NHS
East Midlands
Ambulance Service
NHS Trust

Trust Headquarters
1 Horizon Place
Mellors Way
Nottingham Business Park
Nottingham
NG8 6PY
PALS telephone: 0333 012 4216
Head office telephone: 0115 884 5000
Website: www.emas.nhs.uk

13 March 2020

Confidential

Ms E Serrano
HM Assistant Coroner
Coroner Office
Town Hall
Rose Hill
Chesterfield
S40 1LP

Dear Ms Serrano

Regulation 28 – Prevention of Future Deaths report regarding the case of Mr Gordon Gillott deceased

Thank you for your letter of 4 February 2020 and the accompanying report into the death of Mr Gordon Gillott.

Unfortunately, no correspondence was received by East Midlands Ambulance Service reference concerns raised by the General and Vascular Surgeon at the Royal Derby Hospital until we were contacted by the coroner's office. If we had been contacted we would have supplied the hospital and your office with information regarding transfers between Chesterfield and Derby Hospitals and their time frames in which East Midlands Ambulance Service responded to them over the past 12 months. We would have also given you the information regarding the new national procedure for all requests for transport between hospital sites which commenced on the 1 October 2019. We are pleased to be able to provide you with this information now.

The PFD we have received raises a concern that an ambulance was not dispatched within the Category 2 response standard of 18 minutes on average and responding to 90% of Category 2 calls in 40 minutes. Whilst it is acknowledged that this did not impact on the outcome in this case, there is a concern regarding patient impact of future delays.

When Chesterfield Royal Hospital requested a transfer to the Royal Derby Hospital, East Midlands Ambulance Service was in Capacity Management Plan CMP, level three. The Capacity Management Plan (CMP) is designed to manage demand and resources during high periods of demand, where the supply of normal ambulance service resources is insufficient or potentially insufficient to meet the clinical demand of patients. The aim of the CMP actions is to maximise responses to the most seriously unwell patients. There are four levels of CMP as set out in the table below.

CMP level	**Escalation Trigger**	**EMAS**	**Authorisation**
Normal	No Issues 'business as usual'		
CMP 1	40 calls of any trigger category being held	Regional	EOC Tactical Commander / DM
CMP 2	55 calls of any trigger category being held	Regional	EOC Tactical Commander / Trust Strategic Commander
CMP 3	Prolonged period of demand (not spike) or more than 70 calls being held	Regional	Trust Strategic Commander/ Executive on call
CMP 4	Initiated when a major incident is declared and all other actions have failed to mitigate the circumstances	Regional	CEO/Exec on call & lead commissioner

The delay for the transfer on this occasion was due to higher than anticipated levels of 999 calls (in particular those in the highest priority category) and the impact of hospital handover delays. EMAS must respond to emergencies with the same call prioritisation code in time order for example; category two calls within 19 minutes with a 90th percentile of 40 minutes, this includes whether they are in the community or in a hospital environment.

At the time of Mr Gillott's call the trust was in CMP 3 holding over 70 CMP qualifying calls. The handover delays at the two hospitals involved in the care of Mr Gillott between the hours of 19:00hrs on 7 August and 07:00hrs on 8 August are stated below with 460 ambulances attending the hospitals within this time frame.

Chesterfield Royal Hospital - 19:00hrs 07/08/18 to 07:00hrs on the 08/08/2018 Handover times in minutes. The nationally agreed handover time is 15 minutes.

15 + minutes	20 + minutes	30 + minutes	45 + minutes	30 – 59 minutes	1 -2 hours
132 ambulances	20 ambulances	16 ambulances	1 ambulance	16 ambulance	0 ambulance

Derby Royal Hospital - 19:00hrs 07/08/18 to 07:00hrs on the 08/08/2018 Handover times in minutes. The nationally agreed handover time is 15 minutes.

15 + minutes	20 + minutes	30 + minutes	45 + minutes	30 – 59 minutes	1 -2 hours
186 ambulances	128 ambulances	40 ambulances	13 ambulance	36 ambulance	5 ambulance

The above delays resulted in 34 lost hours of operational response availability; impacting on our ability to attend patients in a timely manner.

EMAS implemented the new national Health Care Professional Admissions and Inter-Facility Transfers Framework on the 1 October 2019. We have included the National Framework for Interfacility Transfers document for your information.

Inter-facility transfers must be from an approved site; transfers requested from other sites will be treated as health care professional admissions. Before the introduction of the new procedure all requests from hospitals were a priority one response based on the category 2 timeframe. The introduction of the new procedure ensures that the correct response standard is obtained and dispatched accordingly. The patient awaiting transfer must be ready to leave for their destination within 15 minutes of the transport arriving. Unfortunately we routinely experience delays on arrival which leads to further delays in transfer of patients.

