London Ambulance Service NHS Trust

Learning from experience

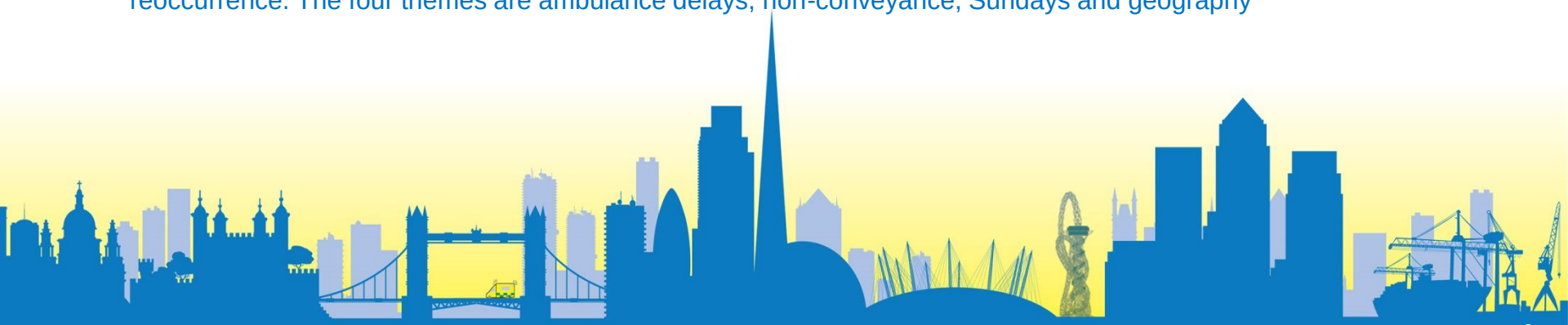
Quarter one 2015-16

Introduction

- The purpose of this paper is to present the pan-organisation themes emerging from Serious Incidents, Claims, Inquests, Complaints and Safety and Risk on a quarterly basis.
- *"The Investigation and Learning from Incidents, PALS, Claims and Complaints"* policy *(*TP054) supports the Trust's commitment to improving safety by learning lessons from the above areas. This report therefore provides systematic analysis of data from the risk management system (Datix) across all categories, identifying themes, trends and actions to prevent re-occurrence; understanding how loss can be minimised and risks managed.
- The report will cover the previous quarter unless otherwise stated, in this case Q1 2015-16 although the analysis itself may take into account before April 2015.

Executive Summary

- In Quarter 1 the top 4 areas for incidents affecting a patient were issues with patient treatment (83 incidents), resource dispatch (37 incidents), conveyance (28 incidents) and removal of patient from scene (26 incidents). These figures are extracted from the current build of Datix where there are acknowledged issues with subcategory coding, limiting effective analysis. For example 112 of 328 incidents affecting a patient are attributed to equipment failure across 9 distinct categories. This will be resolved with the new implementation of Datixweb.
- Of the 9 incidents declared as SIs, 2 have issues with patient treatment and 4 had issues with resource dispatch and ambulance delay appears as a contributing factor across several.
- In Q1 there were 240 complaints of which the 4 largest subjects were delays (96), attitude (52), refusal to send an ambulance (12) and excessive noise (8). The largest contributing areas for complaints were Control Services (106), South area(44), West area (35) and East area (22).
- It follows from this that in addition to departmental updates that 4 overriding themes will be analysed using the statistical evidence, thereby identifying the core issue, presenting lessons learned and actions planned to mitigate reoccurrence. The four themes are ambulance delays, non-conveyance, Sundays and geography

