London Ambulance Service NHS Trust

Learning from experience

Quarter two 2015-16

Introduction

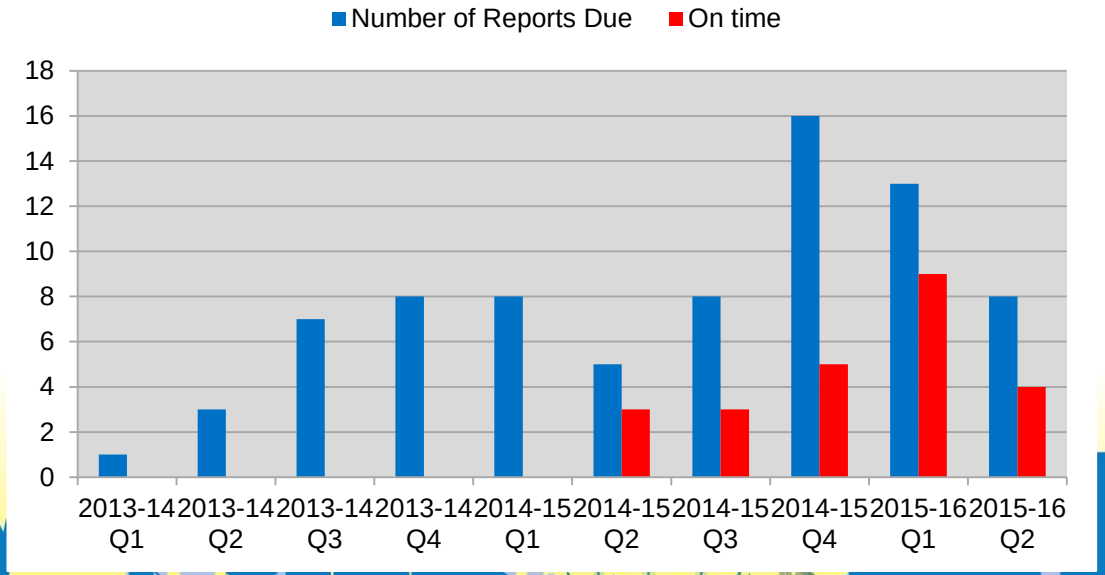
- The purpose of this paper is to present the pan-organisation themes emerging from Serious Incidents, Claims, Inquests, Complaints and Safety and Risk on a quarterly basis.
- *"The Investigation and Learning from Incidents, PALS, Claims and Complaints"* policy (TP054) supports the Trust's commitment 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.
- For the Q2 report we have also included an update from the Patient and Public Involvement and Public Education Committee
- The report will cover the previous quarter unless otherwise stated, in this case Q2 2015-16 although the analysis itself may take into account before July 2015.

Executive Summary

- In Q2 the top 4 areas for incidents affecting a patient were issues with patient treatment (88 incidents, an increase of 5 on the previous quarter), resource dispatch (59 incidents including 29 inappropriate delay prior to resource dispatch), conveyance (30 incidents) and removal of patient from scene (46 incidents). These figures are extracted from the current build of Datix where there are acknowledged issues with subcategory coding, limiting effective analysis. This will be resolved with the new implementation of Datixweb in Q1 2016-17.
- In Q2 there were 273 complaints, an increase of 33 on the previous quarter but 89 less than the same period for last year of which the 2 largest subjects were delays (123), attitude (68). The largest contributing areas for complaints were Control Services (136), South East Sector(32), South West area (16).
- 112 incidents were considered at SIG, with 19 incidents declared as SIs. Of these 4 have issues with patient treatment and 3 had issues with resource dispatch with ambulance delays due to resource levels below planned appearing as a contributing factor across several.
- It follows from this that in addition to departmental updates that several overriding themes will be analysed using the statistical evidence, thereby identifying the core issue, presenting lessons learned and actions planned to mitigate reoccurrence. The 5 themes are
  1. Delays as a result of dispatch of resources during the beginning or end of a shift
  2. The spread of serious incidents (SIs) over the days of the week - Update
  3. Information Governance incidents
  4. Delays due to satellite navigation systems
  5. Delays in arrival due to the unprecedented levels of demand in the control room

