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Our Ref: ACM/MF/KAF

Date: 11 August 2019

Mr Nigel Parsley
Senior Coroner
The Coroners Court and Offices
Beacon House
Whitehouse Road
Ipswich
IP1 5PB

Via email: Coroners.service@suffolk.gov.uk

Dear Mr Parsley,

I write in reply to the concerns you raised with me on 17 June 2019 as Chair of the Association of Ambulance Chief Executives (AACE) through a Regulation 28 PFD report following the inquest of Master Oliver Hall.

Firstly, we would like to offer our condolences to the family and those affected by this tragic passing.

To clarify, AACE is a private company owned by the English Ambulance NHS Trusts. It exists to provide ambulance services with a central organisation that supports, coordinates and implements nationally agreed policy. Our primary focus is the ongoing development of the English ambulance services and the improvement of patient care. We are a company owned by NHS organisations and possess the intellectual property rights of the JRCALC UK ambulance service clinical practice guidelines. AACE is not constituted to mandate or instruct ambulance services however we do have national influence via the regular meetings of ambulance Chief Executives and Trust Chairs along with a network of national specialist sub-groups.

I will address your three key concerns in the order given:

1) **It is apparent that there is a failure in the process of the transfer information regarding a patient's original disposition by the NHS 111 Service to the ambulance service and treating clinicians on the ground....It was then identified that the current East of England Ambulance service system does not provide the ambulance crew (and therefore in this case subsequently the GP's) with relevant information.**

The failure to transfer the most relevant information in this instance is very regrettable. English ambulance services use a number of different Computer Aided Dispatch (CAD) systems and one of two authorised triage platforms to assist them in handling emergency calls effectively. From the narrative report of the inquest, it is clear that information was originally given to the ambulance control room by the NHS 111 service that was not then fully shared with the ambulance resource deployed.

Having consulted with our National Heads of Control Services Group, it is apparent that the process of sharing this information is necessarily selective. This is partly to avoid overburdening clinicians/responders with excessive or non-relevant information and partly because the mobile data terminals in responding resources (ambulances or cars) have limits on what can be displayed. The systems used vary across the country and the exact nature of what is displayed in the vehicle is determined by the individual ambulance service within the limits of the technology it utilises. We understand that East of England Ambulance Service has reviewed their local processes to take on board your concerns.

Although the process and systems are well established, improvements can always be made. I am pleased to inform you that during 2020/21 elements of the new National Emergency Services Mobile Communication Programme will be implemented across all ambulance services and this will include a greater ability to manage information through the new National Mobilisation Platform. This may in turn allow us to further standardise the types of information displayed on the mobile data terminals in ambulance vehicles.

2) Your concern regarding medical professionals being able to make an informed decision with regard to possible delays in ambulance attendance and that under the current system (highlighted in this case) a medical professional requesting an ambulance will not be told if the delay is 39 minutes or less

Work has been ongoing over the last two years to improve the handling of emergency calls received from Health Care Professionals (HCP). NHS England have now published the National Framework for Healthcare Professional Ambulance Responses which clarifies the new roles and processes. The section reprinted below is pertinent in this instance

HCP Level 2 (HCP 2) Category 2 (18 Minute mean response time)

This level of response is based on the clinical condition of the patient and their need for immediate additional clinical care in hospital in an emergency department or acute receiving unit (i.e. medical or surgical assessment unit, delivery suite).

Patients with a National Early Warning Score (NEWS2) of 7 or greater may trigger a request for this level of response, as may the opinion of a HCP who has assessed the patient.

Patients with a NEWS2 of 6 or less may be suitable for an HCP Level 2 response by exception only and HCPs, where possible, should detail the clinical reason. Examples in this category may be patients with sepsis, myocardial infarction, CVA, acute abdomen, acute ischaemic limb, acute pancreatitis, major gastrointestinal haemorrhage and overdose requiring immediate treatment.

Whilst these calls may be flagged within the Trust CAD system as being from a HCP (for AQI reporting purposes), they must be presented and displayed in the Trust CAD system in the same way as Category 2 calls from the public and responded to accordingly.

In essence, it is the patient's condition that determines the prioritisation of response so that a call from an HCP will receive the same level of response as that of a public 999 call – driven by the clinical condition of the patient.

Whether an ambulance is called by the public or an HCP, it is extremely difficult for a call taker to give accurate information regarding the expected time of arrival of a response. This is due to the fluid and ever-changing nature of emergencies. It is not uncommon for a responding ambulance to be diverted from one emergency to another that has been assessed as more urgent or indeed for a responding ambulance to be flagged down at another incident they may be passing. For these reasons, call takers do not commit to an estimated time of arrival, rather they are asked to say 'help is on its way and please ring back if the patient's condition changes'.

3) **A lack of clarity was apparent over the current national institute for health care and excellence on the treatment of sepsis and the guidance provided by the joint royal college's ambulance liaison committee, specifically in matters of the pulse rate of 120 in a six year.**

Having consulted with the National Ambulance Service Medical Directors group (NASMeD), they are clear that the difference between 119 or 120bpm as a pulse rate in a 6-year-old child would not be influential on its own. The attending ambulance staff have been taught that the assessment of the child with regard to severity of illness and possible causes would be influenced by a range of observations, signs, symptoms and history. It is fundamental to ambulance service clinical practice to ascertain a comprehensive history of events and conduct a thorough patient assessment. It is only by doing this that information received can be verified and form part of subsequent decision making.

Ambulance services are all supportive of the clinical guidelines used across the UK and developed by JRCALC but are fully cognisant that these are guidelines for interpretation as are those published by other organisations.

Since being made aware of the disparity in pulse ranges quoted by NICE, JRCALC and other guidelines we have asked JRCALC to consider whether there is sufficient evidence to change their current guidance for ambulance staff.

I trust you feel that I have answered your concerns fully and thank you for bringing them to my attention.

Yours sincerely

A. C. Marsh.

Professor Anthony C. Marsh
Chairman, Association of Ambulance Chief Executives

CC: Martin Flaherty OBE, Managing Director, AACE