**REPORT TO BOARD OF DIRECTORS**

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| **DATE:** | 28th September 2022 |
| **SUBJECT:** | Learning from Deaths - Summary Report and Dashboard Q1 2022/23 |
| **PRESENTED BY:** | Dr C Grant, Executive Medical Director |

**LINK TO BOARD ASSURANCE FRAMEWORK:**

| SR01 | SR02 | SR03 | SR04 | SR05 |
|---|---|---|---|---|
| ☒ | ☐ | ☐ | ☐ | |

| SR06 | SR07 | SR08 | SR09 | SR10 | SR11 |
|---|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

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| **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 Q1 Dashboard (Appendix A) describes the opportunities to learn from deaths. In summary, from Datix records, the contributory factors to patient deaths were identified and were attributed to the incorrect call categorisation and demand exceeding available resources.

The peer review process identified that most (67%) of patients received 'appropriate' care. The key areas identified for improvement were:

- need for more than one set of clinical observations,
- correct utilisation of Manchester Triage System,
- performing ECGs when indicated,
- completing capacity to consent fully,
- recording the details of specific worsening advice
- quality of patient records (documentation)

The peer review identified areas of good practice, including face to face discussions with a GP and family.

The review panel has welcomed new representatives from the Clinical Hub and the Patient and Public Panel. The Clinical Hub clinician allows the insights from Hear and Treat perspective.

In addition, the panel will have regular observers in attendance to raise awareness of the process and embed learning further across the organisation.

The DCIQ Mortality Module dashboard is still under development and should be ready by Q2 reporting.

<table>
<tr><td>RECOMMENDATIONS:</td><td colspan="4">The Board of Directors is recommended to:<br>• Support 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 the formal process of Learning from Deaths.<br>• Support the annual dashboard (Appendix B) as the report to be published on the Trust public account as evidence of the Trust's annual engagement of a formal process of Learning from Deaths.<br>• Acknowledge the impact of the SJR process in identifying opportunities for improving care and identification of serious incidents previously unknown to the trust.<br>• Acknowledge the good practice identified</td></tr>
<tr><td>CONSIDERATION TO RISK APPETITE STATEMENT<br>(DECISION PAPERS ONLY)</td><td colspan="4">The Trust's Risk Appetite Statement has been considered as part of the paper decision making process:<br><br>☐ Financial/ VfM<br>☐ Compliance/ Regulatory<br>☐ Quality Outcomes<br>☐ Innovation<br>☐ Reputation</td></tr>
<tr><td>ARE THERE ANY IMPACTS RELATING TO:<br>(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<br>Quality and Performance Committee</td></tr>
<tr><td>Date:</td><td colspan="3">13th September 2022<br>26th September 2022</td></tr>
<tr><td>Outcome:</td><td colspan="3">Assurances provided for onward submission to the<br>Board of Directors.</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.<br><br>Appendix A is a summary dashboard of the Q1 2022/23 Learning from Deaths review; it is proposed this document is published on the Trust's public accounts by 30th September 2022 in accordance with the national framework and trust policy. The Q1 dashboard includes output from moderation panels held following the structured judgement reviews (SJRs), for Q1. The learning from the panels is discussed later in this paper.<br><br>The next phase of dashboard development will require dedicated Emergency Operations Centre subject experts to undertake the dispatch and triage review.<br><br>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. |
| 3. | **LEARNING FROM DEATHS DASHBOARD Q1 2022/23: APPENDIX A** |
| 3.1 | The number of patients whose deaths were identified as in scope for review was 106.<br>76 concerns raised in Datix and 30 sampled for SJR - *table 1, Fig.1*. |
| 3.2 | ***Datix Cohort Discussion***<br>Of the 76 patient deaths:<br><br>• 62 internal concerns were raised through Incidents module<br>• 12 external concerns were raised through the Patient Experience module<br>• A further 2 concerns were raised both internally and externally. |
| 3.2.1 | ***Internal Concerns: Tables 2 and 3, figures 2 and 3***<br><br>Of the 62 patients, 44 were reviewed and closed. In 6 cases, the investigation concluded the Trust had potentially contributed in some way to that patient death. No available clinical resource was cited as the main contributing factor to those deaths. |