Serious Incidents

- During Q2 2015-16 19 SIs were declared, compared to 9 in the previous quarter. In total there were 112 incidents that were presented to SIG (an increase of 75%), with 17% on average being declared. 5 Serious Incidents took place in the North Central, 4 in the South East and 3 in East Central and South West.
- Over Q2 there were 11 SIs that were completed and submitted to the CCGs with a further 2 incidents proposed for de-escalation. There were 3 overdue SIs awaiting closure at the end of September at an average of 119 days overdue(skewed by a report requiring compiling from several providers following an End2End review), and this figure has increased to 7 by Mid November but with a significantly reduced average overdue time of 25 days, although one of these reports is completed and will be submitted following agreement from the family. The remaining 6 overdue reports are progressing towards finalisation. However it must be acknowledged that the number of overdue reports is contributed to by a 100% increase in SIs declared from September compared to the first 5 months of the year and a shortage of experienced Lead Investigators.
- The chart below shows a the number of reports being completed and closed within the 60 day timeframe with the column in blue showing the number of reports due and red the number of reports submitted within the timeframe. To note for Q2 although there is drop in the number delivered on time, the average days to submit an overdue report was just under 10 days.



Serious Incidents

- Out of the 19 SIs declared 8 originated as R2 calls and 6 either C1, C2, C3 or C4 calls. Of note 9 incidents declared in Q2 involved a patient in cardiac arrest, a theme to be further explored in a future report. Emerging new themes, some of which will be explored in the report are as follows;
  - Missing PRFs from FRU vehicles, either due to a failure to properly secure the documents when driving the vehicle or issues at station.
  - Issues with accessing new build addresses and E20 Olympic Park due to Satellite Navigation failures. These will also be picked up via the Risk Register
- A number of the SIs had a paramedic as the member of staff with clinical primacy and this will be explored in a future report as we aim to explore routes of qualification with help from the Medical Directorate.
- Over the course of Q2 SIG reviewed 75% more incidents than in Q1, a symptom of a more open reporting culture that demonstrates greater faith in the SI process.

Patient Experience Department

- During Q2 for 2015/16 we received 273 complaints, this is lower than Q2 - 2014/15 (362). 914 PALS enquiries were managed in Q2 - 2015/16 which is also lower than Q2 - 2014/15 (972).
- 10 complaints were considered as a possible Serious Incident with 3 being declared by the Trust. Complaint themes evidence that delays are the most predominate (123 - 45%) with conduct and behaviour the second highest (68 –25%). Other subjects include road handling (26 – 10%), non-conveyance (15 – 5%) and treatment (17 – 6%).
- Complaints that relate to delays are attributed to Control Services, an issue that is currently being reviewd. The following table demonstrates the spread of complaints for Q2.

Complaints by Area	
Control Services (EOC, UOC, CTA etc)	136
A&E Operations - South East Sector	32
A&E Operations - South West Sector	16
A&E Operations - West Sector	15
A&E Operations - North Central Sector	14
Not our service	13
A&E Operations - North West Sector	10
A&E Operations - East Central Sector	9
Contracted Services	7
A&E Operations - North East Sector	7
Unknown or No Trace	4
Patient Transport Services	3
111 Beckenham	2
LAS Headquarters	2
Clinical Hub	1
Community and Co Responder	1
Hazardous Area Response Team	1
Totals:	**273**

Patient Experience Department

Emerging Trends from Q2 complaints

- The interface between LAS and 111 providers causing confusion to patients as to whether ambulances would be dispatched, despite clear closing instructions.
- Inappropriate referral of a patient to attend hospital when in the later stages of labour, the crew should have contacted the nearest labour ward and sought advice from the hospital.
- Clarification of treatment of wounds, we advised that we do not routinely irrigate deep wounds as this procedure is more effective when carried out in a hospital environment and best practice is to carry this out within one hour.
- Following a delay in an ambulance being dispatched, the family were advised that pre-existing conditions and certain types of pain can be especially difficult to assess at initial telephone triage as this can be indicative of a wide range of conditions. The risk is mitigated in that NHS 111 can always arrange an ambulance where their enhanced assessment indicates that it is appropriate.
- Clarification of the rationale for referring lower acuity patients to GP's for further assessment

Patient & Public Involvement & Public Education

Events

During the period of July/August/September we have 181 event requests on our event database. Of these we have attended 134. Staff attend events and often to this in their own time. We have 1001 members of staff on our interested staff list and since January 2015 211 staff have been actively involved in public education.

