South Central Ambulance Service NHS
NHS Foundation Trust

PRIVATE AND CONFIDENTIAL
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Our reference: PFD/HCP Calls

11th September 2017

Dear Mr Osbourne

Thank you for your recent letter dated 19th July 2017 regarding the prevention of future deaths (PFD) report issued following the inquest hearing into the sad death of Mrs Pamela Pritchard. I will now respond to your points in turn before providing you with a summary of the review that SCAS has undertaken regarding the management of calls from Health Care Professionals (HCP).

1. 'That a GP with over 30 years' experience had attended upon the deceased and his view was that she needed to be conveyed to hospital within four hours. When the four hours had expired a family member of the deceased was spoken to by a non-medically qualified 'call taker' who disregarded the previous instruction from the doctor'

   The Trust firmly refutes that the previous opinion of the attending GP was 'disregarded' by the Emergency Call Taker (ECT). Along with our colleagues nationally, SCAS utilises a clinical decision making software system (NHS Pathways) which is designed to be used by non-medical staff to assess the condition of a patient over the telephone at the time of the call. The Department of Health licence the system to be used in this manner.

   As you will be aware, nationally there are a finite number of resources available within the ambulance service and available resources are allocated to events in line with clinical need. When the time frame requested by Mrs Pritchard's GP had expired, because there were no resources available to attend to her, the ECT completed a welfare call to Mrs Pritchard's home to ascertain whether her condition had worsened since the GP saw her or if there were any new signs or symptoms that had developed. This is not the same as ignoring the GP's previous advice and is merely intended to ensure that our patients remain cared for whilst they are awaiting a resource to be dispatched.

   Following an internal review by a senior team of Clinicians within SCAS, we have amended our process to ensure that when any HCP call reaches the requested timeframe

the event will be upgraded to an emergency “blue lights and sirens” response, should the original requested timeframe be reached and a resource has not attended. The call will then be allocated a resource when one is available in line with our normal processes which are of course dependant on the demand that is in place at the time. Full details of our review are explained in more detail in the relevant section below.

2. ‘That when the family made three emergency calls to the ambulance service the ‘call taker’ made the decision not to escalate the priority of the call without seeking advice from a qualified practitioner’

   As you will have read in the Trust’s investigation report, a further copy of which I enclose, the calls made by the family requesting an estimated time of arrival for the ambulance after the expiry of the timeframe requested by the GP, determined that Mrs Pritchard’s condition had not changed or worsened since the GP referral was received. If at any time during this window, Mrs Pritchard’s condition had deteriorated, the ECT would have either utilised NHS Pathways to ascertain if a higher clinical grading was applicable or the call would have been transferred to a clinical member of staff on the Clinical Support Desk (CSD) in order that a clinical assessment of her current condition could be performed.

   Following the internal review by a senior team of Clinicians, processes have been amended to ensure that the third contact with the patient or their family, whether this is an incoming or outgoing call to any patient awaiting admission via the HCP route will involve a Clinician within the Clinical Co-ordination Centre (CCC). In addition, all calls where a patient’s condition has deteriorated will be re-triaged using NHS Pathways and if the disposition for the response is the same or lower than that requested by the HCP, the call will always be passed to a Clinician for further Clinical intervention / assessment.

3. ‘That when an ambulance was not available to respond to the original call from the GP, the ambulance service did not make enquiries with the two adjoining ambulance areas namely East Midlands and East of England, to enquire whether a local ambulance was available to respond.’

   During the inquest, the Trust gave evidence regarding the National Memorandum of Understanding (MOU) that governs instances where a neighbouring ambulance Trust can be contacted to enquire whether they have a resource available that could respond to an event sooner. To explain this point further, National Mutual Aid arrangements are agreed by the National Directors of Operations Group and are approved by the Association of Ambulance Chief Executives (AACE). The arrangement is designed to allow Ambulance Trusts to seek support from neighbouring Trusts during times of crisis and would generally be applied during major incident scenarios. As explained at the hearing, cross border arrangements are restricted to Red 1 / Category 1 calls to ensure that patients with life threatening emergencies can be seen quickly. Lower acuity calls, including HCP calls are not included in these arrangements.