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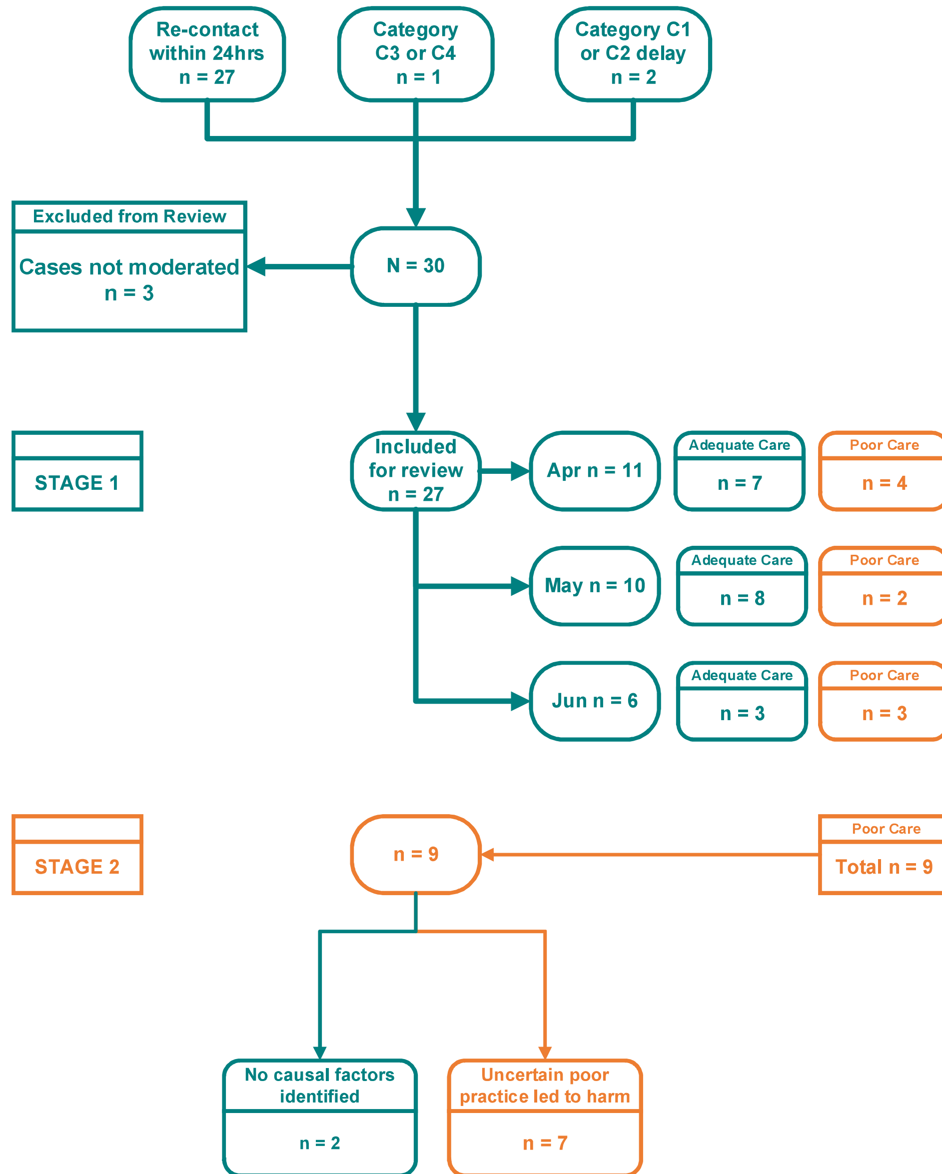
| 3.2.2 | ***External Concerns: Tables 4 and 5 and figure 4***<br><br>Of the 12 patients reported, 11 are still in the early stages of review and so it is unknown at the time of writing if the care given was in line with best practice. One concern has been closed as there were no causal factors identified. The content of the reviews so far suggests the learning themes and therefore opportunities for improvement are:<br><br>• EOC<br>    o Delay in responding to a chest pain patient, resulting in cardiac arrest<br>    o Delay in responding to a patient in labour<br><br>• PES<br>    o Delay in crew informing hospital staff that patient was in ambulance<br>    o Patient left at home, when MTS outcome suggested conveyance to hospital<br>    o Patient who did not have documented capacity to refuse treatment |
| 3.2.3 | ***Concerns raised internally and externally: Tables 6 and 7 and figure 5.***<br><br>2 patient deaths were raised both internally and externally. Both of these investigations are still under review with preliminary learning identified as:<br>• EOC:<br>    o Delay in responding to a patient with difficulty in breathing<br>    o Significant delay in responding to a patient |
| 3.3 | ***Structured Judgement Review (SJR): Cohort Discussion: tables 8, 9 and fig 6.***<br><br>Of the 30 patient deaths:<br>• 27 patient deaths occurred where patients were not initially conveyed, and the service was re-contacted within 24 hours*<br>• 1 patient death occurred where the incident was coded as a Cat 3<br>• 2 deaths occurred where they were initially coded as Cat 1 or Cat 2 and were subjected to a long wait.<br>**These categories are taken from the national framework; the results should not be correlated to the results of the Safe Care Closer to Home audit due to significant differences in audit methodology.*<br><br>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 Q1 dashboard change. There are several reasons why the whole cohort identified are not reviewed:<br><br>• Without a patient report form the review cannot be undertaken<br>• Death not in scope post clinical review<br>• SJR not moderated |

**Learning from Deaths- Structure Judgement Review Outcomes Q1 2022/23**




***Flow chart to describe sample cohort attrition and treatment Q1 2022/23***

Clinical Hub specialists joined the panel in April 2022 to undertake the hear and treat (H&T) reviews.

