[redacted]

Blackpool Clinical Commissioning Group
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FAO: Andrew Bridgman
HM Coroner
Manchester South
1 Mount Tabor Street
Stockport
SK1 3AG

22nd April 2021

[redacted]

Dear Mr Bridgman

Re: Regulation 28 Report into the death of Martin Sullivan

We are writing in response to your Regulation 28 letter dated 2 March 2021 in relation to the death of Martin Keith Sullivan. We note the areas of concern that you have raised and address each of them below. In preparing this response we have liaised with NWAS to provide additional information and context to the matters of concern. At this time, as Commissioners, we also wish to formally take the opportunity to express our deepest sympathies to Martin's family in addressing the concerns you have raised.

1. and 2. The MPDS Algorithm and Rule 6

The choice of which clinical decision support tool to operate in the 999 environment lies with NWAS as the ambulance service provider. MPDS is an internationally developed and accredited tool provided by the International Academies of Emergency Dispatch (IAED) and is used by several UK ambulance services. The outcomes reached after MPDS assessment are aligned to the ambulance response categories. These are nationally determined and not set by NWAS or commissioners.

The identification of ineffective breathing, which would receive a Category 1 response, is an ongoing challenge to all ambulance services. Historically call takers were required to remember phrases or words given by the caller that indicated the patient was suffering from ineffective breathing.

NWAS established an internal task and finish group in 2019 to understand the issues in more detail and to feed into the national review process. On reviewing the outcomes of this task and finish group NWAS decided that further work was still required to further improve the identification of ineffective breathing and there was wider recognition of the issue. This has been taken forward nationally as this is a theme raised by all Ambulance Trusts utilising MPDS. NWAS, alongside other ambulance trusts, are part of a national working group to agree revisions to MPDS standards, including the identification and recognition of the importance of ineffective breathing.

A series of actions were taken in January 2020 to further improve the responsiveness to calls involving ineffective breathing and are summarised as follows: -

- 1:1 training of all their call takers, along with issuing operational educational bulletins and introducing an electronic 'pop up' to aid call takers in identifying ineffective breathing
- Staff bulletins issued to reinforce where and how ineffective breathing should be identified

[redacted]

- A review and reissuing of training packages
- Further and ongoing thematic analysis and reporting
- NWAS developed a simulation-based online training platform, which is waiting to go live, coupled within a focused communications campaign within each of the NWAS Emergency Operations Centres (EOCs)

Progress against these actions is regularly reviewed at each monthly meeting of the commissioner-led Regional Clinical Quality Assurance Committee (RCQAC) to ensure that actions continue to be taken, and to support NWAS in national discussions on the ineffective breathing MPDS algorithm and working closely with the IAED to establish best practice for the identification of ineffective breathing and developing processes that will further reduce future risk.

The current position is that as of January 2021 NWAS perform similarly to other ambulance services in this regard and are not a national outlier in recognition of ineffective breathing.

3. Service Performance and Contracting

In terms of addressing your concerns regarding the performance of the service we felt it would be helpful to compare NWAS performance against the other ambulance trusts for the time in question. In the week in which the incident occurred no ambulance service nationally achieved the Category 1 mean response standard, and only 2 of the 11 trusts achieved the Category 2 mean response standard. Included in the appendix is a visual representation based on national data that shows this position.

All ambulance trusts principally achieve the Category 1 90th percentile standard, but again only 2 ambulance trusts achieved the Category 2 90th percentile standard in the week in question. This highlights the significant operational pressures all ambulance services were facing at the time and the challenges adapting to the new service models needed for the Ambulance Response Programme (ARP) approach nationally adopted in August 2017 (Appendix 1).

In terms of addressing your concerns regarding the funding that is placed to allow NWAS to deliver the service, we have summarised the contacting process as follows. On an annual basis, in line with the requirements of the annually published NHSE/I Planning Guidance, discussion meetings are held between commissioners and NWAS. Their purpose is to negotiate and agree the contract both in terms of cost, volumes of activity based on previous funding levels, achievement of performance standards and agreed internal transformation plans in line with the national Planning Guidance requirements.

The starting point for this is the historical cost of the service, any anticipated increases in overall demand for the service, how the demand is balanced across the acuity of patients and how NWAS respond to the demand managing incidents appropriately. This covers increasing the number of options for patients who would elicit a Hear and Treat and/or See and Treat response to reduce avoidable conveyance. These and other initiatives are designed to ensure that the patient is directed first time to the most clinically appropriate service (only in the cases where a category 1 or 2 response is not clinically indicated). These initiatives are designed to support improvement in ambulance response times and release increased capacity for those patients who do require a category 1 or 2 response and conveyance to hospital. Having agreed the contract, it is then a matter for the trust to determine, operationally, how it will respond to demand and deliver the national standards expected of it. Over the course of each contract year commissioners meet regularly with the trust to monitor levels of demand, performance being achieved and patient safety, and there is a well-defined governance structure in place to enable this to happen.