   In this particular case, the initial call received was a Health Care Professional (HCP) 4 hour call; which is the lowest grading of clinical call that an ambulance service would respond to. As Mrs Pritchard’s clinical condition remained unchanged, following welfare checks, the call category did not change after the expiry of the initial time frame. Therefore, it would not have been possible to contact a neighbouring ambulance Trust to request assistance.

Following receipt of your PFD report, our Medical Director briefly notified [redacted] (Managing Director, The Association of Ambulance Chief Executives) of your concerns during a recent meeting of the National Ambulance Service Medical Directors (NASMeD). Although it is likely that further expansion of the mutual aid arrangements to lower acuity calls would be impractical, [redacted] has agreed to review the current mutual aid arrangements process. If you require any further clarification on this agreement, or would like to discuss this matter further, please contact [redacted] directly using the contact information I have detailed below:

[redacted],
Managing Director
The Association of Ambulance Chief Executives
32 Southwark Bridge Road
London
SE1 9EU

4. <u>That a similar episode had occurred involving the same patient on the 16th February 2017 when the GP had requested a response within 2 hours. The service failed to meet this target by 3 hours 42 minutes'.</u>

   It is deeply regrettable that Mrs Pritchard experienced a delay in attendance on 2 consecutive occasions. The Trust's investigation report provided a brief overview of events in February but your concern regarding future provision of service is better addressed in the section on resource management below.

<u>Provision of a HCP resource</u>

At the time of this incident, a specific HCP resource was not available in the Milton Keynes area; and the response was therefore provided by the front line paramedic ambulances. This service is now being provided by the Red Cross as a Private Provider resource whilst we recruit into the new HCP establishment in this area.

The HCP tier of our resource is planned against historic demand profiles for this level of demand. Details of how the Trust ascertains how many resources are required per shift are detailed below.

<u>Review of HCP call process</u>

As mentioned above, since the sad case involving Mrs Pritchard, a senior team of Clinicians within SCAS have reviewed the way that HCP calls were managed by the Trust. Following this review, the following amendments have been made:

1. All HCP events, regardless of the timeframe originally requested by the HCP, will now be responded to as an emergency "blue lights and sirens" response should the original requested timeframe be reached and a resource has not attended.

2. Any third contact with a patient will be referred to a Clinician regardless of whether this is an incoming call or outgoing call to ensure that any Clinical changes are appropriately addressed and the response timeframe can be adjusted as appropriate.

3. Where an incoming call is made on behalf of the patient and worsening symptoms are disclosed, a full re-triage of the patient will take place using the NHS Pathways triage

system and the appropriate responding priority for those symptoms will be adhered to; including when this is sooner than the originally requested timeframe. If a disposition requiring a lower priority of response is reached, the caller will be transferred to a Clinician for appropriate re-grading of the call.

4. If a third call is received asking for an estimated time of arrival for an ambulance and there are no declared worsening symptoms, the call will still automatically be transferred to a Clinician for further assessment of any changes to the patient's condition.

5. If a welfare check call is made to a patient who is alone at their property, following an HCP booking, and there is no reply; an emergency resource will be dispatched to the address to determine if the clinical condition of the patient has deteriorated and immediate transfer to hospital is required.

The Standard Operating Procedures for the CCC have been amended in line with the Clinical review of HCP events and will be disseminated to staff within the CCC's. An assessment of the implementation process and our Staffs understanding of these changes will be assessed in the monthly ECT assessment paper in November 2017.

Planning and Performance Forecast

In order to offer you further assurance regarding the provision of SCAS services in the future, I have included explanations of how the Trust currently oversees the level of resources that are required on any given shift.

