South East Coast Ambulance Service NHS
NHS Foundation Trust

Agenda No	34-24

Name of meeting	Quality and Patient Safety Committee
Date	20 June 2024
Name of paper	Learning from Deaths Q1 Report 2023-24
Responsible Executive	Dr Richard Quirk, Acting Chief Medical Officer
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Synopsis	The independent random reviews of the care of patients who have died in our care has continued to demonstrate compassionate care in the majority of cases. The main reason for the panel to judge care as 'adequate' or 'poor' is once again related to delays in getting to the patient.
Recommendations, decisions or actions sought	The committee is asked to note the report and the actions that the Trust is taking.

Does this paper, or the subject of this paper, require an equality impact analysis ('EIA')? (EIAs are required for all strategies, policies, procedures, guidelines, plans and business cases).	**No**

Learning from Deaths Report – Quarter 2 – 2023/24

1. Introduction

1.1. When deaths occur, it is important that we review the care to understand if there is anything that we could have done differently before the death, during the death or following the death. This review of care should then improve future care. If carers, relatives, staff or other organisations raise concerns to SECAmb, about the care of a patient at the time of their death, they will be fully involved in any review of the death.

1.2. SECAmb Trust Board approved the Learning from Deaths Policy in November 2019. This policy sets out the national standards of randomly reviewing the care of 20 patients per month (from across the 10 Operating Units) and must include deaths during a C1/C2 delayed response, deaths during a C3/4 delayed response, deaths following hand over of the patient to another provider and deaths where the initial decision was to leave the patient at home and then they subsequently died.

1.3. There are additional statutory requirements to provide information to the Child Death Overview Panel for all children who die, a requirement to report deaths of people with Learning Disabilities to LeDeR (Learning Disabilities Mortality Reviews), a requirement to report all deaths of people with serious mental health conditions to their mental health trust and a requirement to report all obstetric incidents (which meet their criteria) must be reported to the Healthcare Safety Investigations Branch (HSIB).

1.4. This quarter, the Learning from Death Group commissioned a 'deep dive' into the care of patients who died whilst we were present on scene. This was to identify, specifically, if there were any care issues on scene that could have contributed to the death of the patient.

2. Overview of Quarter 2 (23/24) mortality data

2.1. Table 1 shows the total number of deaths per month broken down into sex. Where the sex of the patient has not been recorded or staff have been unable to identify the sex, this is categorised as 'unknown sex'.

Table 1

	2020				2021				2022				2023			
Month	F	M	U	Total Deaths	F	M	U	Total Deaths	F	M	U	Total Deaths	F	M	U	Total Deaths
Jan	277	377	7	661	406	543	0	949	312	425	1	739	318	467	1	786
Feb	265	369	4	638	286	378	1	665	254	355	1	610	279	423	1	703
March	285	413	9	707	248	383	0	631	288	429	0	717	323	430	2	755
April	341	466	11	818	254	366	0	620	275	389	1	665	300	408	4	712
May	265	347	5	617	207	335	1	543	244	389	0	633	299	416	6	721
June	214	325	13	552	204	323	1	528	240	357	1	598	247	404	7	658
July	223	367	2	592	229	403	0	632	294	413	2	709	**201**	**357**	**0**	**559**
Aug	266	370	3	639	208	336	0	544	263	374	3	640	**245**	**377**	**3**	**625**
Sept	204	333	3	540	238	346	0	584	262	345	0	607	**275**	**416**	**0**	**691**
Oct	240	354	0	594	305	406	0	711	280	400	0	680				
Nov	225	380	1	606	254	426	2	682	275	412	8	695				
Dec	334	464	0	798	341	432	1	774	461	579	1	1041				

2.2. Table 2 shows the breakdown of the number of people who died in each age bracket:-

Table 2

Age Range (Yrs)	No. of patients who died – July 2023	No. of patients who died – August 2023	No. of patients who died – September 2023
Under 1 year	4	1	3
1-18	4	3	4
18 – 29	18	13	16
30 – 39	17	18	21
40 – 49	26	31	36
50 – 59	51	66	67
60 – 69	84	86	104
70 – 79	131	140	158
80 – 89	142	166	169
90 – 99	72	94	105
100+	5	3	5
Age unknown	4	4	4

2.3. Table 3 shows the numbers of patients who had an Advance Care Plan (ACP)/Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) forms in place, those who were 'dead on arrival' and those on whom we attempted resuscitation:-

Table 3

	No. of patients who died – July 2023	**No. of patients who died – August 2023**	**No. of patients who died – September 2023**
Dead on arrival	250 (45%)	297 (48%)	303 (44%)
Resuscitation attempted	151 (27%)	168 (27%)	191 (28%)
Advance Care Plan/Do not attempt resus (DNACPR)	131 (23%)	130 (21%)	175 (25%)
Professional Decision not to Resuscitate	23 (4%)	24 (4%)	18 (3%)
End of Life	3	3	6

3. Review process

3.1. In accordance with the Trust's Learning from Deaths policy, 20 random cases have been selected to be reviewed per month (60 reviews per quarter). The 20 cases were from across the 10 Operating Units. The Structured Judgemental Review (SJR) is the nationally approved review process and SJRs were carried out on the 60 cases.