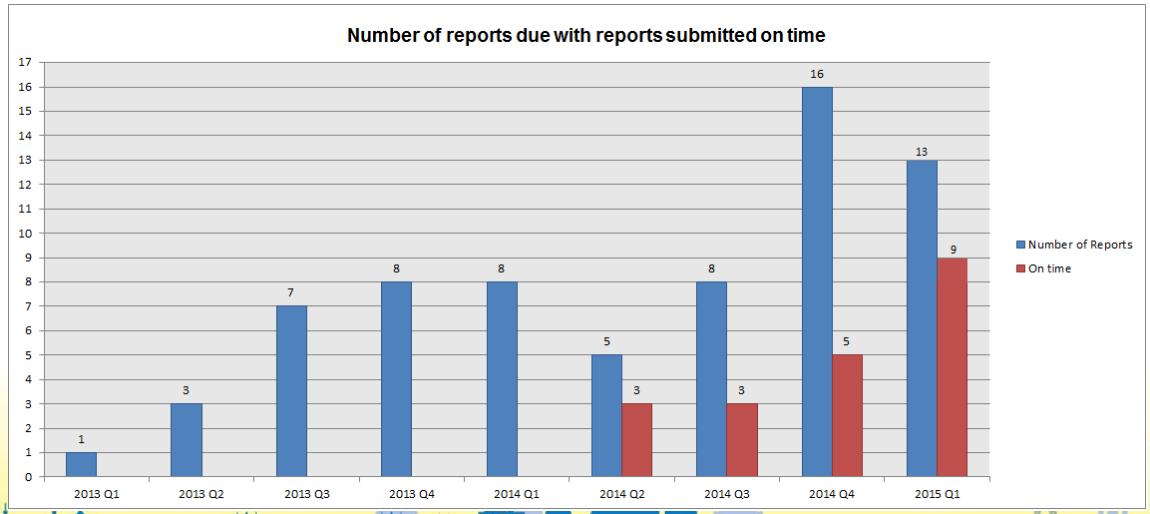


Duty of Candour

- There is now a legal duty for the LAS to act in an open and honest way with our patients who experience incidents that cause them at least moderate harm. As a result of this legislative change the organisation ratified a new Duty of Candour policy in June to reflect this change. The core principles of this policy are to ensure;
  - A patient has a right to expect openness from their healthcare providers.
  - The Trust will learn from mistakes with full transparency and openness.
  - A proactive approach to patient safety with the onus on risk management systems and processes identifying incidents which require review and learning.
- Following the operational restructure and the creation of the Quality Governance and Assurance Manager positions there are sector based Duty of Candour Champions. These roles will lead on the assessment of incidents, triaging harm levels and being the first point of contact for patients or relevant persons as a Family Liaison Officer.
- For all Serious Incidents it is now routine for the patient/relevant person to be contacted initially by the Governance Manager to introduce the FLO and to confirm any details for the patient. The FLO is then required to offer a meeting in person within 10 days of the incident being declared and must offer to involve the patient/relevant persons in the on-going investigation. Once the SI report is completed the FLO must then share the report with the family. Due to the legislation being written with Acute Trusts in mind we have at this early stage identified some issues with contacting the patients as Next of Kin details are not always available, and we have had some reluctance from relevant persons to meet with our staff. In these circumstances we still share the report, noting their refusal and respect their decision to not be involved in the process.
- For all “moderate harm” incidents the Legal Services department and Governance and Assurance undertook an exercise of asking the medical directorate to review all incidents raised on Datix between December 2014 - March 2015 coded as moderate harm to assess if Duty of Candour was invoked. Of the 22 that were entered as moderate harm, upon review from the Medical Directorate 4 were agreed to be of actual moderate harm. These were then allocated to the relevant Quality Governance and Assurance Manager for the sector to be followed up on. A similar exercise is now being undertaken for those up to the present day.

Serious Incidents

- During Q1 2015-16 9 SIs were raised, compared to 10 in Q4 of 2014-15. In total there were 64 incidents that were presented to SIG, with 14% on average being declared. 3 incidents took place in the West sector, 2 in the South East and 1 in East Central, North Central and South West.
- Over Q1 there were 20 SIs that were completed and closed by the CCGs with a further 18 reports completed but requiring further information before closure. There were 6 SIs awaiting completion that were overdue in April, but this figure had reduced to 3 by the end of June, demonstrating a commitment to clearing historical SI reports.
- The chart below shows a upwards trend of reports being completed and closed within the 60 day timeframe with the column in blue showing the number of reports due and purple the number of reports submitted within the timeframe;



