NHS
East of England
Ambulance Service
NHS Trust

Norwich office
Hospital Lane
Hellesdon
Norwich
Norfolk
NR6 5NA

Tel: 07525 906775

10th July 2019

Dear Ms. Blake,

Re: Regulation 28 – Christopher Williams (31st May 2019)

I am writing to you following the inquest of Mr Christopher Williams and the Trusts receipt of a Regulation 28. In order to address your concerns, as outlined in Section 5, I will outline the Trusts current position and areas which are being considered for change/being changed.

The amount of time taken for the ambulance to arrive which was markedly outside the Trust's guidelines.

Following a review in April 2017 commissioned by NHS England and NHS Improvement recommendations were made on the best service model, pricing review, capacity and demand analysis and the commissioning/contract model. The review was undertaken by Deloittes and ORH, a company specialising in operational modelling for emergency and health services. The findings were published on the 11th May 2018 and recognised the resource gap between the existing funding for the Trust and what is needed to meet demand. This was factored in to our emergency operations contract with funding released to enable to increase front line staff by 330 full time equivalents by 2020/21.

To date the Trust have recruited 491 frontline staff with a further 270 frontline offers of employment in process.

To support timely release of Trust resources from hospital sites the Trust has worked with system partners to ensure early escalation of hospital handover delays which is supported in a regional handover protocol and operating procedure.

The failure by the call handler to both escalate Mr Williams worsening condition and her incorrect use of the haemorrhage algorithm.

Emergency Call Handlers work using a triage system called Medical Priority Dispatch Solution (MPDS). This system is designed and owned by the International Academy of Emergency Dispatch (IAED).

We work with the IAED to improve standards of triage and to also identify where a protocol does not meet the needs of patients, whilst also understanding that in an emergency environment where 999 calls are triaged by non-clinicians there will be some calls which will need clinical support/ intervention in reviewing the response. The Trust's Audit and Training Manager will be shortly meeting the IAED's UK Manager, following which the Trust will draft and submit a Proposal for Change (PFC) to the Academy asking that they identify a neurological deficit pathway which could be used in the triage of 999 calls.

This proposal will also be sent through to the National Ambulance Services Medical Directors (NASMeD) for their consideration and support.

In the case of Mr Williams, whilst there was no protocol which addresses neurological deficit, this had no negative detriment to the care provided or the response assigned by the AOC as the highest level of response was achieved (Category 1).

As stated in [redacted] report we have re-enforced the escalation process in the initial training with Call handlers and also through a series of 1-2-1 sessions with existing staff.

When the ambulance transported Mr Williams to the NNUH he was kept on board the vehicle awaiting a space in the Emergency Department, despite a bed already arranged several hours before by the GP. This information was unknown to the crew and resulted in several hours delay in Mr Williams being investigated and treated which may have contributed to his death by sepsis.

In the initial call the HCP called and asked for the patient to be conveyed to the Norfolk and Norwich University Hospital, the clinician requested for the patient to be taken to the Emergency Assessment Unit. When we received a 999 call from the property identifying that the patient's condition had deteriorated the dispatcher allocated on the new call as it was of a higher priority, in line with 20180525 Ambulance System Indicators. Due to the dispatcher assigning to the new call it is apparent that information pertaining to the destination of the patient was omitted as the information is sent to the crew using data. We are in communications with the CAD supplier to make an alteration to the duplication process which would allow pertinent information to be transferred from the original call into the call which EEAST are "running on". Having a technical solution will minimise risk of human error. As an interim arrangement we will ask all dispatch staff to ensure that any pertinent information of this kind is transferred into the new call, until there is a technological resolution in place.

We are also working with our colleagues in other Ambulance Services who use the same CAD to share best practice and solutions with regards to how information is recorded and subsequently transmitted to attending resources.

Should you have any further questions or if you would like any of the areas outlined above expanded upon please do not hesitate to contact me. Please also contact me if you would like to accept the offer to visit the Emergency Operations Centre to arrange a date and time that suits you and your staff's needs.

Kind regards,

Dorothy Hosein
Interim Chief Executive