3.3.1 ***Structured judgement review methodology***

The process requires the reviewing clinicians to make explicit statements upon the practice under review using the 'Sequence of Events' (SoE) and 'Patient Report Form' 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.

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| | 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:*** |
| | 27 patient deaths were presented by reviewers and following the moderation panels, the outcomes of the reviews were determined as described in the table below. 18 patients (67%) received adequate care. |

| Month | Very Poor | Poor | Adequate | Good | Very Good |
|---|---|---|---|---|---|
| **Apr 22** | | 4 | 7 | | |
| **May 22** | | 2 | 8 | | |
| **Jun 22** | | 3 | 3 | | |

*Moderation Panels held on 07/06/2022, 19/07/2022, & 09/08/2022*

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'*.

The Patient and Public Panel (PPP) representatives joined the moderation panels for May and June, and their initial feedback was around the 'adequate care' rating. They have asked if this rating can be changed to something more suitable such as 'appropriate care'. It was explained that these are nationally agreed statements which would require national group approval.

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

9 cases were identified as needing second stage review. In 2 cases, no other causal factors were identified as contributing to harm and simply the care experienced by the patient in terms of assessment, management plan and disposition were below expected levels one might reasonably expect.

The second stage review for the 7 remaining patients remained as uncertain whether 'poor' practice had led to harm.

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

*Poor Practice: Table 11 fig 7.*

The panel identified areas for improvement were to:

- Record repeated observations
- Perform ECGs when appropriate to do so
- Assess and document capacity to consent appropriately
- Apply Manchester Triage System (MTS) correctly
- Document patient and family wishes for joint decision making

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| | • Provide a comprehensive clinical narrative within the EPR, especially details around GP discussions and specific worsening advice<br><br>*Good Practice: Table 12 fig 8.*<br><br>The panel review identified numerous positive examples of practice over and above expected practice. This included:<br><br>• Crew waited for GP to arrive and discussed patient's condition with GP and family. Clear documentation of GP discussions with family and actions.<br><br>*Actions:*<br><br>• Requested configuration changes to the EPR around the diagnosis of death form<br>• Case escalated to Review of Serious Events (ROSE) meeting<br>• Case escalated for a local clinical review<br>• Feedback to private provider around their paper PRF and used of pathfinder |
| 3.4 | ***Dissemination Process***<br><br>A commitment to disseminating and promoting good practice has been made by the Consultant Paramedic (Medical Directorate) through the Area Learning Forums and individual clinicians.<br><br>Good practice letters have been circulated to commend 10 clinicians who through their care and professionalism have supported families and patients to experience a good death during Q1.<br><br>Observers continue to join the panels during Q1 and this demonstrates to staff an open and transparent process of review. Immediate feedback from the observers has been extremely positive and this inclusivity will certainly support closing the gaps in care. |
| 3.5 | ***Report Development***<br><br>DCIQ: Mortality Module<br><br>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.** | **LEGAL, GOVERNANCE AND/OR RISK IMPLICATIONS** |
| 4.1 | 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. |

| 5. | **EQUALITY OR SUSTAINABILITY IMPLICATIONS** |
|---|---|
| **5.1** | No equality or sustainability implications identified. |
| **6.** | **RECOMMENDATIONS** |
| **6.1** | The Board of Directors is recommended to:<br>• Support 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 the formal process of Learning from Deaths.<br>• Support the annual dashboard (Appendix B) as the report to be published on the Trust public account as evidence of the Trust's annual engagement of a formal process of Learning from Deaths.<br>• Acknowledge the impact of the SJR process in identifying opportunities for improving care and identification of serious incidents previously unknown to the trust.<br>• Acknowledge the good practice identified |

# NWAS Learning From Deaths Dashboard Quarter 1 2022-2023 (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 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 |
|---|---|---|---|---|
| April | 47 | 33 | 70.2% | 8 |
| May | 33 | 22 | 66.7% | 4 |
| June | 26 | 17 | 65.4% | 3 |
| **This Quarter** | **106** | **72** | **67.9%** | **15** |
| **This Financial Year** | 106 | 72 | 67.9% | 15 |

** 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.*

*Data source: An amalgamation of both the Datix cohort and the Sample cohort data sources detailed below. Last accessed 12/08/2022.*

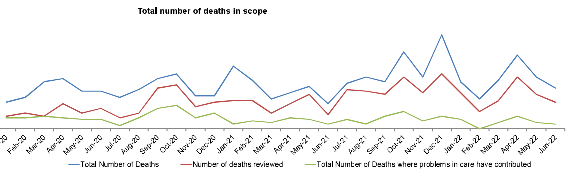



*Figure 1.*

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.

## Concerns raised in Datix Breakdown

**Datix Cohort Description**: The 'must review' category includes incidents raised to the organisation and recorded via Datix as 'deaths that occurred 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 occurred; 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'.