Serious Incidents

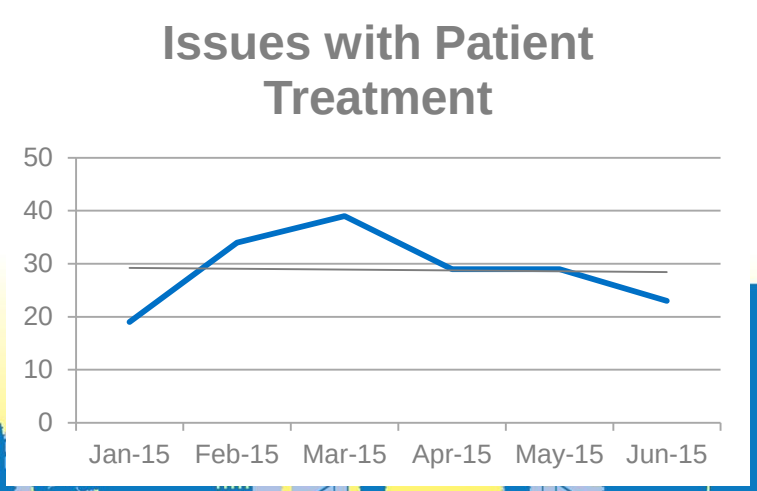
- Building themes from such a small number of Serious Incidents can lend itself to over emphasis on certain aspects. 3 incidents originated as R2 calls and 6 either C1, C2 or C4 calls. Of note 4 incidents declared in Q1 the patient had a presenting complaint as vomiting (1 R2, 1 C2 and 2 C4).
- As an emerging theme the following common features existed;
  - 3 out of the 4 calls for vomiting patients were correctly handled in EOC. The incorrectly handled call should have been triaged as an R2, not a C4 as the wrong protocol had been selected.
- The lessons learned from these incidents include;
  - •Paramedics who frequently supervise staff should be given the opportunity to learn from other registered staff and benefit from peer review.
  - •Correct categorisation is of paramount importance when triaging an emergency call and any errors made can have catastrophic effects
- 4 out of the 9 SIs had a paramedic as the member of staff with clinical primacy and this will be explored in the Q2 report as we aim to explore routes of qualification with help from the Medical Directorate.

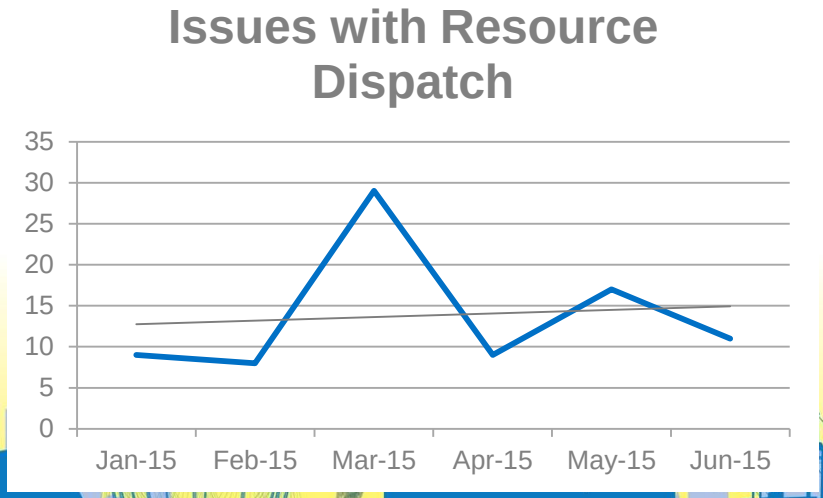
Patient Experience Department

- Upon analysis some of the issues that PED deal with are not so commonly seen in other areas of the organisation such as Legal Services and S&R. Acknowledging this, the largest current issue raised to PED is delays, especially in regards to C2 calls. This has been highlighted previously.
- Further contributing factors include referral to 111 and poor staff attitude. This is a continuing theme which is increasingly inked to challenging the validity of the 999 call and operational pressures. The 111 script has been changed to make patients feel more cared for.
- Other significant themes arising are;
  - Failure to triage at the appropriate priority
  - Welfare ring backs due to lack of capacity following delays
  - Application of the re-triage protocol
  - Mental health & self-harm protocol - asking if the patient feels violent which if they give an affirmative results in their being given a different service to any other comparable patient group
  - Advising people to leave their door unlocked thus making them potentially vulnerable when there is a long delay in an ambulance arriving
  - Advice not to move someone that can be unhelpful in the circumstances of a long delay
  - Failure to adhere to Trust policy regarding LAR
  - Poor triage of post-partum haemorrhage which was recently picked up as a patient story at the Trust Board