3.2. His quarter the review panel has been expanded to include the Practice Development Leads as well as the Chief Medical Officer, Deputy Medical Director, Assistant Medical Director (Critical Care), both Consultant Paramedics (Urgent Care) and the End of Life Care Lead.

3.3. Table 4 shows the outcomes of the Structured Judgemental Reviews of the 60 randomly selected deaths in Quarter 2 23/24.

Table 4

	Excellent Care	Good Care	Adequate Care (good enough)	Poor Care	Very Poor Care	N/A
Initial Management and/or Pre-scene (initial call handling, categorisation; response time, appropriateness if vehicle and staff dispatched)	19 (36%)	24 (45%)	7 (13%)	3 (6%)		
On scene handling (Care)	24 (45%)	26 (49%)	2 (4%)	1 (2%)		
Transfer and Handover (Including discharge and worsening care advice)	10 (19%)	11 (21%)				32 (60%)
Other Aspects of Care (quality and legibility of records)	20 (38%)	25 (47%)	8 (15%)			
Overall Assessment of Care	24 (45%)	24 (45%)	4 (8%)	1 (2%)		

3.4. **Learning from each phase of care**

Most judgemental reviews undertaken identified good or excellent care. Of particular note is the level of compassionate care provided to families and carers. There is some identified learning from each phase of the care as detailed below:-

3.4.1. Initial Management

In the 10 cases where care was seen to be 'adequate' or 'poor', the reason for the majority of these ratings was a delay in reaching the scene. The majority of calls are classed as Category 1 and should receive a response within 7 minutes (on average). For all of those incidents where the Trust has taken longer than 7 minutes to arrive on scene, the reviewers have not identified any significant harm caused to those patients as they were either already dead, were receiving adequate bystander CPR/defibrillation or getting there sooner was unlikely to make a difference to the outcome.

The specific delays are as follows:-

- 36 minutes to attend a C2 call.
- A short delay to attend a C1 call.
- A delay of 10 minutes to attend a C1 call. Insufficient information passed from control to the crew.
- Call backs made to the patient but no escalation when no response was received.
- 14 minute delay in attending a C1 call.
- A more than 1 hour response to attend a C2 call.
- 9 minute delay in attending a C1 (but no harm caused as patient had a DNACPR).
- 2 minute delay from control assigning a C1 to the crew being allocated.
- Delay in getting to a C1 call – but expected death when arrived.
- Only 1x Double Crewed Ambulance sent to a C1 arrest when policy says two should be sent.

The reviewers also assessed the likelihood of success of resuscitation if the crews had arrived any earlier and felt that in the majority of cases, the outcome is unlikely to have been any different.

3.4.2. On Scene Handling

Most cases reviewed this quarter were found to have excellent or good care on scene.

The adequate care identified in the 'on-scene' element was related to:

- Resus was interrupted when moving the patient from the house to the ambulance.
- A complication with achieving an airway by the crew, which was resolved when the Critical Care Paramedic arrived.

The poor care identified in the 'on-scene' element was related to:

- No Basic Life was started by the crew on arrival even though there was no DNACPR present in the property.

3.4.3. Transfer and Hand over

Transfer and Hand over judgements are not relevant in every review as the crew may not convey/transfer a patient who has died/dying.

3.4.4. Other aspects of care (including documentation)

The 'other' care issues that were graded as 'adequate' were as follows:-

- Lack of detail about the incident.
- Not enough documented on the shocks given and the time of those shocks. Also the wrong clinician name was documented as intubating the patient.
- No photo of the DNACPR was uploaded to the ePCR.
- Limited clinical notes written in the ePCR.
- Limited notes written in the ePCR.
- Critical Care Paramedic's notes were good in the ePCR but limited notes written by the crew.
- Lack of information written in the clinical notes and no ECG completed.

3.4.5. Overall Care

Where the overall care has been judged as ‘adequate’ or ‘poor’ this is related to the concerns written above in the other elements of care provided.

4. Referrals to the Learning from Deaths panel

4.1. During this reporting period, no cases were referred to the Serious Incident Group for assessment.

5. Learning from the random review of 53 deaths

5.1. In the majority of the 53 reviews undertaken, the care of the patient was good or better. In most cases, our policies were correctly followed, thorough history taking was completed, examinations were robustly recorded and the outcomes for the patient were clearly documented.

5.2. In a small number of reviews there was a delay in attending the patient. The reviewers have not found evidence that these delays significantly impacted on the outcome for these patients.

5.3. Crew members are making sensible and compassionate judgements when talking to relatives and carers about resuscitation attempts and are clearly documenting these conversations.

5.4. Support from Operational Team Leaders (OTLs) and Critical Care Paramedics (CCPs) in the management of complex arrests is clearly documented and it is evident that everything that could be done to save life is being attempted.