Types of events we attend are:

Alcohol awareness
Careers
Deaf awareness
First aid badges (Brownies, Cubs etc)
Knife crime awareness
Mental health
People who help us/Jobs on the move/Superheroes
BLS and cardiac awareness
Drugs awareness
Diabetes, stroke and other condition specific messages
Junior Citizen
Learning disabilities
Older people, e.g. pensioners' groups
Road safety initiatives

Key areas of focus within the department are;

- **Mental health focus groups** - We want to improve the services we decided to speak to people who have experience of having a MH condition and have used our services in the past. We held 7 MH focus groups including one for staff across London between March and September 2015, each involving a small-group discussion guided by a trained independent facilitator and we await the final recommendation report.
- **Dementia focus groups -** We have decided to have another 4 focus groups aimed at dementia patients and their carers by December
- **Taxi survey** - We are currently in the process of arranging a survey to patients who have been sent a taxi after calling 999. So far the questions have been designed and we are waiting for the clinical hub to send us data of patients who have been asked their consent to take part in the survey.

- **Safe Drive Stay Alive (SDSA)** - SDSA is a partnership between the emergency services, TFL and 13 London boroughs. It has been running for 10 years in London and is delivered in theatres to audiences of between 300 – 600 16 – 19 year olds and shows them the consequences of dangerous driving. The objective is that the audience learns the five main causes of a crash, together with avoidance strategies.

  The success of SDSA comes from tight quality control and the credibility of its presenters. It takes place against the backdrop of a film about a crash, involving young fatalities. At strategic moments throughout the course of the film, a paramedic, other members of the emergency services, together with members of the public who have been victims of road crashes, share their real life experiences. The impact on the audience is dramatic and the feedback from the thousands of young people, and teachers, who have witnessed the event (in excess of 15,000 this year), has been positive.

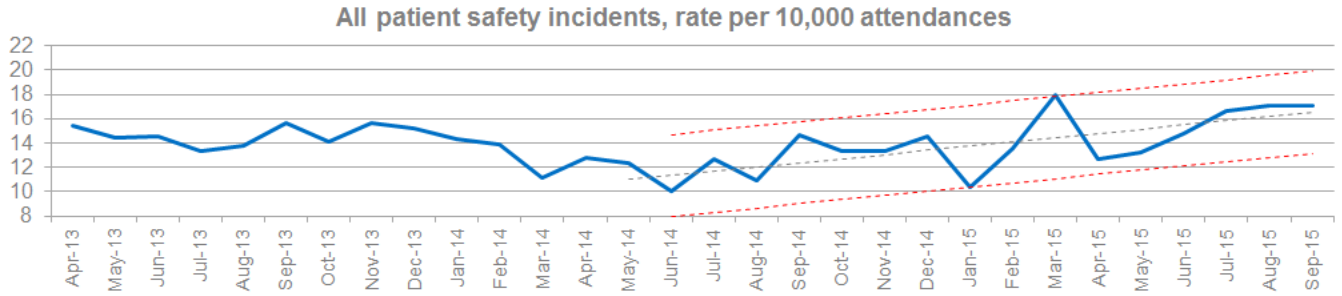
  The programme has also been run for adult and experienced drivers with a similar outcome.