On the day of Mr Gillott's transfer the division had already completed four transfers from Chesterfield Royal Hospital. Other Trusts have introduced their own IFT transport platform to avoid prolonged waits when the ambulance service is experiencing high demand.

From the introduction of the new procedure EMAS have responded to the following transfers from Chesterfield to Derby as below and their average timeframes are shown below.

Month Name	Pickup Hospital	Hospital	Total IFT CAT 2	Crew waiting time for patient to be ready to leave	Mean Response
October 2019	Chesterfield Royal Hospital	Royal Derby Hospital	8	00:20:44	00:40:27
November 2019	Chesterfield Royal Hospital	Royal Derby Hospital	6	00:25:18	00:39:50
December 2019	Chesterfield Royal Hospital	Royal Derby Hospital	7	00:26:21	00:29:32
January 2020	Chesterfield Royal Hospital	Royal Derby Hospital	3	00:29:54	00:34:25

We continue to monitor performance and take action to improve our operational response. I have enclosed a copy of a table outlining the actions we are taking, including those that are in collaboration with system partners

I hope that the information provided satisfies the questions you have raised and demonstrates the changes that have been implemented to improve IFT responses.

I can only apologise to the vascular surgeon that we did not provide the transfer in a timely manner and we are more than happy to keep an open dialogue with the hospital if they have any future concerns.

Please do not hesitate to contact me further if you require any other assistance in this matter.

Yours sincerely

Richard Henderson
Chief Executive

Encs

NHS
East Midlands Ambulance Service
NHS Trust

Mitigating Actions to Improve Quality and Performance
December 2019

It is recognised that there are multiple factors impacting EMAS' ability to respond to emergency calls in a timely manner, some of which are internal and some of which are external. The table below shows actions being taken by EMAS, including examples of collaborative work with system partners to improve our operational performance and hence the quality of care that we can provide. Actions being taken to monitor and mitigate risks to quality associated with current performance are also described.

Four Pillars of Performance			
Demand (largely external) *	**Resourcing (internal)**	**Internal Efficiencies (internal)**	**External Efficiencies (external)**
• Frequent caller team actively case managing patients • Joint proposal with DHU (111) regarding extending triage time from 30-60 mins (on hold as result of national directive) • Collation of data regarding lack of or failed alternative pathways for sharing with commissioners (crews using button on GTAC) • Collation of data relating to inappropriate 111 pass throughs for sharing with DHU and commissioners	• Recruitment as per workforce plan on track (c274 more WTE than this time last year) • Use of PAS to supplement rotas and meet ORH2 rota requirements (and beyond at times) • Clinical operational/ corporate managers forward facing at times of peak pressure • Robustly managing sickness and other abstractions • Cancellation non-essential meetings • Training programmes scheduled to avoid busiest winter period • Offering incentivised OT shifts over busiest winter period	• Tactical cells in operation 24/7 in each division to monitor in real time job cycle times and intervene as appropriate to promote efficiencies e.g. mobilisation time/ on scene time/ non-conveyance/ pre and post-handover/ resources per incident etc • Individual PIN reports showing job cycle times/ conveyance rates used in staff reviews • Avoiding drift into other divisions for non-life-threatening calls (increasing efficiency by reducing travel time) • Make ready to increase vehicle availability for clinical response	• Working in collaboration with acute partners to implement protocols to free up crews to respond to patients waiting in the community e.g. Rapid Handover (Lincs) and Ambulance Escalation Pod (LLR) • Managerial presence in EDs managing turnaround and supporting staff • TAC cells in operation 24/7 in each division to monitor in real time job cycle times and intervene as appropriate to promote efficiency including pre-handover

	• Promoting flu campaign and monitoring uptake (incentives)	• Reduced vehicle off road time by proactive maintenance • Benchmarking with and learning from other services • Increasing hear and treat (e.g. MH clinicians in EOC to manage MH calls) • Safe non-conveyance guidance for technicians on scene (using NEWS2) • Clinical Assessment Team (CAT) targeting calls most likely to be suitable for non-conveyance	

Further actions to monitor and mitigate risk

- Strategic and tactical commander rotas and business continuity exec on call – appropriate system escalation in response to dynamic risk assessment
- Winter concept of operations (winter plan)
- Capacity management plan to ensure limited resource targeted at most clinically urgent (C1/C2)
- Welfare calls and re-prioritisation where performance targets not met with referral to CAT for further assessment/ escalation as appropriate
- Monitoring quality metrics including PSIs/SIs/FCs/PALS/ACQIs/CPIs
- Internal process of proactive harm reviews for prolonged waits with appropriate escalation of cases where required
- CCG facilitated end to end harm review process for prolonged waits with appropriate escalation of cases where required
- Learning from Death reviews

*we cannot directly impact activity that comes into the service but we can influence the way that activity is managed which would reduce demand on other parts of the system