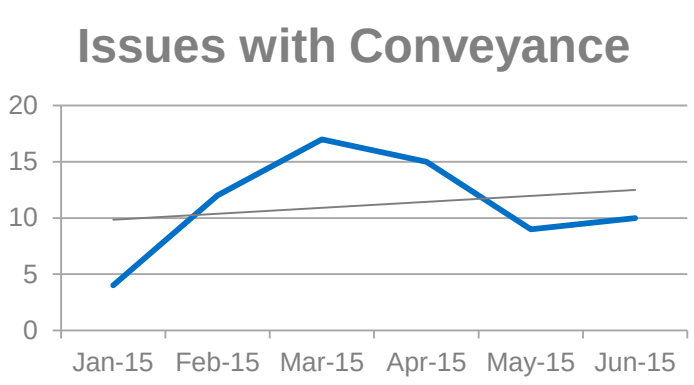
Safety and Risk

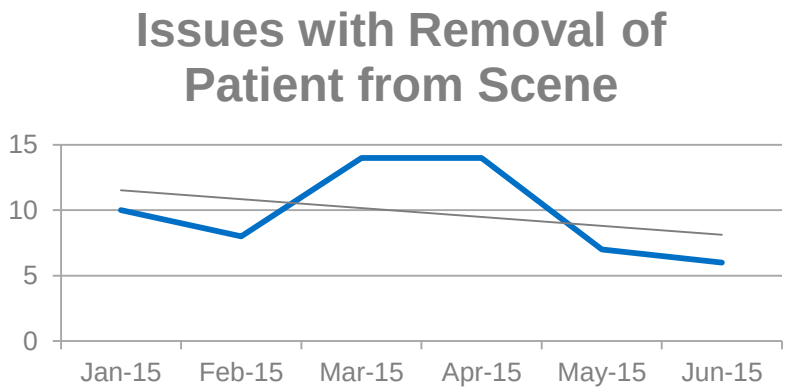
- The backlog created as a result of staffing shortages in Q1 2015-16 has been significantly reduced and it is planned that the backlog will have been cleared by the end of Q2 2015-16. Therefore figures extracted from Datix for Q1 2015-16 reflect the fact that not all incidents may have been entered for each month. For this reason data has been taken from Q4 2014-15 together with Q1 2015-16 to identify trends over the longer-term compared to a single quarter trend.
- There has been a slight reduction in patient safety incidents since January 2015 as demonstrated below. This, however, is not reflected in the short-term where the trend is more markedly downward, possibly reflecting the data entry backlog.
- By contrast the trend with Resource Dispatch Issues is gradually increasing. This trend is exaggerated in the short-term (Q1 2015-16), where the rate of increase is at a greater level. This may become an even greater rate of increase when the data backlog has been cleared.



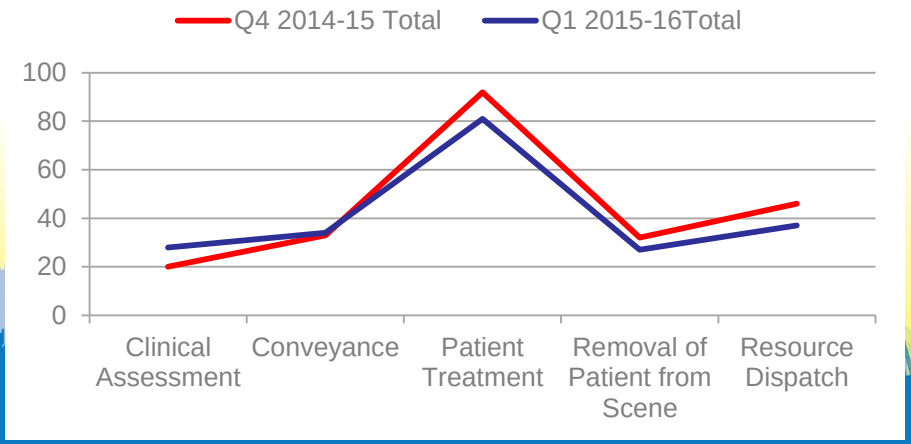


- Two other significant contributors to overall incidents are issues with conveyance and issues with removals of patients from scene
- Over the longer term (Q4, 2014-15 and Q1, 2015-16) the trend with Conveyance Issues is noticeably increasing. However, the trend in the short-term (Q1 2015-16), is by contrast markedly downward, possibly due to the backlog.
- The trend with Removal of Patients from Scene Issues is noticeably downward. This trend is markedly exaggerated in the short-term (Q1 2015-16), where the rate of decrease is at a greater level, although this would likely level out due to the backlog clearance