- **Friends and Family Test results – Q2 (FFT)**

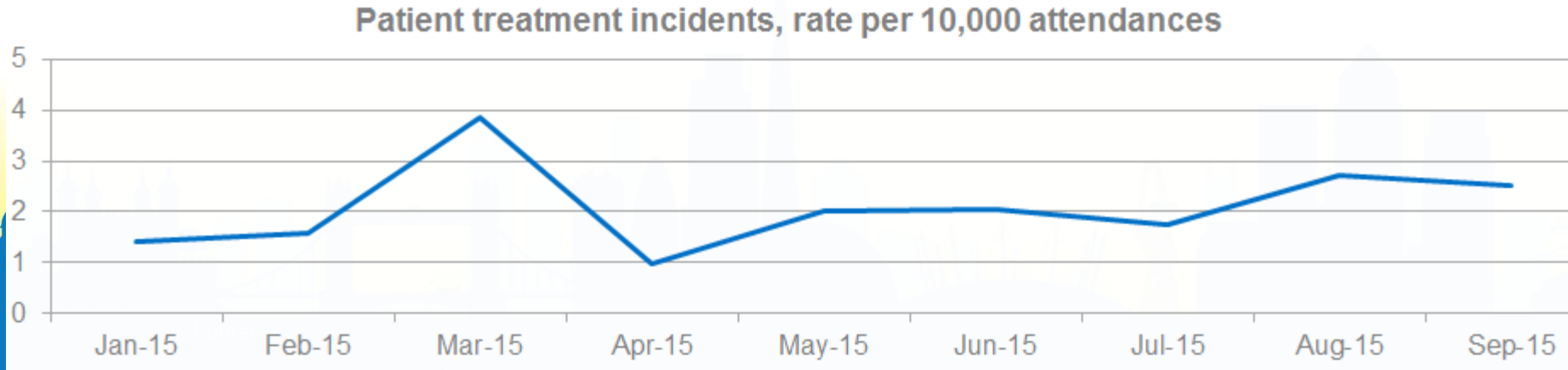
Friends and Family Test figures			
	Jul-15	Aug-15	Sep-15
Extremely likely	14	4	5
Likely	5	1	0
Unlikely	0	0	0
Neither likely or unlikely	0	0	0
Extremely unlikely	0	0	0
Don't Know	0	1	0
Blanks	0	0	0
PTS responses	14	3	4
Number of PTS journeys	7412	4084	4562
See & treat responses	5	3	1
Number of see & treat patients	22229	22431	21615

Safety and Risk

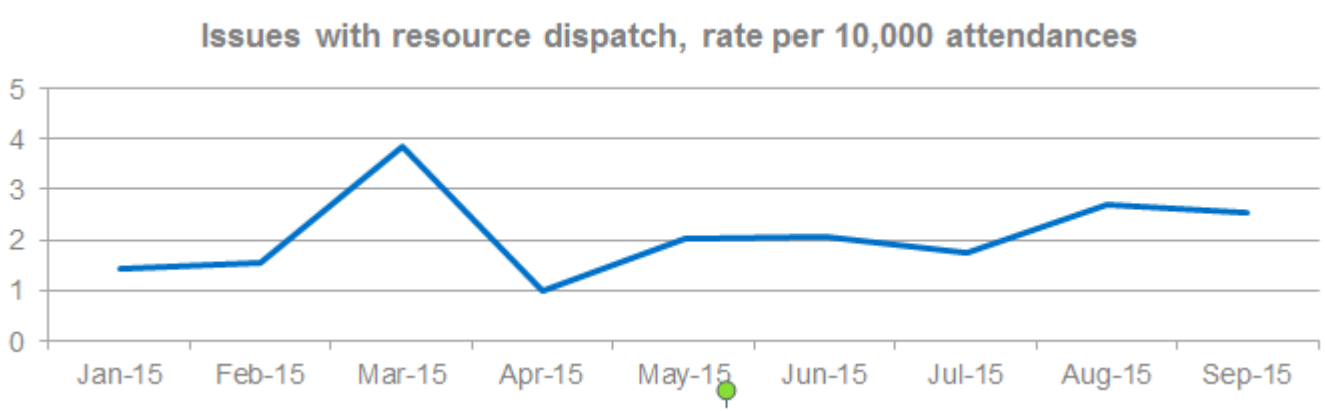
- The backlog created as a result of staffing shortages in Q1 2015/16 has been cleared. Received incident forms are now entered onto Datix within an average of 1.6 days from the day of receipt, compared to 26.5 days in June 2015.
- Reports of all patient safety incidents (including clinical incidents) have been steadily rising in number since June 2014, a trend that continues. In terms of incident rate, there is a current rate of 17.1 reported patient safety incidents per 10,000 attendances (approximately 1 incident in every 584 attendances).

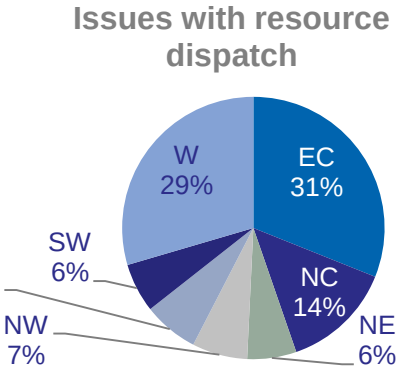


- Issues with patient treatment remain the most common patient safety incident, and remain steady at a rate of 3.5 reported incidents per 10,000 attendances (~1 in 3000).