Demand levels are forecasted based on historic analysis looking back at previous year's levels, ideally at least 3 years. At the start of the year demand growth is projected based on year on year levels and this growth factor is applied to every day of the year, and then apportioned to each hour based on the percentage of demand that historically occurs in each hour. During the year this forecast is revised based on a short term forecast using growth patterns experienced in the previous six weeks.

Utilisation ratios are calculated again using historic analysis to identify the level of performance achieved in relation to the utilisation factor. This factor is then applied to the forecasted demand levels to identify the required number of ambulance resources required every hour of the year in each dispatch node. This is also then updated on a short term forecast basis using a six week pattern.

The number of rapid response cars available on individual shifts is a static figure linked to geographic deployment plans. Overnight ambulance levels have a minimum level reflecting required geographic cover rather than pure demand requirement which would be lower. For example demand may suggest only needing 6 ambulances but a minimum level of 10 in an area ensures all towns are effectively covered.

Currently cars and ambulances can be crewed by either a Paramedic or an Ambulance Technician and an Emergency Care Assistant. A small number of cars are crewed by Specialist Practitioners and these are targeted at minor illness and injury cases that can be treated at home. Enabling this provision of service ensures that the patient receives the right care at an early stage.

Resources are planned utilising both SCAS employed resources and Private Provider crews when the required number of resources cannot be met by employed staff. The planning uses an agreed

rota pattern to meet forecasted demand requirements. SCAS rotas are planned 4 weeks prior to the week in question with any identified gaps then passed to Private Providers to fill. This process is automated utilising our rostering systems enabling a better match to requirement; therefore mitigating the risk of a gap in resource occurring.

Current on-going mitigating actions

As well as ensuring that the above planning processes are in place, the Trust continues to demonstrate complete commitment to patient safety and resource management; undertaking long wait reviews, prioritising workload, undertaking independent and system wide escalation actions.

In conjunction with the CQC and our external stakeholders, an action plan has been agreed to ensure that response times for emergency and urgent care services can be met. The action plan is being monitored via the SCAS Executive Management Group and progress is reported to the Quality and Safety Committee and Trust Board as well as externally at Contract Quality Review Meetings with Commissioners.

As part of ongoing work into demand management, there is continuing collaboration between operations, the clinical directorate and business intelligence and other providers to understand and reduce long waits through new ways of working and deployment of resources.

Key actions going forward are to continue to engage with the teams at acute hospitals if handover delays occur; meaning there is a delay in the resource becoming available to attend to waiting incidents. The clinical team are also undertaking reviews of cases as required if handover delays and queuing are an issue.

Recruitment plans are also in place and are being monitored via the Workforce Board. New ways of working and alternative pathway work continues; an example being working with the Fire Service so that they can respond to incidents and provide basic life support / treatment whilst a SCAS resource is being arranged.

As you may be aware, following successful clinical trials, NHS England have decided to implement national changes to the way that the ambulance service responds to 999 calls under the new Ambulance Response Programme (ARP). These changes aim to ensure that all patients receive a clinically appropriate response within a clinically appropriate timeframe. They will allow the introduction of a more efficient operating model designed to provide more transporting ambulance resource with less reliance on solo responders in response vehicles. Over time Ambulance Trusts will be able to re-engineer their resourcing to increase ambulance capacity and work towards reducing transport delays for low acuity patients and HCP calls. SCAS will be progressively introducing this new response programme during the latter part of 2017.

We would like to take this opportunity to invite you to meet with our Medical Director, [redacted] if you would like to discuss the new ARP programme or if there are any further matters that you would like clarification on. If you would like to arrange a meeting, please contact his PA, [redacted] using the contact details below:

Tel: [redacted]
Email: [redacted]

I hope that this letter has addressed your concerns, but please do come back to either myself or [redacted] if you wish to discuss this matter further.

Yours sincerely

Will Hancock
Chief Executive Officer
Enc.