- The quarter totals (Q4, 2014-15 Q1, 2015-16) when compared show a close comparison in the rate of incident reported as can be seen in the chart below.



Legal Services

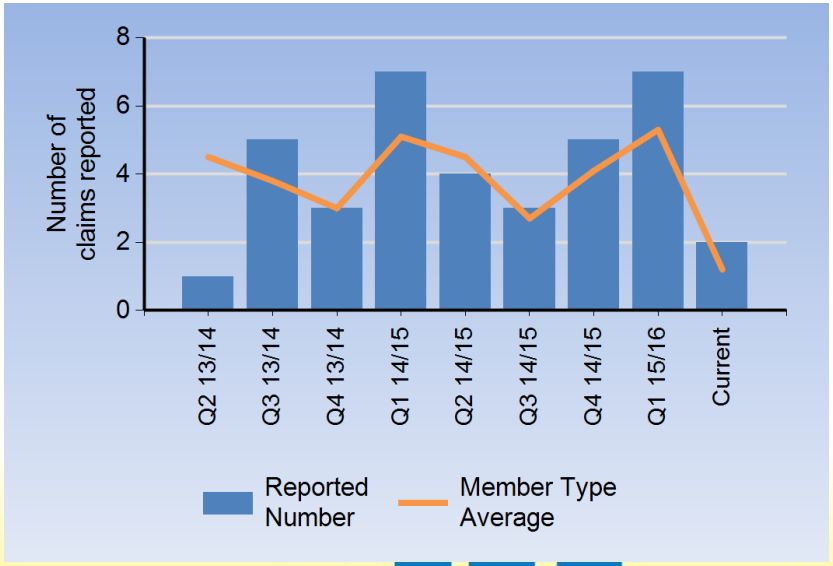
Claims

As of 30/6/2015 there were 36 clinical negligence claims reported and open with the NHS Litigation Authority compared with 35 in the previous quarter.

In 2014/15 37.5% of clinical negligence claims were closed after the payment of damages and 62.5% were closed without the payment of damages. The shelf life of clinical negligence claims against the LAS was 2.24 years compared with 2.8 years for other ambulance service trusts, 3.9 years for the regional average, and 3.94 years for the national average reported to the NHSLA.

Allegations made in the claims open on 30/6/2015 included :

- Assessment and treatment
- Spinal injury and immobilisation
- Obstetric emergency – time on scene
- Not conveyed to hospital
- Not recognising stroke may have occurred
- Call mis-triaged
- Delay in dispatch



Inquests

The number of inquest files opened has increased. In 2014 944 files were opened and in 2015 as of 30/6/2015 305 inquest files were opened. Of the inquest files opened 70 were identified as problematic / contentious in 2015 compared with 60 files in 2014.

From the review of inquest files conducted by the Clinical Advisor (Legal Services) the following issues were highlighted:

- Lack of capacity assessment
- Delay in transport / recognition of time critical features / lack of blue call
- Primacy of care by the senior clinician
- Mental health referral / safeguarding

The Clinical Advisor (Legal Services) added that there was some scope for further investigation / research into the human factors in decision making with patients who have time critical features identifiable from observations / presentation and then not transporting expeditiously or without a blue call. This was not to say that the delays necessarily caused / contributed to the patient's outcome.

Learning from Experiences

Theme 1 - Issues with Resource Dispatch

As to be expected with current operational pressures, ambulance delays continue to be a key theme across all reporting departments.

Findings

The largest two subcategories are inappropriate delay prior to resource dispatch and no ambulance dispatched due to lack of resources. Root causes incidents include inadequate resources at the time of the incident, increased service demand and delays caused by incorrect categorisation of 999 calls. There have also been incidents where FRUs were sent within the 8 minute target but a subsequent delay in an ambulance arriving caused harm to the patient(s).

