South Central Ambulance Service NHS
NHS Foundation Trust

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Cllr Yvonne Constance
Chairman
Oxfordshire Joint Health Overview & Scrutiny Committee
County Hall
New Road
Oxford
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11 March 2015

Dear Yvonne,

Re: Faringdon Incident

Thank you for your letter dated 24th February 2015 regarding the continued concerns surrounding the road traffic collision incident in Faringdon on 26th April 2014. I apologise that the report submitted to the committee did not manage to answer your queries effectively. I have attempted to answer the queries you have raised in more detail below.

Call handling / dispatch

- *Why were calls relating to the incident seemingly transferred to different respondents? Why was there a time delay of 10 minutes between the call being received and details being passed to SCAS? And why were Hampshire originally rung?*
  999 calls are handled by a BT operator and they are connected to the appropriate emergency service that is requested. When calling from a landline, this is normally connected to the local ambulance service without any incidence; on occasions when calling from a mobile phone, the closest cell tower that provides the connection may be located within the boundaries of another ambulance service. In this case it appears that the call was connected to South Western Ambulance Service (SWASFT) as BT believed this to be the appropriate ambulance service from where the call was being made. Due to the increase in mobile phone usage about 10% of the calls received in SCAS are relating to calls outside our area and every ambulance service will have a similar number.

  In April 2014, when a 999 call was received in SWASFT for a patient that is out of their catchment area, the responsibility to pass the details of the 999 call to the appropriate ambulance service sat with the emergency call taker. As the call taker can often remain on the phone to the caller, this can lead to a substantial delay.

  During the course of the investigation SWASFT has been unable to answer this question definitively and it has been attributed to human error as Hampshire is also covered by South Central Ambulance Service (SCAS). During the course of their investigation, SWASFT have confirmed they have all the appropriate contact details for both control rooms in SCAS. Since this incident, SWASFT has changed their processes and it is now

the responsibility of the dispatch team to pass the details to the appropriate ambulance service so the chances of this situation reoccurring have been reduced.

- *Why could ambulance personnel not locate the incident?*
  During the course of the joint investigation, we have been unable to ascertain whether there was any difficulty locating the incident. The computer aided dispatch (CAD) systems of SWASFT and SCAS has shown that there was no difficulty in entering the location of the incident into the system. Statements from an attending ambulance crew do state that they used their initiative to contact crews that were on scene to confirm the location of the incident and the best route for them to approach the incident. It is unclear whether this is what has been referred to, within the complaint letter; however all ambulance crews appear to have taken the quickest route to the scene once they had been dispatched.

- *Why was the dispatch from Didcot Resource Centre not made until after a meal break?*
  Within SCAS we operate an Operational Front-line A&E Staff Meal Break Policy. The purpose of this policy is to ensure that all operational staff receives appropriate rest periods and balances these against the needs to provide patient care. The policy has clearly defined parameters where patient needs can take precedence over rest periods, however this is balanced that after this need has been met, the operational staff are then able to have their rest period. During this incident, the demand had outstripped resources and therefore the operational staff had already had their rest periods delayed or interrupted prior to this incident occurring. This incident was graded as a Green emergency (emergency response within 30 minutes) and therefore would not have met the criteria for delaying or interrupting a rest period.

  In June 2014, SCAS reviewed the policy and it has been amended to allow for rest periods to be delayed if a clinician decides that the condition of the patient(s) should take priority over a crew receiving their rest period as the policy directs. This policy is reviewed periodically as a minimum annually and is monitored in reference to any impact it has to patient safety and patient experience. The policy is currently in the process of review. However I am sure you appreciate that it is vital that staff are given rest periods in order that fatigue does not impact safety when travelling at high speed or when making critical decisions in patient care.

- *Why was the DCA NA305 not dispatched from Oxford City Resource Centre until after the meal break, and even then why was there a 6 minute delay from the end of the meal break to the dispatch?*
  The delayed dispatch after the end of a meal break appears to have been caused by human error. The dispatch desk that covers the West area was operated by a dispatch assistant that was standing-in to cover the vacant dispatch position. Whilst they were an experienced dispatcher, an oversight was made on this occasion, most likely due to the high demand that we were experiencing in the morning of this incident and the number of incidents the dispatcher was monitoring. The dispatch assistant has now evidenced their learning from this incident, and the Trust is confident that this has reduced the risk of reoccurrence.

<u>Resources</u>

- *Why at the time of the incident did SCAS not have a RRV backup, it was 45 minutes before dispatch?*
  At the time of the incident SCAS did not have a Rapid Response Vehicle (RRV) back up policy. This meant that once a resource arrived at the scene of an incident, any request for further resources did not carry a level of priority; therefore all categories of emergency calls would have taken preference over the request for a further resource on scene. Since this incident, we have reviewed and changed this policy and we now backup based on priority communicated to dispatch from the first clinician on scene. These priority categories are comparable to our emergency call categories and allows

for resources to be appropriately diverted based on the clinical need of the patients. We have also established Health Care Professional vehicles which are available to transport patients to hospital with lower acuity needs without the need for a blue light response or paramedic level clinical care.

