Yorkshire Ambulance Service NHS
NHS Trust

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PRIVATE & CONFIDENTIAL

Mrs S.L Slater
Assistant Coroner for South Yorkshire (East District)
Coroners Court and Office
Crown Court
College Road
Doncaster
DN1 3HS

Date: 9 June 2017

Dear Mrs Slater,

Inquest touching the death of Barry Hodges

Response to Regulation 28 Report to Prevent Future Deaths dated 24 April 2017

Thank you for your report dated 24 April 2017, issued under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.

The purpose of this letter is to provide you with a full response to the concerns set out in your report, in so far as these are issues which can be addressed by the Trust at this stage.

1) **Protocols for ambulance dispatch and review of resources were not adhered to and there appeared to be an absence of any system to "safety net" should an individual operative not manually refresh and look at the system.**

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There is now a process in place within Emergency Operations Centre (EOC) whereby a "Call Alert" is highlighted on the Dispatcher's, Team Leader's and Duty Manager's computer automated dispatch (CAD) screen. This alert highlights when an incident has not been allocated. We are also in the process of identifying the possibility of a system change to identify when a resource check has not been completed within the target timeframe. The introduction of these systems enables the direct managers of the Dispatchers to be made aware of any live incidents that have not been allocated a resource during the incident.

Also the timeframes for resourcing of incidents for amber category calls has been reduced to 5 minutes from the original 10 minutes, this new time target has been communicated to all staff in the EOC. Further awareness on the importance of reviewing available resources will be emphasized to all staff at the EOC training away days throughout June and July 2017.

We have also further introduced a systems change to assist the EOC management teams with identifying details that have not had a resource allocated within time scales. The system now shows a "minus minute" indicator on the Dispatcher's, Team Leader's and Duty Manager's CAD screen which indicates for each incident how many minutes have passed without a resource being allocated. This enables the Team Leader or Duty Manager the ability to monitor all incidents to ensure they are compliant with timescales.

The Trust is in the process of introducing revised colour coding of calls – the Trust will in the future be changing the amber category to red to ensure visually these calls are prioritized appropriately. Evidence based previous experience and working nationally with the Association Ambulance Chief Executives (AACE) that Red category calls create an increased awareness against other colours.

We are also reducing the expected time to allocation for amber details (soon to be Red) from 2 minutes to 30 seconds once coding is confirmed or the detail is available for dispatch from the waiting stack. This change will assist in responding to these patients sooner and reduce any delays at the beginning of the dispatch process. The new process will be discussed, shared and educated on the EOC training away days with all staff and will also be visible on all dispatch bays in the updated Dispatch Quick Reference Guide.

2) **A lack of knowledge/training/understanding of the protocols that 4 resources were available at different times but none were utilised.**

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The Trust has intense training away days for all EOC staff set up to take place throughout the summer months. Part of these training away days will include reiterating to all EOC staff the core elements of their role, especially around the fundamental aspects of review, revise and allocate with emphasis on not delaying allocation to high priority calls.

The attached (Appendix 1) Operational Alert was produced on 24 April this year to further reiterate to staff the need to allocate the most appropriate resource available without delay.

EOC staff members have monthly 1:1's at which the Trust are now able to produce personal performance information, this enables the manager to review whether the dispatcher is meeting appropriate targets, this includes information regarding resourcing of incidents. If it is found there are areas which require improvement the Trust allocates a team champion to sit with the staff member to supervise their work until it is felt that the staff member is performing satisfactorily.

We are also in the process of introducing a Standard Operating Procedure (SOP) to ensure that Emergency Operations Centre Dispatchers are delivering consistently good standards of care to the patients of Yorkshire, this is attached (Appendix 2). This process will facilitate a fair and appropriate audit of incidents in the live environment to ensure that Dispatchers are supported in their role and areas of concern are addressed immediately where possible.

All dispatch staff can be put through a Practice Developer Referral (PDR) for training and support to make sure relevant competencies meet the standard required.

3) **Time scales were breached without further action ie. escalation to Senior Management, Clinicians or allocation of resources.**

Performance frameworks have been introduced to audit individual staff members to improve the quality of the service provided on an individual basis.

As a Trust all category 1, 2 and 3 (Purple, Amber, Yellow) delayed response incidents are reviewed by the clinical hub and reported on the Trust's incident reporting system, Datix, this enables an incident to be declared and investigated if required. All patient harms are recorded to ensure an investigation is commenced should this be required.

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The Trust reviews all purple calls of 10 minutes and above delayed responses, along with all amber calls of 30 minute and above delayed responses and all yellow calls of 120 minutes and above delayed responses. This audit ensures the Trust monitors the reasoning behind delayed responses and learns lessons from them quickly.

To assist with patient safety in relation to excessive and delayed responses, staff have been reminded of the reporting process and also reminded of an amendment to the definitions of delayed responses.

Dispatchers are to follow the Dispatch Escalation and Excessive Timeframes guidance which can be found on the back page of the Dispatch Quick Reference Manual and also in the Dispatcher SOP.

I hope the above response is satisfactory, please do not hesitate to contact me should clarification be required.

Yours faithfully

Rod Barnes
Chief Executive Officer
Yorkshire Ambulance Service NHS Trust

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