is defined as the expected practices and procedures in compliance with guidance. Any practice identified as beyond expected practice is defined as *'good'*. Any practice identified as not reaching expected practice is defined as *'poor'*.

3.3.3 ***SJR Stage 2 Outcomes:***

Three (3) cases were identified as needing second stage review following Stage 1. It was identified that it was uncertain whether poor practice had led to harm for all three (3) cases in terms of assessment, management plan and disposition.

3.3.4 ***SJR Learning Outcomes: Tables 11 -12***

Poor Practice: Table 11 fig 7.

The panel identified areas for improvement were to

- Increase observations and/or investigations recorded
- Apply MTS/Pathfinder appropriately and correctly, ensuring that decisions are recorded
- Assess and document capacity to consent appropriately
- Escalate complex cases
- Recognise differential symptoms and red flags
- Provide detailed observation history to AVS providers
- Attach/transmit ECGs to the electronic patient record (EPR)
- Perform 12-lead ECGs for patients presenting following a transient loss of consciousness (TLOC)
- Provide a comprehensive clinical narrative within the EPR, especially details involving GP discussions and worsening advice

Good Practice: Table 12 fig 8.

The panel review identified numerous positive examples of practice over and above expected practice. This included

- Performing additional investigations and assessments beyond expected practice
- End of life recognised, and specialist pathway used
- Discussion around best interests and their wishes documented
- Supportive to family, condolences offered and signposted to bereavement care, and extended family contacted for emotional support
- Family provided with incontinence sheets and body wipes

3.4 ***Dissemination Process***

A commitment to disseminating and promoting good practice has been made by the Consultant Paramedic (Medical) through the area learning forums (ALFs) and individual frontline staff.

The opportunities for improvement identified as general themes from the Datix review and more specifically from the SJR review will be taken to ALFs by the Consultant Paramedic, Medical on a bi-annual basis.

Good practice letters have been circulated to commend 13 clinicians who through their care and professionalism have supported families and patients to experience a good death during Q4.

3.5 ***Report Development***

DCIQ: Mortality Module

The Clinical Audit Team has been working with the DCIQ team to improve the mortality module. Improvements have been made to the forms to improve data capture and reporting. Work is still ongoing to develop the dashboards.

4. RISKS

4.1 ***DX3408:*** *(risk score 6)* There is a risk that the lack of resource will mean the competing priorities to perform additional high risk defined audits (such as the Learning from Deaths audit) will not be undertaken in their entirety and this will have a negative impact upon the annual clinical audit plan resulting in a failure to provide assurance to the trust and regulatory bodies.

It is not possible to complete the 'call' element of the review without a dedicated EOC subject expert. Until this is resolved, all SJRs can only be 75% complete. Findings from each of the SJR panels held have highlighted this element as crucial towards identifying potential risks in practice.

5. LEGAL, GOVERNANCE AND/OR RISK IMPLICATIONS

5.1 There are no legal implications associated with content of this report and the data gathered to produce the dashboard has been managed in accordance to the Data Protection Act 2018.

6. EQUALITY OR SUSTAINABILITY IMPACTS

6.1 No equality or sustainability implications have been raised as a concern from this report.

7. RECOMMENDATIONS

7.1 The Trust Board is recommended to:

- Agree the quarterly dashboard (appendix A) as the report to be published on the Trust public account as evidence of the Trust's developing engagement with a formal process of learning from deaths.
- Note the risks associated with the development of the Learning from Deaths process notably the continued absence of the call handling/dispatch and triage review.
- Acknowledge the impact of the SJR process in identifying opportunities for improving care and identification of serious incidents previously unknown to the trust.
- Acknowledge the good practice identified including:
    - Crew recognised end of life and specialist pathway used
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- Acknowledge the dissemination process as described in 3.4