### Internal Concerns - Incidents (including SIs)

| Total Datix Death incidents in scope | | Risk grading | | |
|---|---|---|---|---|
| | | 1 or 2 | 3 | 4 or 5 |
| April | 28 | 9 | 4 | 15 |
| May | 17 | 3 | 4 | 10 |
| June | 17 | 2 | 6 | 9 |
| **Total** | **62** | **14** | **14** | **34** |

*Table 2.*

| Month | Number of Deaths Closed on Datix | Of those closed, Number of Deaths likely due to the service provided by the Trust | Lessons Learned complete for those closed and Deaths likely due to the service provided by the Trust |
|---|---|---|---|
| April | 22 | 4 | 4 |
| May | 12 | 2 | 2 |
| June | 10 | 0 | 0 |
| **Total** | **44** | **6** | **6** |

*Table 3.*

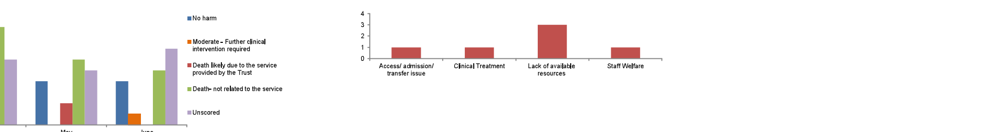



*Figure 2.*

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

Access/ admission/ transfer issue; Clinical Treatment; Lack of available resources; Staff Welfare

*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 08/08/2022. Last accessed 09/08/2022.*

### External Concerns - Complaints

| Month | Number of Complaints | Incidents Closed on Pat. Exp. | Number closed and Deaths likely due to the service provided by the Trust |
|---|---|---|---|
| April | 5 | 0 | 0 |
| May | 4 | 0 | 0 |
| June | 3 | 1 | 0 |
| **Total** | **12** | **1** | **0** |

*Table 4.*

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

*Data source: Datix Patient Experience search 'Risk Score: 4 & 5' Incident Date @lastquarter, last extracted using PE Listing report on 08/08/2022. Last accessed 09/08/2022.*

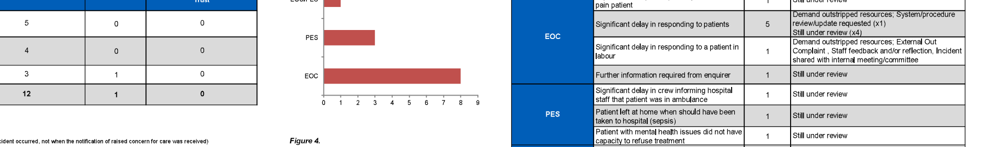



*Figure 4.*

| Service Line | Summary of concern | Frequency | Action Themes (may have multiple) |
|---|---|---|---|
| EOC | Significant delay in responding to a chest pain patient | 1 | Still under review |
| | Significant delay in responding to patients | 5 | Demand outstripped resources; System/procedure review/update requested (x1)<br>Still under review (x4) |
| | Significant delay in responding to a patient in labour | 1 | Demand outstripped resources; External Out Complaint , Staff feedback and/or reflection, Incident shared with internal meeting/committee |
| | Further information required from enquirer | 1 | Still under review |
| PES | Significant delay in crew informing hospital staff that patient was in ambulance | 1 | Still under review |
| | Patient left at home when should have been taken to hospital (sepsis) | 1 | Still under review |
| | Patient with mental health issues did not have capacity to refuse treatment | 1 | Still under review |
| EOC/PES | Significant delay in responding to patient | 1 | Still under review |

*Table 5.*

### Internal and External Concerns - Incidents and Complaints

| Month | Number of concerns that have been raised internally and externally | Incidents Closed on both modules | Number closed and Deaths likely due to the service provided by the Trust |
|---|---|---|---|
| April | 1 | 0 | 0 |
| May | 1 | 0 | 0 |
| June | 0 | 0 | 0 |
| **Total** | **2** | **0** | **0** |

*Table 6.*

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

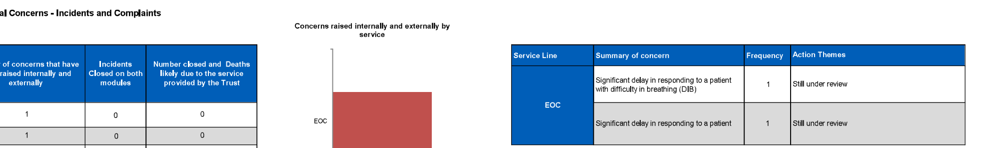



*Figure 5.*

| Service Line | Summary of concern | Frequency | Action Themes |
|---|---|---|---|
| EOC | Significant delay in responding to a patient with difficulty in breathing (DIB) | 1 | Still under review |
| | Significant delay in responding to a patient | 1 | 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 08/08/2022. Information recorded on these incidents: last accessed 09/08/2022. 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 08/08/2022, Last accessed 09/08/2022.*

## Structured Judgement Review Sample (SJR) 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 initially 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 |
|---|---|---|---|
| April | 13 | 11 | 4 |
| May | 11 | 10 | 2 |
| June | 6 | 6 | 3 |
| **Total** | **30** | **27** | **9** |

