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17th February 2021

Email:

Dear,

I am writing in response to your enquiry under the Freedom of Information Act 2000 (FOIA) reference FOI 201215.

You requested the following information, please also see our response below:

- 1. How many serious untoward incidents were recorded by your organisation in (i) 2019/20 and (ii) from 1/4/2020 to 30/9/20, where the degree of harm was recorded as “severe” or “death”?**

Number of closed Serious Incidents (SI) with the level of harm listed as Severe or Death.

2019/2020	Severe Harm	Death
Total	14	0

01/04/2020 to 30/09/2020	Severe Harm	Death
Total	5	0

- 2. How many serious untoward incidents were recorded by your organisation in (i) 2019/20 and (ii) from 1/4/2020 to 30/9/19 where the degree of harm was recorded as “severe” or “death” AND where there was either a delay in the ambulance arriving at the incident scene or a delay in the ambulance handing the patient over to a hospital?**

The number of SIs reported due to Delayed Despatch/ Attendance.

2019/2020	Delayed Dispatch / Attendance	Severe	Death
Total	9	9	0

01/04/2020 to 30/09/2020	Delayed Dispatch / Attendance	Severe	Death
Total	1	1	0

3. Please provide me with a brief summary of each of the incidents in Q.2 stating (i) the degree of harm recorded and (ii) a brief summary of the incident including how long the delay was and why the delay occurred and the consequences for the patient of the delay.

We are unable to give a description as this may lead to identifying the incident and those involved. All harms are as in the answer to Q2, severe.

Incident Number	Delay reason	Delay above expected response times ¹
1	Incorrect categorisation of call coupled with high demand	Delay 38min
2	Did not recognise the clinical urgency of the patient and missed opportunities to upgrade this call	Delay 4hr 45
3	The initial triage did not recognise the patient's atypical symptoms as cardiac chest pain. Subsequent clinical and welfare contacts missed the opportunity to upgrade the triage disposition. A shortfall in operational resourcing led to the delayed ambulance attendance.	Delay 4h 55min
4	Non-compliant initial triage as a result of insufficient probing. There were also missed opportunities to re-triage the call to a higher disposition coupled with higher than predicted demand	Delay 5h 25min
5	Increased demand coupled with the Operational Unit down staffing hours shortage	Delay 5h 54min
6	Higher than predicted demand	Delay 1h 22min
7	High call volume, and a lack of resources due to a shortfall in staffing in the operating unit	Delay 3h 27min
8	Communications difficulties (language barrier) preventing a full understanding of the patient's medical situation	Delay 0h 15min

¹ Expected response time is the mean response time eg. The national standard for a Category 1 response is to attend within 7 minutes for 90% of these calls.

Incident Number	Delay reason	Delay above expected response times ¹
9	High call demand	Delay 0h 23min
10	Lack of available resources; critically low staffing as a result of high abstraction rates from sickness and Covid-19 staffing restrictions	Delay 0h 29min

I hope you find this information of some assistance.

If for any reason you are dissatisfied with our response, kindly in the first instance contact Caroline Smart, Head of Information Governance via the following email address:

FOI@secamb.nhs.uk

Yours sincerely

Freedom of Information Coordinator
South East Coast Ambulance Service NHS Foundation Trust