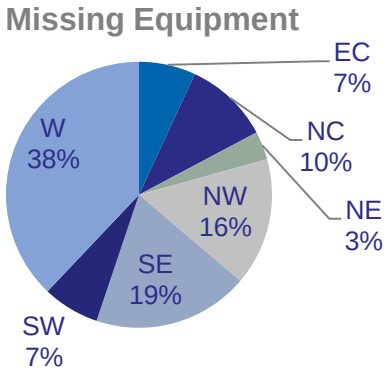


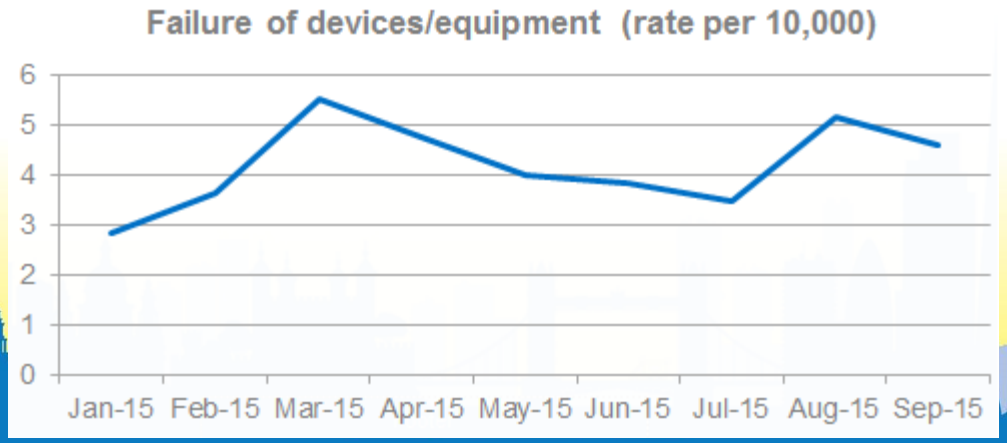
- Issues with resource dispatch have been rising slowly since April 2015, now being reported at a rate of 2.5 incidents per 10,000 attendances (1 in 4000). This is predominantly in the West (29%) and East Central sectors (31%), although it must be noted that EC reports a higher number of incidents overall due to their participation in the Datixweb Incident Reporting Trial.

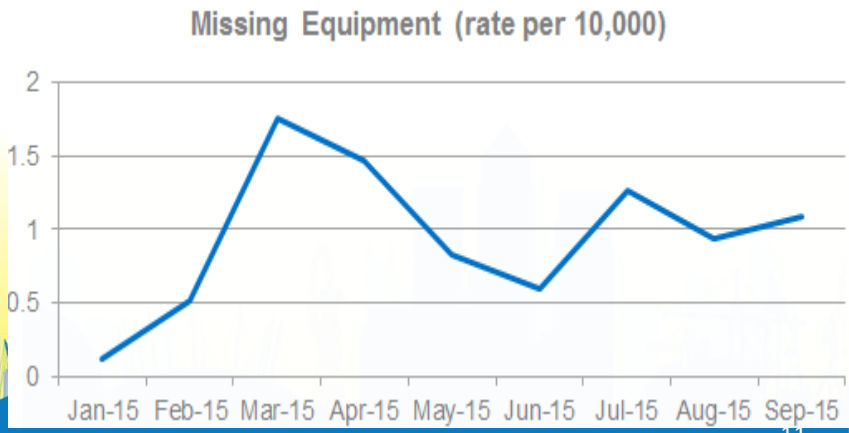




- Issues with failure of devices and equipment, and issues with missing equipment, continue to steadily rise. Currently 4.5 attendances out of 10,000 experience an equipment failure (~1 in 2200), and about 1 in 10,000 experience missing equipment which causes a detriment to patient care. Over a third of all reported cases of missing equipment originate from the West sector, 30% of these involving missing technician drug packs.







Legal Services

Claims

The NHS Litigation Authority have provided member Trusts with claim scorecards which identify the value and volume of claims by cause giving rise to the claims and by injury to the claimants. The scorecards were taken from data held by the NHSLA as at 30 August 2015 on reported claims arising from incidents between 1 April 2010 – 31 March 2015. The scorecards for the LAS are summarised below. High value claims are defined as having an estimated value of £1 million and over, and low value as less than £1 million; high volume is defined as 3 or more claims and low volume as less than 3 claims. The LAS had reported 60 claims with an estimated value of £21,356, 000.