- *Why did SCAS not have a DCA available?*
  On the day in question all our ambulances were fully utilised, either attending patients or having delayed rest periods. The Trust received a spike in demand and we were receiving call volumes above the predicted amount from 07:00 until 15:00. This high demand resulted in response to calls being delayed due to the demand outstripping the number of available resources; all calls were responded to on a clinical need basis using the call handling triage system, NHS Pathways. This categorised the calls into the national standards of Red (life-threatening) or Green (emergency but not life-threatening). This call triaged into the national standard of a Green call and therefore Red, life-threatening calls would have taken priority over this incident.

- *What contingency plans are in place to cover shortfalls in staffing – note West were covering shortfalls in Bicester regarding dispatchers and assistants and there were sicknesses on top.*
  The staff within the Emergency Operations Centre (EOC) are resourced on a rota system to ensure that the right number of staff are available to match demand. If a shortfall is identified early, relief staff are utilised to fill these gaps. Short-notice shortfalls including sickness will be attempted to be covered by requesting staff to complete the shift on overtime.

  In addition since the time of this incident SCAS has virtualized its call centres which allows all calls to be handled by any call handler rather than be limited to be directed to the call centre within the area. This allows us a great deal more flexibility to deal with shortfalls and unexpected spikes in demand which can happen fairly frequently in small areas.

  If we are unsuccessful in filling any shortfall, there are established minimum levels of staff that we can run the control room with. Contingency planning can include moving staff around to ensure the required minimal standard is in place across all required areas or increasingly training staff to be interoperable within disciplines e.g. across EOC and 111. Where necessary staff can be moved between the two control centres, Bicester and Hampshire. The Trust operates a business continuity plan in case of any catastrophic event and this includes falling below the required staffing requirements.

- *What planning was in place to manage the impact of maintenance being completed at the EOC?*
  From our investigation the Trust found that we had not planned adequate management resource to support the EOC whilst maintenance work was being completed. There was planning in place as the layout of the EOC was adapted to allow the work to continue without impacting upon normal service delivery; however the plans did not take into consideration the increased risk of managing the EOC across a larger physical area and with maintenance work requiring management support as well. The Trust has learnt from this incident and robust planning occurs when maintenance is planned.

- *Was the failure to answer the phone call at Bicester due to staff shortage?*
  The phone that the SWASFT EOC Manager rang to discuss the ambulance back up to the incident was a corded phone on the EOC Manager's desk at Bicester. At the time of the call, the manager was managing the maintenance work and the EOC that was split across a larger physical space; therefore they were appropriately not at their desk where the phone was located. The planned staffing levels for the EOC that day did include two managers, however one of them reported sick in the morning and it was not possible to cover the position on such short notice. The Trust has learnt from this incident and is exploring options of a wireless telephone that could be used by the EOC Manager to

enable them to answer the phone where ever they are within the EOC.

- *Why were only 4 out of 16 DCA vehicles available at the time?*
  As explained above all the ambulances were fully utilised at the time of the incident. On page 10 of the full report into the incident, the utilisation review diagram shows that at the time of the incident, 13:36, only one ambulance was available within Oxfordshire. At this point SCAS were not aware of the incident. When SCAS were made aware of the incident, at 13:48, there wasn't a transportable ambulance available across Oxfordshire to respond to a Green emergency call.

Follow Up recommendations

- *What does it mean that SCAS Dispatch assistant and ECT will undertake 'reflective practice'?*
  Reflective Practice is an academic piece of work where an individual completes a full assessment of their practices with relevant review of appropriate literature to evidence learning has occurred and a change of their working practice will ensue. Reflective Practices are commonly used as a way to capture and evidence learning to show continuous professional development and improvement of practices within Health and Social Care Professionals.

- *What specific policies are SCAS reviewing in respect to this incident?*
  The Trust have reviewed our Operational Front-line A&E Staff Meal Break Policy and our Prioritising Back Up To Rapid Response Vehicles Policy and these continue to be reviewed on a regular basis.

- *What is the progress on all the policy recommendations?*
  The Prioritising Back Up To Rapid Response Vehicles Policy was last formally reviewed in January 2015. The Operational Front-line A&E Staff Meal Break Policy was last formally reviewed in June 2014 and is currently under review again at this present time. The Policies are reviewed informally every 3 months and formally every year.

- *What progress is there on arrangements for sharing and learning?*
  The report has been shared between SWASFT and SCAS with the recommendations being implemented across both organisations. Feedback has been provided to the complainant and to the staff involved within the incident. I am still in the process of providing feedback to Coleshill Parish Council and the patients involved within the incident; I aim to have this completed prior to the Health Overview and Scrutiny Committee Meeting scheduled in April.

The Trust is a learning organisation, and I hope that the more detailed explanations to your queries provide you with assurance that we have captured the learning from this incident and implemented changes to our practices to improve the service we deliver to our patients. Feedback is being provided to Coleshill Parish Council and the patients involved within the incident, once this has been completed, the Trust consider this complaint to be resolved.

The aim of South Central Ambulance Service is to offer a high quality, caring and flexible ambulance service that puts patients first. We welcome service users raising concerns in order that we can continually improve our services. May I therefore take this opportunity to thank you and the committee for your feedback over this incident.

Yours faithfully,

Richard McDonald
Area Manager