*Table 8.*

| | SJR Category Type | | |
|---|---|---|---|
| Month | C1 and C2 Long waits | C3 and C4 Deaths | 24 hr Re-contact Deaths |
| April | 2 | 0 | 11 |
| May | 0 | 1 | 10 |
| June | 0 | 0 | 6 |
| Total | 2 | 1 | 27 |

*Table 9.*

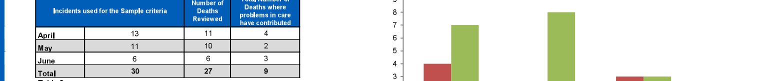



*Figure 6.*

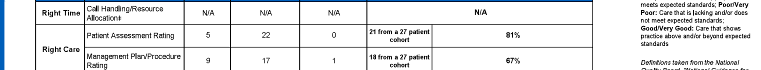
| | SJR Element | 1 or 2 - Poor or Very Poor | 3 - Adequate (Appropriate)† | 4 or 5 - Good or Very Good | % Patients receiving Adequate or Good Care | |
|---|---|---|---|---|---|---|
| Right Time | Call Handling/Resource Allocation‡ | N/A | N/A | N/A | N/A | |
| Right Care | Patient Assessment Rating | 5 | 22 | 0 | 21 from a 27 patient cohort | 81% |
| | Management Plan/Procedure Rating | 9 | 17 | 1 | 18 from a 27 patient cohort | 67% |
| Right Place | Patient Disposition Rating | 6 | 21 | 0 | 21 from a 27 patient cohort | 78% |

*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 27 patients)

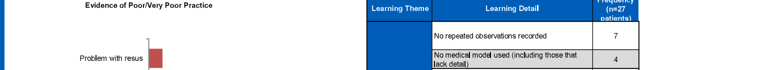



*Figure 7.*

| Learning Theme | Learning Detail | Frequency (n=27 patients) |
|---|---|---|
| Problem in assessment, investigation or diagnosis | No repeated observations recorded | 7 |
| | No medical model used (including those that lack detail) | 4 |
| | No chest examination recorded | 2 |
| | Breathing assessment lacks details | 1 |
| | No assessment of confusion (delirium, 4ATs, fluids and urine) | 1 |
| | No pertinent negatives recorded | 1 |
| | No ECG performed when appropriate to do so | 2 |
| | Capacity to consent not assessed correctly | 4 |
| Problem relating to treatment and management plan | MTS not used | 2 |
| | MTS not applied correctly | 4 |
| | No specific worsening advice/red flags/risk | 4 |
| | Details of the GP discussions not recorded | 2 |
| | No referral to AVS/GP/alternative providers when appropriate to do so | 5 |
| | No discussion with family members regarding patient's condition/DNACPR/EoLC | 1 |
| | No Safeguarding referral made when appropriate to do so | 1 |
| | No documentation of patient/family wishes for a joint decision | 2 |
| | No evidence of sepsis being considered | 3 |
| | No senior advice being sort | 1 |
| Problem with resus | Poor Senior clinical advice given around the continuation of ALS for 20 mins despite airway being comprised, asystole and ineffective bystander CPR. | 1 |
| Problem with medication | IV paracetamol administered to a ?sepsis patient when no reason was clearly indicated. | 1 |
| Problem of any other type | Quality of EPR | 7 |
| | No documented use of the COVID assessment tool for conveyance decision support | 1 |

*Table 11.*

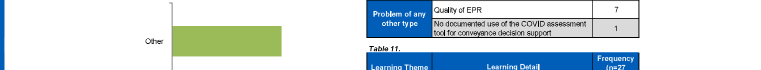
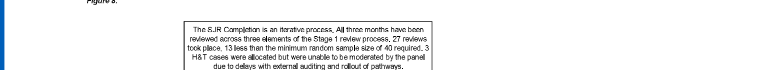



*Figure 8.*

| Learning Theme | Learning Detail | Frequency (n=27 patients) |
|---|---|---|
| Additional treatment and management plans | Crew waited for GP to arrive and discussed patient's condition with GP and family. Clear documentation of GP discussion with family and actions. | 1 |
| Other | Quality of EPR | 4 |

*Table 12.*



The SJR Completion is an iterative process. All three months have been reviewed across three elements of the Stage 1 review process, 27 reviews took place, 13 less than the minimum random sample size of 40 required, 3 H&T cases were allocated but were unable to be moderated by the panel due to delays with external auditing and rollout of pathways.

*Data source: Informatics queries. SJR data source: DCIQ Learning from Deaths module, last accessed on 12/08/2022.*

# NWAS Learning From Deaths Dashboard Annual 2021-2022 (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 datasets 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 | 65 | 62 | 95.4% | 14 |
| Q2 | 89 | 71 | 79.8% | 16 |
| Q3 | 135 | 87 | 64.4% | 24 |
| Q4 | 101 | 45 | 44.6% | 10 |
| Total | 412 | 347 | 84.2% | 90 |

* 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.