Table 1 – cause of claim

Cause	High value high volume	High volume low value	Low value low volume
Fail / delay referring to hospital	1	6	3
Fail / delay treatment	2	16	
Fail / delay admitting to hospital	1	10	1
Lack of assistance / care		5	
Inappropriate treatment		4	
Fail to recognise complication of treatment		1	
Fail to supervise		2	
Fail / delay diagnosis		1	
Operator error		2	
Unexpected death		1	
Self harm			1
Other		3	
Total	4	51	5

Table 2- injury claimed

Injury	High value high volume	High volume low value	Low value low volume
Cerebral palsy	2		
Brain damage	1	1	
Other infection	1		
Fatality		24	3
Fracture		6	
Cardiac arrest		5	
Unnecessary pain		4	1
Liver damage			1
Psychiatric / psychological damage		2	
Cardiovascular condition		1	
Stroke		1	
Scalp damage		1	
Amputation - lower		1	
Loss of baby		1	
Poor outcome – fractures etc		1	
Anaphylactic shock / allergic shock		1	
Removal of testicle		1	
Cosmetic disfigurement		1	
Total	4	51	5

Legal Services

Table 3

The claims scorecard data showed that delay was cited in 41 out of 60 claims. Table 3 sumarises the reasons for delay. In 7 claims it was alleged the patient was not conveyed to hospital and that resulted in a delay in treatment.

Cause of Delay	Number of Incidents
Conveyance Time	16
Lack of Resources	6
Triage Error	6
Triage Error and Lack of Resources	3
Triage Error and Conveyance Time	3
Not Conveyed	7
Not a Delay	19
Total	60
Total Incidents involving Triage Error	12
Total Incidents involving Lack of Resources	9
Total Incidents involving Conveyance Time	19

Inquests

The number of inquest files opened has increased further. As at 30/9/2015 634 inquest files were opened, compared with 944 files in 2014. Of the inquest files opened in quarter 1 30 were identified as problematic / contentious and 39 in quarter 2.

From the review of inquest files conducted by the Clinical Advisor (Legal Services) the following actions / learning were identified.

- To audit whether blue calls were placed appropriately – in reply CARU advised that these were included in the CPI checks on PRFs and in October 2015 195 out of 215 calls deemed to be time critical a blue alert call was made, showing a 99% compliance with the CPI. However, CARU recommended that data should be quality assured and this could be undertaken by peer review.
- To alert staff in the core skill refresher training under hot topics to the risk of taking false assurance from a patient's ability to speak and having a GCS of 15 despite having abnormal observations.
- To remind EMTs about their role and taking primacy of care when working with TEACs in discussions between crew staff and clinical team leaders or the re-issue of the TEAC scope of practice with a prompt on primacy of care.

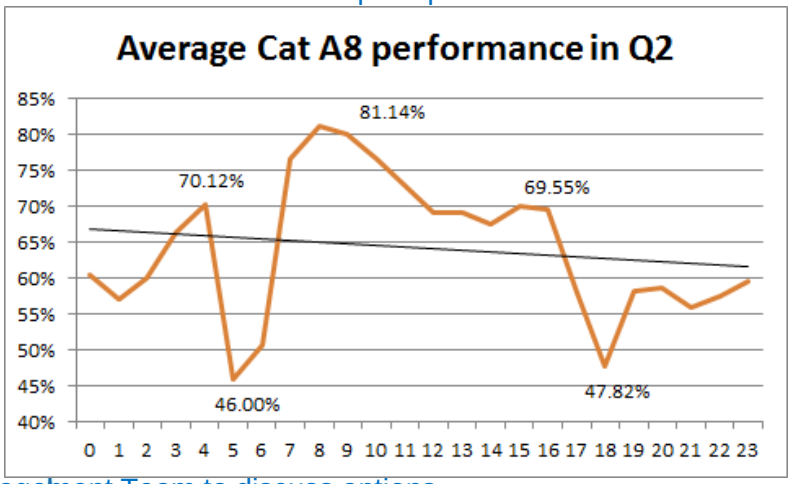
Learning from Experiences

Theme 1 - Delays as a result of dispatch of resources during the shift changeover