5.5. Consistent with other ambulance trusts, we do not have a system to identify patients who have died within 24-48 hours of admission to hospital to be able to review their pre-hospital care. NHS Improvement are looking into ways of identifying these patients.

5.6. A theme this quarter is the depth of documentation written by the crew in the ePCR. This learning will be shared at the Learning from Deaths Group to ensure crews are reminded about the need to thoroughly document the care in the ePCR.

6. Deep Dive – The care of patients who die in our presence

6.1 The Learning from Deaths Group commissioned the panel to do a deep dive into the care of patients who die whilst we are with them on scene.

6.2 The panel reviewed every death in July, August and September 2024 where the patient was alive when we arrived on scene, but subsequently died. There were 101 patients who met this criteria. The results of this review are set out below.

6.3 Table 5 shows the summary of the standards of care provided to those patients who died in our presence.

Table 5

	Excellent Care	Good Care	Adequate Care (good enough)	Poor Care	Very Poor Care	N/A
Initial Management and/or Pre-scene (initial call handling, categorisation; response time, appropriateness if vehicle and staff dispatched)	40 (40%)	40 (40%)	10 (10%)	10 (10%)	1 (1%)	
On scene handling (Care)	46 (46%)	41 (41%)	9 (9%)	5 (5%)		
Transfer and Handover (Including discharge and worsening care advice)	26 (26%)	22 (22%)				53 (53%)
Other Aspects of Care (quality and legibility of records)	46 (46%)	39 (39%)	14 (14%)	2 (2%)	1 (1%)	
Overall Assessment of Care	40 (40%)	38 (38%)	19 (19%)	4 (4%)		

6.1. **Learning from each phase of care – deep dive into patients who die in our presence**

6.1.1. Initial Management

In the 101 cases where care was seen to be 'adequate' or 'poor', the reason for the majority of these ratings was a delay in reaching the scene.

The specific delays are as follows:-

- A 1 hour 5 minute response to a C2
- Delay to a C1 call
- 16 minute response to a C1 with no harm
- 12 minute response to a C1
- 10 minute response to a C1
- Delay to a C1 call
- More than an hour response to a C1
- Delay to a C1

- Concerns that a C1 response was allocated to a patient who was end of life
- 1 hour 35 minute response to a C2 call.
- A patient with end of life care was given a C1 disposition
- A C1 response was allocated to a patient at end of life.
- 13 minute delay to a C1 patient
- Delay to responding to a C1
- Delay to responding to a C1
- Delay to responding to a C1
- Significant delay to a C2
- More than 1 hour before a CFR responded followed by a crew
- 9 minute delay to a C1
- Care line call – control did not do a 1st party call back so did not give haemorrhage advice
- 3 hours response to a C2
- 60 minute response to a C2

6.1.2. On Scene Handling

Most cases reviewed this quarter were found to have excellent or good care on scene.

The adequate care and poor care identified in the 'on-scene' element was related to:

- Oxygen was given to a patient who was end of life which was inappropriate
- The patient had severely deranged observations but the crew stayed on scene for 35 minutes
- Patient had deranged observations – delay in managing this
- Dying patient was given observations and assessments which were unnecessary
- Limited notes about on scene care
- No comfort measures documented
- Crew did an ECG in a patient at end of life
- No Basic Life Support given despite no DNACPR
- Delay in resus due to moving patient to the vehicle
- Poor documentation
- Exerting the patient may have contributed to their collapse

6.1.3. Transfer and Hand over

Transfer and Hand over judgements are not relevant in every review as the crew may not convey/transfer a patient who has died/dying.

6.1.4. Other aspects of care (including documentation)

The 'other' care issues that were graded as 'adequate' or 'poor' were as follows:-

- 12 cases had poor documentation
- Post Return of Spontaneous Circulation – patient had obs but they were not documented
- No picture taken of the DNACPR for the notes
- Missing phot of DNACPR

- Crew on scene for 2 hours after Recognition of Life Extinct

6.1.5. Overall Care

Where the overall care has been judged as ‘adequate’ or ‘poor’ this is related to the concerns written above in the other elements of care provided. There were two cases where care was judged as poor due to the lack of ability to secure an airway by the crew until the Critical Care Paramedic arrived. These two cases will be reviewed further to understand why this occurred.

7. Conclusions

The panel have identified many examples of very good compassionate care. Delays in getting to the patient continues to be the leading cause of concern related to care of people at the end of their life or care of relatives when the patient.

The deep dive review into the care of patients who died whilst we were on scene showed a very similar picture to our random reviews. The most common cause of adequate or poor care was a delay getting to scene. There were two issues where the crews struggled to secure an airway until the Critical Care Paramedic arrived and the panel will review why this occurred. The care of patients at whose death was expected (e.g. those patients at the end of life with a diagnosed terminal condition) sometimes involved unnecessary assessments and observations. The Panel will work with our end of life care specialists to adapt training for crews to reinforce correct procedure.

Dr Richard Quirk
Deputy Medical Director/Acting Chief Medical Officer
March 2024