Data source: An amalgamation of both the Datix cohort and the Sample cohort data sources detailed below. Last accessed 08/08/2022

**Total number of deaths in scope**

Jan-20, Feb-20, Mar-20, Apr-20, May-20, Jun-20, Jul-20, Aug-20, Sep-20, Oct-20, Nov-20, Dec-20, Jan-21, Feb-21, Mar-21, Apr-21, May-21, Jun-21, Jul-21, Aug-21, Sep-21, Oct-21, Nov-21, Dec-21, Jan-22, Feb-22, Mar-22

— Total Number Deaths (Datix and SJR Sample) — Number of Deaths reviewed — Total Number of Deaths where problems in care have contributed

Figure 1.

Those in scope must have died under the care of the ambulance service (from call handling to before handover completion), 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.

## Concerns raised in Datix Breakdown

**Datix Cohort Description**: The 'must review' category includes incidents raised to the organisation and recorded via Datix as 'deaths that occurred 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 occurred; 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 likely due to the service provided by the Trust'.

### Internal Concerns (including SIs)

| | Total Datix Death incidents in scope | Risk grading | | |
|---|---|---|---|---|
| | | 1 or 2 | 3 | 4 or 5 |
| Q1 | 16 | 6 | 4 | 6 |
| Q2 | 38 | 3 | 9 | 26 |
| Q3 | 60 | 8 | 7 | 45 |
| Q4 | 26 | 2 | 7 | 17 |
| Total | 114 | 19 | 27 | 94 |

Table 2.

| Month | Number of Deaths Closed on Datix | Of those closed, Number of Deaths likely due to the service provided by the Trust | Lessons Learned complete for those closed and considered caused by the incident |
|---|---|---|---|
| Q1 | 16 | 2 | 2 |
| Q2 | 32 | 7 | 4 |
| Q3 | 44 | 11 | 10 |
| Q4 | 18 | 5 | 5 |
| Total | 110 | 25 | 21 |

Table 3.

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

Q1, Q2, Q3, Q4

No harm; Moderate - Further clinical intervention required; Death likely due to the service provided by the Trust; Death - not related to the service; Unscored

Figure 2.

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

Lack of Available Resources; Information; HART Staffing Issues; Equipment missing/lost; Emergency response; Communiction; Communication/ Consent/Confidentiality; Clinical Treatment; Clinical Assessment

Figure 3.

Data source: Datix Incidents query 'Inc.: LfD (DoH Expected Death or Death) Listing Report - Incident Date @lastfinancialyear' and 'Inc.: Wild Card Search (death/dead/deceased/died) Incident Date @lastfinancialyear. Last extracted 02/08/2022. Last accessed 08/08/2022

### External Concerns

| Quarter | Number of external concerns raised | Number of concerns closed | Number closed and death likely due to the service provided by the Trust |
|---|---|---|---|
| Q1 | 3 | 3 | 0 |
| Q2 | 3 | 3 | 0 |
| Q3 | 8 | 5 | 1 |
| Q4 | 12 | 7 | 1 |
| Total | 26 | 18 | 2 |

Table 4.

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

Data source: Datix Patient Experience search 'Risk Score: 4 & 5' Incident Date @lastfinancialyear, last extracted using PE Listing report on 02/08/2022. Last accessed 08/08/2022.

**External concerns by service line**

EOC, PES, 111

Figure 4.

| Service Line | Summary of concern | Frequency | Action Themes |
|---|---|---|---|
| EOC | Significant delay in responding to patient | 7 | 1. Not upheld, No actions; 2. Reflection and/or feedback; incorrect coding of call; 3. Not upheld, Demand outstripped resources; 4. Demand outstripped resources; incident shared with review panel and internal meeting/committee; 5. Not upheld, Demand outstripped resources; 6. Still under review; 7. Still under review |
| | Significant delay in responding to a suspected stroke patient | 2 | 1. Reflection and/or feedback; demand outstripped resources; 2. Still under review |
| | HCP concern regarding a significant delay in responding to a sepsis patient | 1 | Still under review |
| | Significant delay in responding to a patient with chest pain | 1 | Still under review |
| | Significant delay in responding to a patient with DIB | 4 | 1. Not upheld, Demand outstripped resources; Call handled correctly; Incident monitored safely; 2. Demand outstripped resources; reflection and/or feedback; resourcing levels were not appropriate anywhere across the Trust on night of incident; commendation to dispatcher for effective; monitoring of incident EMD guidance re: EOC0001 & EOC0015 to be circulated; still under review; 3. Demand outstripped resources; reflection and/or feedback; incorrect coding of call; 4. Demand outstripped resources; reflection and/or feedback; incorrect coding of call |
| | Significant delay in responding to a falls patient leading to cardiac arrest | 1 | Demand outstripped resources; guidance issued on principles of dispatch; HART to be included in review of Trust Meal & Rest Break policy |
| PES | Family raised a concern around the mobilisation of a bariatric patient from upstairs to ambulance, patient went into cardiac arrest on stretcher | 2 | Feedback and recirculated bulletins around mobilisation of bariatric patients; Not upheld, no actions |
| | Relative concerned clinicians lacked appropriate equipment (Defibrillator) | 1 | Not upheld, Reflection and/or feedback |
| | Patient left a home when should have been taken to hospital (sepsis) | 1 | Reflection and/or feedback; inappropriate use of MTS; refresher training to be undertaken |
| | Management of a deteriorating patient from ambulance to hospital, patient went into cardiac arrest during handover | 1 | Still under review |
| | Diagnosis of potential C-Spine injury (later confirmed) in a patient presenting as medical cause not traumatic in nature | 1 | Positive feedback/commendation provided to crew; not upheld |
| | Concern raised about the use of terminology for a trauma incident | 1 | Good communication during handover although some confusion around silver trauma and frail injured patient pathway (FrIP) |
| | HCP concern patient was incorrectly conveyed to UCC instead of ED | 1 | Crew acted appropriately as per GP instructions, not upheld, no actions |
| | HCP concern raised around the mobilisation of a baby in cardiac arrest | 1 | Reflection and or feedback |
| 111/EOC/ PES | Significant delay in responding to patient | 1 | Still under review |