As to be expected with current operational pressures, delays due to variances in the number of crews available during shift changeover times have contributed to several Serious Incidents

Findings

An analysis was done of the 19 SIs that were declared in Q2 2015) within which 11 incidents had crews in attendance. Of these, 4 SIs (36% of the 11 SIs) occurred around the hours of 6am and 6pm (16% of the day) when it was possibly the start or end of the shift for the ambulance crew. It is not possible to confirm actual shift start and finish times for each crew, however based on the crews' call signs their start/end times are around the same time as the incident. This demonstrates a correlation between shift changeover and Serious Incidents. Further analysis was conducted on the incidents raised to the Serious Incident Group but not declared or that an internal concise investigation was requested. Of the 13 undeclared incidents involving an ambulance delay, 7 incidents occurred around the same time as the changeover between shifts. See below for average CatA8 performance across the day for Q2, noting drops at the two shift changeover times. This is matched by C1 and C2 performance which follow the same drops in performance level.



Lessons learned include;

The organisation will need to explore various options for reducing the impact of a drop in available vehicles at shift changeover.

Action plans

This issue is being discussed at a subgroup of the Senior Management Team to discuss options for mitigating this risk and reducing the number of SIs that occur during shift changeover periods. Any actions resulting from this will be submitted to the SMT.

Learning from Experiences

Theme 2 Information Governance – Missing PRFs

There was one declared Information Governance (IG) SI in Q2 involving the loss of patient data due to documentation not being handed in correctly at the end of a shift. Due to the number of PRFs lost, the occurrence of similar past incidents and the data on the forms this was declared as an SI. Other similar undeclared incidents occurred involving the loss of patient data across Q1 to Q3, however the amount of documentation did not meet the Information Commissioners Office threshold for declaration..

Findings – The two themes which emerged from the IG incidents was paperwork being left on vehicles and discovered either by staff or the public outside the ambulance station, and paperwork being passed to another staff member to complete drug forms, whereas they should have been placed in the secure drop-off or 'black box' at the station.

Lessons learned include;

IG training is of paramount importance for all LAS staff including operational staff.

Care needs to be taken when handling PRFs and ensuring that all PRFs are handed in at the end of the shift

Action plans

1. IG training for all staff who have reported missing PRFs
2. Senior Managers exploring methods for reducing the risk of losing PRFs
3. Local Sector managers exploring processes at stations affected and reminding staff not to leave PRFs unsecured while driving, especially those on FRUs

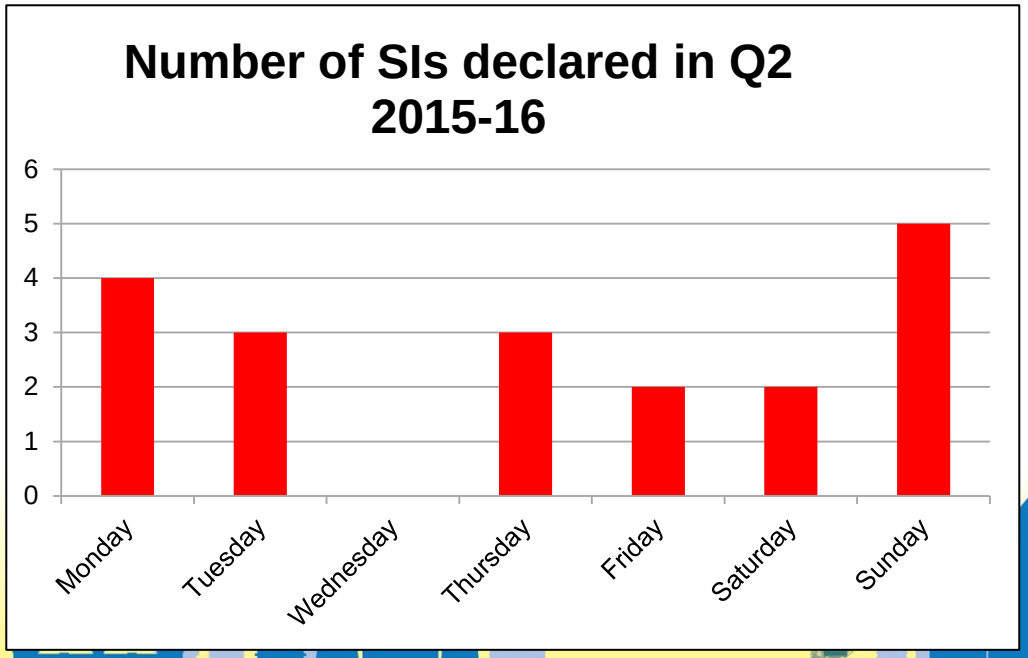
Learning from Experiences

Theme 3 – Sunday Revisited

In Q1 it was found that there were more SIs that occurred on a Sunday than on any other day, and due to the increase in SIs in Q2 we thought it would be worthwhile to look at this issue again with the benefit of further data.

