NHS
Yorkshire
Ambulance Service
NHS Trust

20 November 2019

PRIVATE & CONFIDENTIAL
Mr. D. Urpeth
Assistant HM Coroner for South Yorkshire (Western)

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Sent by e-mail only

Dear Sir,

Re. Prevention of Future Deaths report – Mr. Arthur Jepson

I write further to your letter enclosing your prevention of future deaths report following the inquest of Mr. Arthur Jepson, which the Trust received on 25 September 2019.

Firstly, may I extend my apologies on behalf of Yorkshire Ambulance Service NHS Trust to the family of the late Mr. Jepson. Following Mr. Jepson's inquest on 3 October 2019 at the Medico-Legal Centre, Sheffield you outlined your concerns regarding the apparent lack of a review of Mr. Jepson's call following a two hour period to ascertain whether the incident needed re-categorisation. Although as described in your letter, you felt that given the evidence heard at the inquest, it would have been unlikely to have changed the outcome for the late Mr. Jepson, you were concerned that this may have an impact upon other patients' care.

As outlined in the Trust's letter to you dated 4 October 2019 from the Legal Services Department, it is regrettable that information regarding the Trust's call-back standard operating procedure was not alluded to in written and oral evidence and to provide assurance that there was, and continues to be, a procedure in place to ensure that incidents are reviewed once the expected response timescales had been exceeded. As was heard within the oral and written evidence at the inquest, the Trust was experiencing high demand at the time of Mr. Jepson's call, especially within the area of South Yorkshire and unfortunately a call-back was not made to Mr. Jepson once two hours had elapsed for which I apologise.

Your letter has prompted the Trust to refresh its approach to dealing with such matters and to build upon work already ongoing within the Emergency Operations Centres ("EOCs") with improving its processes and procedures. As outlined within the letter from the Trust on 4 October 2019, there is work currently ongoing to create a centralised Senior Clinical Advisor standard operating procedure ("SOP") and the current call-backs and comfort calls SOP has been identified as forming an integral part of this revised central SOP.

The new centralised Senior Clinical Advisor standard operating procedure was ratified at an internal governance meeting on 19 November 2019 and it is anticipated that the new procedure will be in place by early December 2019.

It is intended that at times of high demand, or for patient care, it may be appropriate for senior clinical advisors ("SCAs") to undertake call backs and comfort calls. To provide a structured approach to this process a filter exists within the computer aided dispatch ("CAD") system and this filter allows for incidents which have exceeded their expected timeframe to be viewed separately from other incidents awaiting dispatch by the allocated clinician. In addition to this, any incident likely to breach the mean time will be visible.

The SCA should speak with the patient wherever possible and should introduce themselves and ask if anything has changed since the initial call was made. If no change has occurred, the SCA will explore the options of alternative transport however if this is unavailable or not a possible option, then the SCA will reassure the patient that an ambulance response will be with them as soon as possible and advise them to call back via 999 if the patient's condition deteriorates. If there has been a change in the patient's conditions then a Manchester Triage System ("MTS") triage must be completed by the clinician and re-categorised as appropriate, using a dedicated upgrade / downgrade code.

It is expected that Category 1 incidents with excessive response times will be assessed and given support by the dedicated Category 1 Clinician separate to the process outlined above.

In order to gain assurances that the processes are effective, reporting mechanisms shall be put in place to ensure that the revised call-back procedures are being undertaken and ensuring that any excessive incidents receive regular contact to establish whether the Trust's response is still appropriate and safe.

I trust this letter is to your satisfaction and once again, my sincerest condolences to the family of Mr. Jepson.

Yours faithfully,

Rod Barnes
Chief Executive Officer
Yorkshire Ambulance Service NHS Trust