Lessons learned include;

1. **The importance of welfare calls, including to gain a better understanding of the situation.** The comprehensive use of welfare calls can mitigate the risk of incorrect triaging of calls. However it must be noted that over 97% of calls audited are correctly triaged. Welfare call backs require sufficient and consistent resourcing in the CHUB
2. **There is no feedback mechanism to acknowledge the RIB has been read and understood by clinical staff.** However corporate communications are secondary to effective operational line management. The new Clinical Team Leaders with 50% management time built into workplans should help increase visibility of clinical updates.

Action plans

The organisation is acutely aware of the resourcing difficulties currently faced. Consequently actions plans for delay related Sis are relatively consistent. Key actions include;

1. EOC managers should undertake face to face briefings for all relevant EOC staff with immediate effect, highlighting:
    - Ring back prioritisation of vulnerable patient held calls
    - Establishing and noting when vulnerable patients are alone
    - Following established guidance when no reply is received on ring back. In particular widening resource availability during times of peak call volume by considering alternative resources
2. Continue expansion of the Clinical Hub and EAC recruitment to increase ambulance availability
3. Continue increased recruitment including 200 Australian Paramedics and retention, roster changes. Annual leave agreements are still in place and on target.

Learning from Experiences

Theme 2

Non-conveyance– Failure to convey patients has been identified as a theme in claims, adverse incidents and potential serious incidents. The Trust is undertaking a continuous non-conveyed re-contact audit to identify patients who re-present within 24 hours and require emergency conveyance to hospital. In addition CARU are also preparing a report in to the issue that is due to be complete by the end of the year.

Findings – In 2015-16 we have had 3 Serious Incidents declared and several more non declared incidents raised to SIG where a decision to not convey the patient was made and this later resulted in either a subsequent blue call to hospital or a patient death. Presenting conditions range from vomiting, epigastric pain, chest pain, elderly faller, diarrhoea and fainting. These can be complicated by mental health issues and refused conveyance and include two calls where no patient contact was made (call cancelled upon arrival and patient's son refusing entry)

Lessons learned include;

1. LAS guidance in relation to older fallers does not emphasise sufficiently the potential for significant underlying injury in older patients who have fallen and appear apparently well.
2. There is a drive within ambulance services to reduce unnecessary hospital admission in favour of accessing alternative appropriate care pathways such as Urgent care Centres. Although the criteria for conveyance or referral to such centres are necessarily broad, there needs to be acceptance that for an appreciable number of patients the appropriate conveyance destination will continue to be the nearest Emergency Department

Action plans-

1. LAS Falls guidance should be reviewed and updated where necessary to emphasise risk assessment in relation to antiplatelet agents
2. Mental capacity assessments should be evidenced where a patient is refusing to be conveyed
3. Further actions and conclusions to be made following the CARU Non conveyed recontact audit. In addition to this all cases that are potentially SIs will continue to be taken to SIG for review.