Table 5.

### Concerns raised internally and externally

| Month | Number of concerns raised internal and externally | Incidents Closed on both modules | Number closed and death considered caused by the incident |
|---|---|---|---|
| Q1 | 1 | 1 | 0 |
| Q2 | 6 | 5 | 2 |
| Q3 | 6 | 5 | 4 |
| Q4 | 3 | 1 | 1 |
| Total | 16 | 12 | 7 |

Table 6.

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

**Concerns raised internally and externally by service line**

PTS, EOC, PES, 111

Figure 5.

| Service Line | Summary of concern | Frequency | Action Themes |
|---|---|---|---|
| EOC | Significant delay in responding to a baby with DIB | 1 | Still under review |
| | Significant delay in responding to a patient with chest pain | 1 | Demand outstripped resources; system/procedure review/update requested |
| | Significant delay responding to a patient with DIB | 6 | 1. Demand outstripped resources; missed opportunity to divert ambulance from lower acuity incident (Death – likely due to the service provided by the Trust); 2. Demand outstripped resources; reflection and/or feedback; measures put in place for all EMDs to see which incidents have waited the longest; training/guidance given re: ineffective/agonal breathing, EOC0001, EOC0015 and EOC0062; 3. Demand outstripped resources; failure to propose self-conveyance to ED for long wait patient; 4. Reflection and/or feedback; failure to recognise the potential seriousness and complexity of the condition; incident shared with internal meeting/committee; 5. Still under review; 6. Still under review; |
| | Significant delay in responding to a suspected stroke patient | 2 | 1. Demand outstripped resources, No actions; 2. Significant delay in responding to a suspected stroke patient |
| | Significant delay in responding to patient | 3 | 1. Demand outstripped resources; duplicate calls need to take re-categorisation into account; system/procedure review/update requested; 2. Demand outstripped resources; system/procedure review/update requested; 3. Still under review |
| 111, EOC | Significant delay in responding to patient | 1 | Demand outstripped resources; system/procedure review/update requested |
| PTS | Management of a deteriorating patient from ambulance to hospital, patient went into cardiac arrest during handover | 1 | Not upheld |
| PES | Concern raised around the management of a patient with abdominal pain | 1 | Individual learning around JRCALC abdominal pain assessment and management. Considering further medical referral or ED attendance. A disparity of management between JRCALC abdominal pain and MTS Abdominal pain. This is to be discussed at the Area Learning Forum for further discussion. |

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 @lastfinancialyear. last extracted 02/08/22. Information recorded on these incidents: last accessed 08/08/2022. Datix Incidents query 'Inc.: LfD (DoH Expected Death or Death) Listing Report - Incident Date @lastfinancial' and 'Inc: Wild Card Search (death/dead/deceased/died) Incident Date @lastfinancialyear - Listing Report': last extracted on 02/08/2022. Last accessed 08/08/2022

## Structured Judgement Review Sample (SJR) 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 initially conveyed and the ambulance service was recontacted within 24 hours.

**Structured Judgement Review Sample**

| | Incidents used for the Sample criteria | Number of Deaths Reviewed | Total Number of Deaths where problems in care have contributed |
|---|---|---|---|
| Q1 | 43 | 27 | 12 |
| Q2 | 42 | 31 | 7 |
| Q3 | 61 | 31 | 8 |
| Q4 | 60 | 26 | 3 |
| Total | 206 | 115 | 30 |

Table 8.

| Month | C1 and C2 Long waits | C3 and C4 Deaths | 24 hr Re-contact Deaths |
|---|---|---|---|
| Q1 | 2 | 6 | 37 |
| Q2 | 5 | 7 | 29 |
| Q3 | 13 | 6 | 40 |
| Q4 | 11 | 11 | 38 |
| Total | 30 | 30 | 143 |

Table 9.

| | SJR Element | 1 or 2 - Poor or Very Poor | 3 - Adequate* | 4 or 5 - Good or Very Good | % Patients receiving Adequate (appropriate) or Good Care | |
|---|---|---|---|---|---|---|
| Right Time | Call Handling/Resource Allocation | N/A | N/A | N/A | N/A | |
| Right Care | Patient Assessment Rating | 21 | 88 | 6 | 94/115 patients | 82% |
| | Management Plan/Procedure Rating | 22 | 81 | 12 | 93/115 patients | 81% |
| Right Place | Patient Disposition Rating | 19 | 94 | 2 | 96/115 patients | 83% |

Table 10.

