# Independent harm analysis of seasonal SI cases – summary of findings

## Background

Following a Risk Summit chaired by NHS England in January 2018, 22 SIs were declared as a consequence of an internal Trust document being presented to MPs detailing potential patient safety incidents. These incidents pertained to specific delays in ambulance attendance from 17 December 2017 to 16 January 2018. As such, the Risk Summit panel Chair asked for an independent review of these cases and oversight of the potential harm that may have been caused to those patients arising from those delays. An approved SI panel was convened to assure the SI process which sat weekly. An independent harm analysis of those 22 incidents took place on 20 February 2018 and on 26 April 2018.

For clarity, two of the cases were not ready for review until 26 April 2018. Both of these cases have now been reviewed by HM Coroner and the final independent harm analysis has been added to this report. All cases have been assessed by the same panel members using identical methodology since the required information has been received.

## Rationale

Due to both the nature and sensitivity of the cases and as recognition that this analysis could have national learning as an outcome, the Trust's regulators required an additional process outside of the Trust's formal governance processes for additional oversight.

## Membership

The panel comprised of:

Dr David Kirby - Consultant in Emergency Medicine

Dr April Brown - Senior Clinical Lead from NHSI

Cath Slater - CCG Associate Director – Nursing and Quality

Kate Barlow - CCG Quality Assurance Lead for Out of Hospital Services (Interim)

EEAST were represented at the panel for the provision of information at the panel's request. They were not involved in the decision-making process. Representatives were the Deputy Director of Clinical Quality, Safety and Risk Lead, patient safety officers and Head of the Portfolio Office.

## Terms of Reference

- To review all cases against the core criteria of the Risk Summit action; `was harm caused by a delay in ambulance attendance' using the established National Learning and Reporting System (NRLS) Framework as a benchmark
- To review any information from the Trust using all available resources, including open and transparent access to Trust reporting platforms, patient care records, information

from other healthcare partners, patient or relative requests and lastly, consider any information from HM Coroner

- To reach a majority decision on cases where the panel may not be in full agreement with the Chair of the panel (Consultant in Emergency Medicine) taking any final decisions
- To review those decisions against the initial reporting of harm by the Trust

It is important to mention the discussion by the panel and the Trust pertaining to the decisions that had already been reached by HM Coroner in these cases. Whilst this information was not used to influence the panel's decision, this harm analysis was only based against the NRLS criteria of harm and was not in any way to contradict or challenge any decision from HM Coroner as those are based strictly on legal and medical criteria and expertise. The panel recognised that the definition of harm is solely against the NRLS criteria and should not be confused with or be seen to challenge the established coronial processes.

Methodology

Using a line by line approach, each SI to be identified by its DATIX WEB reporting number in order to maintian patient anonymity.

The DATIX report to be reveiwed for the intial information and panel ask for specific information to aide their questioning. At the introduction of further information, the panel discuss and debate the case from time of the initial ambulance call to arrival time, treatment, onwards conveyance where appropriate and patient experience and outcome. As patient care records are availaible, previous medical history may be considered with the acknowledgement that not all cases have in-depth details and the panel may not know the full scope of the patients medical or social history.

The panel will discuss, debate and challenge the information leading to a conclusion against the NRLS framework.

Once decided, any information from HM Coroner may be reviewed and further consideration given to the case where appropriate.

A summary of findings are as follows. According to the National SI framework and as discussed and agreed within the panel, the initial harm code provided by the Trust is prior to an investigation and/or receipt of all related information. As such, this assessment was always stated as tentative and subject to change.

**Summary of harm:**

Harm in the sense of the coding for NRLS is defined as *injury, suffering, disability or death*[1].

- **No Harm** No discernible harm caused by the patient safety incident
- **Low Harm** Any unexpected or unintended incident that required extra observation or minor treatment and caused minimal harm to one or more persons.
- **Moderate Harm** Any unexpected or unintended incident that resulted in further treatment, possible surgical intervention, cancelling of treatment, or transfer to another area, and which caused short-term harm to one or more persons.

- **Severe Harm** Any unexpected or unintended incident that caused permanent or long-term harm to one or more persons.
- **Death** Any unexpected or unintended event that caused the death of one or more persons.