The investment over recent years has been in response to changes in demand and the national Ambulance Response Programme (ARP) standards that were introduced in August 2017. This replaced the previous targets with a fairer system whereby ambulance trusts would be measured on both their mean and their 90th percentile performance for each category of patient. Commissioners have invested significantly in the ambulance service since the introduction of the ARP standards.

The contract is based on achievement of the national ARP Targets at a North West level. This is in line with national policy and remains the current position. We have set out below a summary of the investment made by commissioners between 2016/17 to March 2019/20. This is summarised in table 1 below.

Table 1 – Commissioner investment agreed with NWAS

Total NWAS Funding Available	£	Year on Year Growth	Growth since 2016/17
2016/17	222,910,434		
2017/18	248,735,780	11.6%	
2018/19	261,393,154	5.1%	
2019/20	283,349,758	8.4%	27.1%

Note: The majority of the funding available to NWAS is for use by them in delivering front line services. A small proportion of the overall funding is for specific use including funding such as Hazardous Area Response Teams (HART) and targeted support over the winter periods.

At the point of contract agreement, it is then for NWAS to implement an approach that will deliver the outcomes agreed, i.e. ARP standards. Commissioners do not specifically determine how many ambulances they have, where these are distributed, what shift times they operate and so on. This level of operational detail is down to internal NWAS planning and service delivery.

The specific point raised in your letter of NWAS seeking additional investment in November 2019 and being utilised from February 2020 is not recognised by commissioners as an external funding issue. As stated above it remains for NWAS to determine in year any shift in allocations of funding flexibly within and across the Trust to maintain patient safety and achieve the national performance standards, performance, and patient safety. Therefore, we are unable to comment further on the point made as this was not a request made by NWAS to commissioners and our understanding is that this would be an internal operational matter for NWAS.

We monitor performance by sector, sub-regional and on an overall regional trust performance daily. In terms of the actual deployment of resources this remains as described a matter for NWAS to operationally manage. We have asked NWAS to provide additional information on the activity on the day in relation to resources deployed at trust sub-regional and sector level at the time of this tragic incident. On the day of the incident at 06:22 between the first and second call NWAS had 162 incidents awaiting allocation – a high number of which were C2. Of the 162 waiting incidents, 82 were in GM.

Planned resources are determined by NWAS and based on predicted activity for the particular day. Of the 6 ambulances on duty in the Oldham sector at 06:16, when the call for this patient was received, 1 was unavailable in line with the Meal & Rest Break policy and finished shift at 06:30, and the remaining resources were already committed to incidents. The 1 unavailable resource finished shift at 06:30 and after the day shift commenced, was allocated to a longer waiting category 2 incident. A further 2 resources cleared during the call cycle but were unavailable in line with Meal & Rest Break policy. Both of these resources finished shift at 07:00**.**

The availability of resources to respond to the incident in question and any impact of the changing daily profile is a matter for NWAS. However, the level of planned responding resources will vary due to the time of day in relation to predicated levels of activity and the level of demand at different times of the day (Appendix 2).

As commissioners we are responsible for holding NWAS to account for the achievement of the ARP standards. In the monthly contracting meetings, we highlight any issues of performance and strive to work

with the trust to improve their performance, recognising any challenges and seek to agree remedial action plans within the contract terms and conditions.

Following extreme pressure on the service in early November 2020 NWAS reviewed the effectiveness and appropriateness of their Demand Management Plan (DMP) in place at the time and the triggers and actions aligned to them.
The DMP was subsequently replaced with a new Patient Safety Plan (PSP) on 26th November 2020. The aim of the PSP is to enable NWAS to respond earlier in terms of escalation in a timely and appropriate manner to increased service pressure, enabling an NWAS wide response as soon as identified triggers are met.

The trigger thresholds from the DMP in many areas have been reduced to assist earlier implementation of actions to reduce the number of calls waiting and improve service responsiveness. The PSP is more interactive with the local health care economy as well as internally across NWAS, including NHS 111 and Patient Transport Service.