**SJR Stage 1 Overall Care Assessment**

Q1, Q2, Q3, Q4

Very Poor; Poor; Adequate; Good

Figure 6.

* SJR Scoring Key:

**Adequate:** Care that is appropriate and meets expected standards; **Poor/Very Poor:** Care that is falling 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 SJRs.

### Structured Judgement Review - Learning Themes (Review of 115 patients)

**Evidence of Poor/Very Poor Practice**

Invasive procedure; Resuscitation; Assessment, investigation or diagnosis; Clinical monitoring; Treatment and management plan; Other

Figure 7.

| Learning Theme | Learning Detail | Frequency (n=115) |
|---|---|---|
| Problem in assessment, investigation or diagnosis | Lack of clinical observations/ repeated observations | 14 |
| | Capacity to consent not assessed correctly | 1 |
| | Lack of mental health assessment | 1 |
| | Poor assessment/investigation | 2 |
| | Family informed crew there was a DNACPR in place and crew commenced resuscitation and then ALS | 1 |
| Problem relating to treatment and management plan | No referral to AVS/GP/alternative providers when appropriate to do so | 2 |
| | No SDS/self care/worsening advice given | 6 |
| | No senior clinical advice sought | 2 |
| | No safeguarding referral made when appropriate to do so | 2 |
| | Lack of patient safety netting undertaken | 2 |
| | MTS/Pathfinder not used/not applied correctly | 10 |
| | No narrative regarding GP discussion | 1 |
| | Poor handover to AVS guarding sepsis markers | 1 |
| | Failure to recognise differential symptoms and red flags | 1 |
| | NWAS COVID-19 guidance not followed | 1 |
| | No discussion with family members regarding patient's condition/DNACPR/EoLC | 1 |
| Problem with clinical monitoring | No ECG attached, digital tracker with DETAC | 2 |
| Problem in resuscitation | Intraosseous inserted whilst waiting for DNACPR documents | 1 |
| | TOR protocol not followed | 1 |
| Problem of any other type | Poor clinical documentation/incomprehensive PRF | 8 |
| | Distress caused to patient's family | 2 |
| | Unconscious clinician Bias when dealing with high intensity users | 2 |
| | By not making contact, crew did not establish whether patient was alive or not | 1 |
| | Indication for a 12-Lead ECG missed | 2 |
| | Misunderstanding of DNACPR/Futile arrest | 2 |
| | EOC to check if clinical support is needed for prolong on scene time to support making | 1 |

Table 11.

**Evidence of Good/Very Good Practice**

Additional treatment and management plans; Additional assessments, investigations and diagnosis; Additional Clinical Monitoring

Figure 8.

| Learning Theme | Learning Detail | Frequency (n=115) |
|---|---|---|
| Additional assessments, investigations or diagnosis | Assessment of patient with additional investigations and assessment beyond expected practice | 3 |
| Additional treatment and management plans | Crew made multiple attempts to gain entry to a Mental Health Self Harm patient's property with excellent escalation before requesting permission to force entry when no answer from patient. Detailed description of recent police search & seize records as well as general scene. | 1 |
| | Patient recognised to be approaching EoL; crew liaised with patient, family members and GP to ensure best interests were met | 4 |
| | Crew showed exemplary behaviour and treatment towards a patient approaching EoL. Crew attended local Hospice to obtain bed pans for patient and discuss supporting patient's spouse. Crew also provided emotional and informational support to patient, spouse and caregivers | 1 |
| | Supportive to family, condolences offered and signposted to bereavement care, extended family members contacted for emotional support. | 1 |
| | Provision of personal hygiene | 1 |
| | Collective decision making and safety netting between crew, SPTL, AP and GP whilst respecting the patient's wishes to remain at home. | 1 |
| | Crew demonstrated care and compassion by allowing a natural death and supporting the family/caregivers in the process. | 2 |
| | Detailed management plan to support the patient in the community who is at risk of dying and refusing conveyance. | 2 |
| | Crew made multiple attempts to encourage a patient to be treated and conveyed for a life-threatening condition, despite being met with violence/aggression by patient | 1 |
| | Crew showed exemplary behaviour and treatment towards a mental health self-harm patient, ensuring thorough safety-netting of the patient took place through safeguarding referrals, police liaison, referral to the patient's GP, and the Emergency Duty Team (EDT) | 1 |

Table 12.

Data source: Informatics Reports, SJR data source: Learning from Deaths SJR Database & DCIQ, last accessed on 23/06/2022.