*For clarity, death in the context of NRLS reporting states the following example: *An ambulance responding to an emergency call on blue lights goes through red traffic lights at an intersection. A car approaching the intersection has a green light, does not see the ambulance and attempts to cross. The ambulance is unable to stop and hits the car on the driver's side. The driver of the car suffers multiple injuries and later dies in hospital.*

The following table is taken directly from the NRLS coding:

| PD09 Mapping | Degree of harm (Severity/Actual Impact on patient) |
|---|---|
| No code | No harm |
| B | Low (Minimal harm - patient(s) required extra observation or minor treatment) |
| C | Moderate (Short term harm - patient(s) required further treatment, or procedure) |
| D | Severe (Permanent or long term harm) |
| E | Death (Caused by the Patient Safety Incident) |

**Trust SI coding post harm analysis**

| | | |
|---|---|---|
| No harm | 7 | 32% |
| Low harm (requiring additional monitoring or minor treatment as a result of the delay) | 8 | 36% |
| Moderate harm (harm directly attributable to the delay requiring treatment) | 4 | 18% |
| Severe harm (Significant harm directly attributable to the delay requiring treatment) | 3 | 14% |
| Death (directly attributable to the delay) | 0 | |

1. https://www.eforms.nrls.nhs.uk/staffreport/help/ALL/Dataset_Question_References/Patient_details/Individual_patient/Impact_on_patient/PD09.htm

The following table gives an overview of the movement of coding from the initial pre-investigation level assigned, to the level determined by the independent panel – in many cases with additional information acquired since the initial level of harm was applied:

| Web number | STEIS number | Initial harm code | Collaborative harm code | Change |
|---|---|---|---|---|
| | | Moderate | Moderate | ↔ |
| | | Moderate | No harm | ↓ |
| | | Moderate | Moderate | ↔ |
| | | No harm | Low harm | ↑ |
| | | No harm | Low harm | ↑ |
| | | Moderate | Severe | ↑ |
| | | Moderate | Low harm | ↓ |
| | | Moderate | No harm | ↓ |
| | | Moderate | Moderate | ↔ |
| | | Moderate | Moderate | ↔ |
| | | Low harm | Low harm | ↔ |
| | | Moderate | Severe | ↑ |
| | | Moderate | No harm | ↓ |
| | | Low harm | Low harm | ↔ |
| | | No harm | No harm | ↔ |
| | | Low harm | Low harm | ↔ |
| | | Moderate | Low harm | ↓ |
| | | No harm | Low harm | ↑ |
| | | Moderate | Severe | ↑ |
| | | No harm | No harm | ↔ |
| | | Moderate | No harm | ↓ |
| | | Moderate | No harm | ↓ |

***Note: All potentially patient identifiable information has been redacted in this table***

**Lessons to be learned locally and for the regional and national healthcare systems**

The following is a summary of conclusions drawn by the independent panel which should be considered as system learning locally, regionally and nationally.

Local learning for EEAST – specifically from the 22 SIs

1. To ensure capacity and demand is forecast well in advance to enable the safest response to patients.
2. To ensure early escalation of hospital handover delays through the appropriate chain to ensure opportunities for early action and response.
3. To ensure the Trust support the continued reduction in handover to clear times which will enable crews to respond quickly to calls waiting in the community.
4. To review the use of the PSIT teams and HALO with commissioner colleagues, alongside the launch of the Safer Handover process agreed by the Trust and NHSE.
5. Expedite recruitment of additional EOC staff to reduce human factors issues brought about through reduced staffing. To also support staff for coding and the management of the stack when at heightened levels of surge.
6. Further work is needed to ensure that directory of services are up to date and actively utilised.
7. To review with the CCGs the process of inter-hospital transfers and to provide some education regarding the requirement of a `paramedic ambulance' to provide the transfer.

National learning

1. The welfare call process is established to safeguard patients and to mitigate risk and therefore needs to be resourced appropriately.
2. Call triage scripts for patients who have fallen and remain on the floor should be reviewed as this could cause harm to some patients, e.g. those with diabetes.
3. Call coding and quantification of harm should be reviewed nationally for consistency in light of this review.
4. Commissioners need to ensure that ambulance services are involved in the development of local service delivery options and that ambulance trusts are utilising those alternative pathways efficiently and effectively, i.e. a falls response service.
5. National review of an engagement strategy with relevant independent care providers to review policies and procedures in relation to patients who have fallen with no apparent harm. This would also apply to end of life care policies.

Regional and national learning for other providers

1. The ambulance trust should ensure that there is an up to date directory of services which is easily accessible and part of the script in EOC i.e. falls services, parish nurses, crisis interventions etc.
2. Commissioners and providers (including the ambulance trust) to work with local Primary Care networks to develop a more effective approach to managing GP/HCP calls.

*This analysis was commissioned by NHS Improvement and NHS Ipswich and East Suffolk Clinical Commissioning Group which is the lead for the Consortium of 19 CCGs which commission the ambulance service.*