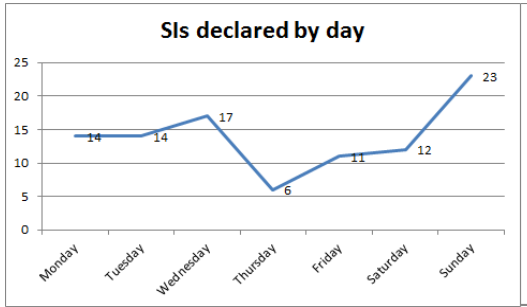
Learning from Experiences

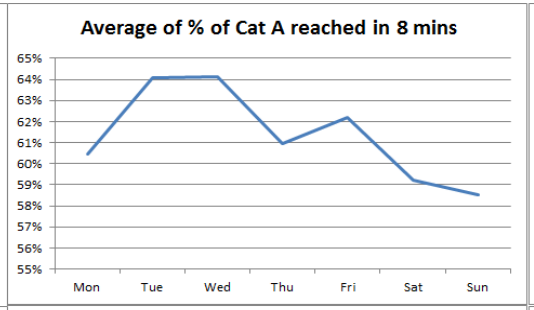
Theme 3 - Sunday

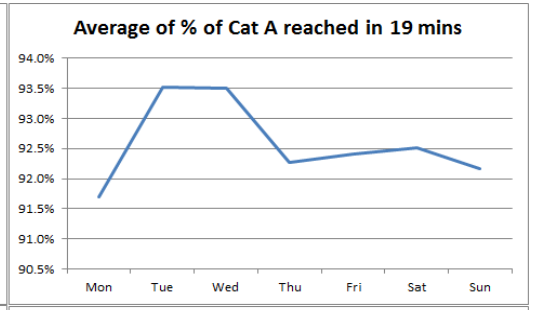
Over the last 2 years the LAS have declared more Sis in relation to actions taken on a Sunday than on any other day with 23 compared to an average of 12 on the other 6 days. Over the Period of April 2014 to June 2015 Cat A8 performance has been 58.5% on a Sunday compared to 61.4% throughout the rest of the week. Sunday CatA19 performance has been closer to the average with 92.2% compared to 92.6%. The average number of CatA incidents is 2.2% higher on a Sunday than for the whole week, however the average number of total incidents is 1.7% lower than the average. As can be seen below the average number of hours worked on a Sunday is less than the rest of the week which may explain the increase in SIs due to resource issues.

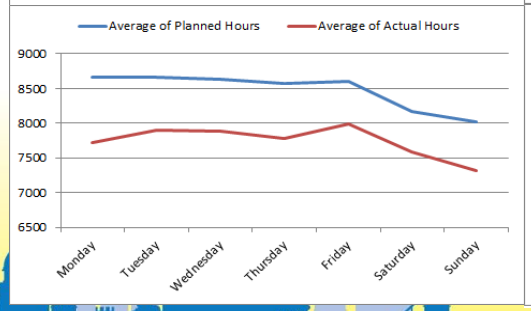
Findings

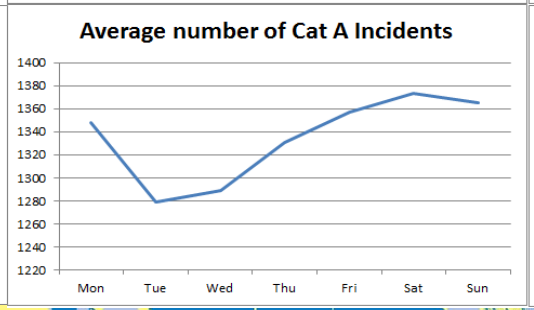
Out of 23 SIs declared for actions taking place on a Sunday, 11 of these are related to resource levels. This suggests any spike in activity on a Sunday would be difficult to respond to and there is a higher level of risk for patients. Sunday has had the highest CAT A demand for the week on more occasions than the other days (16 occasions), but Monday is a close second with 14 occasions.

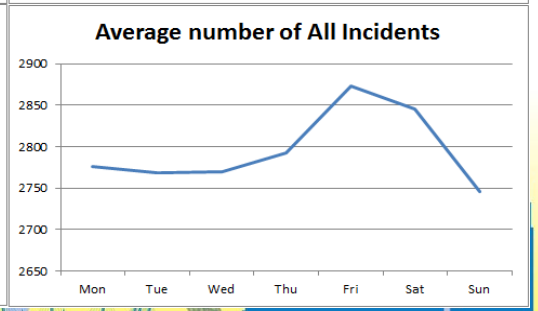












Lessons learned include;

1. The importance of effective job planning. This must reflect CatA demand which peaks over the weekend before dropping on Tuesdays and Wednesdays. Skill mixes should also reflect the Cat A demand while acknowledging the overall drop in demand.
2. Poor hospital turnaround times reduce the numbers of active crews at any one time

Action plans

1.The Head of Resourcing is aware of the link between particular days of the week and Increases in SIs. There are comprehensive resource plans in place but evidence states more staff are on leave or report sick over weekends. In the past when we were closer to establishment we did target overtime to when we believed it gave the greatest benefit but that is not possible at present with the amount of shifts we have to cover. However if Sunday staffing is maximised there is a risk of a cost earlier in the week. Directed overtime bulletins offering triple time OT for week-ends only have been used, making a difference but at an unsustainable cost.
2. CHUB staffing needs to reflect demand to help improve resource dispatch
3. NETs are being used to tackle calls of lesser severity to free up resources