Findings

During Q2 more SIs again occurred on a Sunday than on any other day, however the difference was much less dramatic. This could be due to the same size being smaller than that explored in the Q1 report which looked back to “013-14, however it does still support the message given previously. In Q2 5 incidents occurred on a Sunday, compared with 4 on a Monday, 3 on a Tuesday or Thursday and 2 on a Friday or Saturday. No incidents occurred on a Wednesday in Q2 (see chart below). There were an average of 1372 Cat A calls on a Sunday compared to an average of 1324 for the rest of the week, with Saturday the highest with 1395 and Tuesday the lowest with 1254. Sunday Cat A performance was on average 62.5% compared to 65% for the rest of the week.



Lessons learned include;

The trend with increases in SIs on Sundays and over the weekend period is continuing. Therefore the lessons learned remain from Q1. However it must be acknowledged that an action plan to mitigate this is required.

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

This issue is being referred on to a subgroup of the Senior Management Team to discuss options for mitigating this risk and address the number of SIs that occur on Sundays including the resource levels. Any actions resulting from this will report into the Clinical Safety and Standards group..

Learning from Experiences

Theme 4 - Satellite Navigation system issues and delays

There was one declared SI because the satellite navigation system on a vehicle was not updated with the roads within the Olympic Park to enable the crew to access the Velodrome. Additionally, there was an RCA requested for an incident involving the E20 postcode, and this is being looked into. One further incident involved a new-build address that was not on the system, resulting in a delay in attendance. This incident has not been declared but the risk is being added to the Risk Register.

Findings

The access to E20 Olympic Park, (in particular the Velodrome) is difficult, especially for crews not used to the area. In addition with the large increase in new property developments across Greater London the need to acknowledge the risk of not being able to find new builds must be done formally. LAS Sat Navs are updated on a regular basis but may not keep up with the pace of property development and are reliant on individual postcodes being registered in a timely fashion.

Lessons learned include;

Crews were not always aware that the satellite navigation on ambulances may not accurately route to addresses in E20

Crews have had to rely on EOC being able to talk them into new build locations.

Action plans

1. An audit was quickly put into place with a corresponding Map book replacement plan initiated.
2. Edition 14 map books are actively being put onto all vehicles and paper maps are available on all stations.
3. This has been included in the RIB twice in November
4. The risk regarding updating of new build properties is currently being discussed.

Learning from Experiences

Theme 5 - Delays in attendance due to unprecedented demand in the control room

The LAS uses a Surge policy to ensure that the sickest and most seriously injured patients receive the appropriate and fastest response during period of unprecedented demand. The demand pressure may be due to increased 999 or 111 calls or reduced availability of resources (delayed at hospital, increased sickness, vacancies) or planned/unplanned incidents. The decision to escalate the surge level is made by the 'Gold' team and is done to proactively mitigate the risk for patients. Senior clinical and operational oversight is maintained throughout to ensure it is appropriately managed.

Findings - It was possible to ascertain the Surge level for 15 of the 19 SIs for Q2 and in 12 of these cases the Service was operating at the agreed surge level of Red where the lowest acuity C calls (C3 and C4) may be advised to contact NHS 111 for a further assessment.. For one SI the Service was at Purple (originated as a C2), and for a further two the Service was at Purple Enhanced (one originated as a C2, one as an R2). For the Purple enhanced SIs, However looking back over the last year there have been 5 further SIs on days where the organisation has taken the decision to go to surge purple or purple enhanced due to the high level of demand. This would suggest that there is a correlation between the demand being experienced and the risk of a Serious Incident occurring.

Lesson learned include;

The Trust runs a higher risk of Serious Incidents when levels of demand are at extremely high levels.

Action plans

It is imperative that regular reviews of the Surge plan to ensure triggers for escalation and de-escalation remain appropriate.