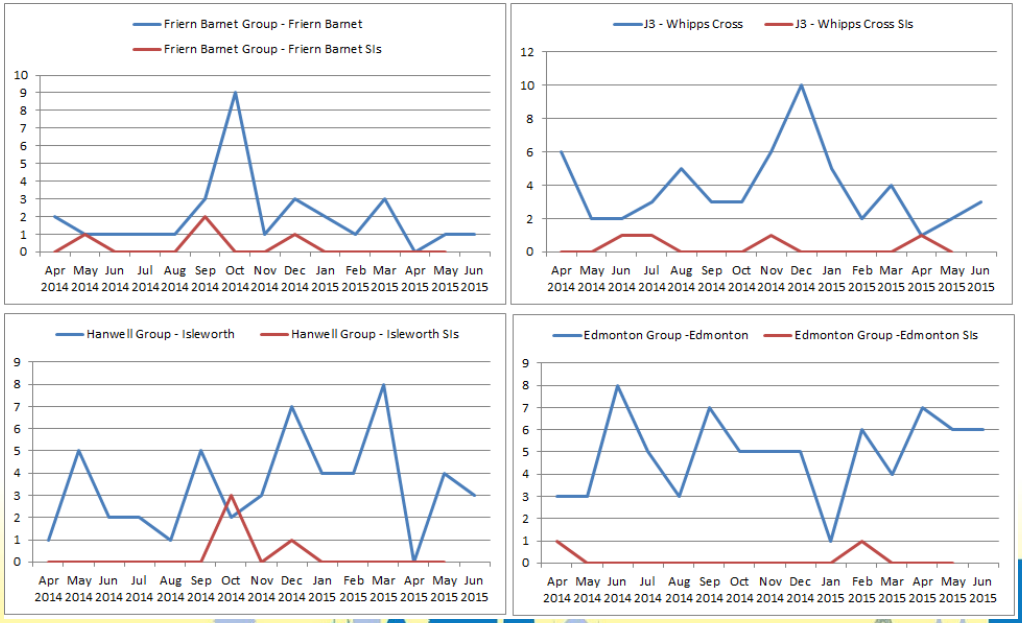
Learning from Experiences

Theme 4 - Geography

By analysing the number of SIs occurring by station from 2014-15 to Q1 and comparing it to the total number of patient safety incidents raised by station it is possible to pick out certain emerging trends that may demonstrate an increase in risk in different London boroughs. It is important to recognise however that this increase may simply reflect a more open reporting culture.

Findings

Over this period three stations have had 4 SIs declared, Friern Barnet, Isleworth and Whipps Cross, the highest across LAS. The % of SIs to patient safety incidents on these three stations are 13%, 8% and 7% respectively compared to a Trust average of 3%. Whipps Cross station has raised the 4th highest number of patient safety incidents in this period, with Isleworth in 7th place and Friern Barnet in 24th place. Therefore it is likely that all Friern Barnet in particular is a relative under reporter of overall incidents. Equally Edmonton station has raised the highest number of patient safety incidents in the period while keeping % of SIs in line with the Trust average at 3%. It must be acknowledged that due to the small number of SIs in total, if a couple are declared in a short time period for a station it will skew the results. However each station should be encouraged to report as much as possible using LA52s. In addition it is important to point out that Islington, Croydon and Deptford have all had 2 SIs in the first 6 months of this year compared to 1, 1 and 0 respectively for the previous 9 months, a marked increase.



Lessons learned include;

1. The Datix implementation project is crucial to ensuring an active and open reporting culture. The ease of which incident reporting can be done must be maximised by exploring the use of mobile devices and call centre options in addition to LA52 pads on vehicles
2. Recent increases in SIs at particular stations could be used as barometers of safety and help identify pinch points in the service.

Action plans

1. Continue with Datix implementation and focus on communications and local training to ensure increases in usage of the system results in a open and reflective reporting culture.
2. Using basic analysis of SI trends it will be possible to identify where stations may have local issues that can be picked up and tackled. The analysis will mitigate any randomness within the individual SIs. This has been done in the South East following an increase in Potential SIs coming to SIG.