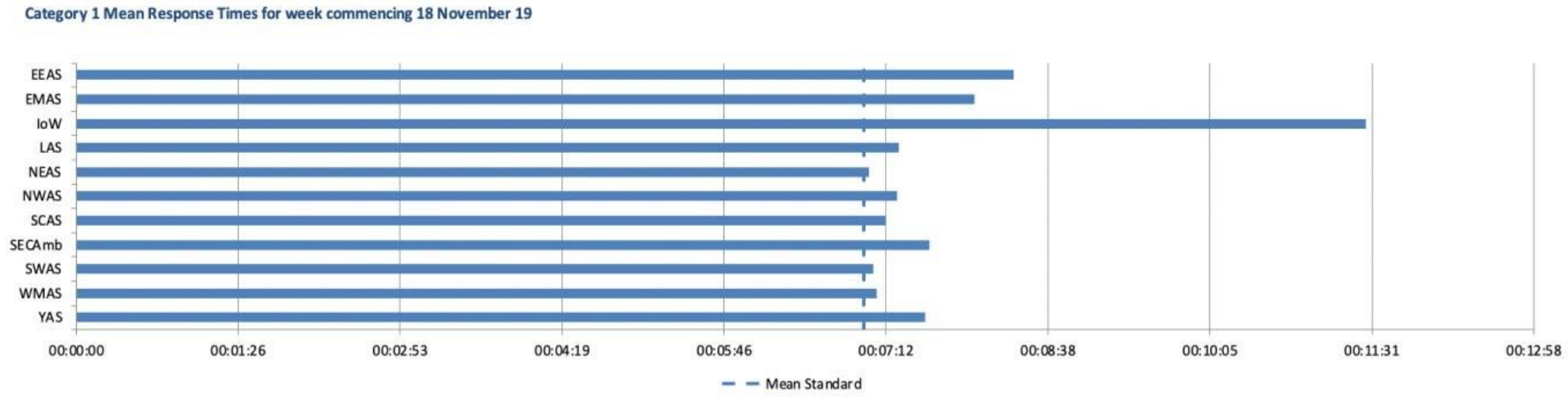
In conclusion we acknowledge the findings made at the Inquest that there were issues with the prioritisation of the call and that on the day NWAS were unable to allocate resources to ensure Martin received care within the ARP target time. In our response we have sought to provide additional details and information to give assurance that there is and has been active, detailed work undertaken to address a nationally recognised challenge in relation to the identification of patients with ineffective breathing. This work continues and receives regular oversight through our clinical governance and quality interactions with the trust. In addition, we have sought to provide more detailed information with regards to the funding of NWAS and the contractual relationship between commissioners and the trust.

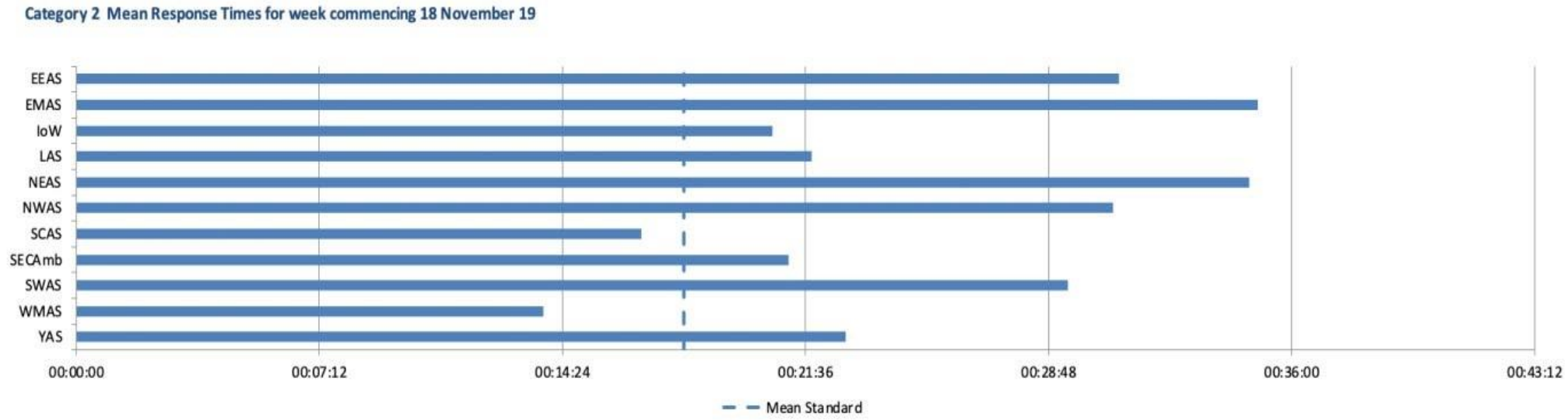
Yours sincerely

Director of Ambulance Commissioning (North West)
Hosted by NHS Blackpool CCG

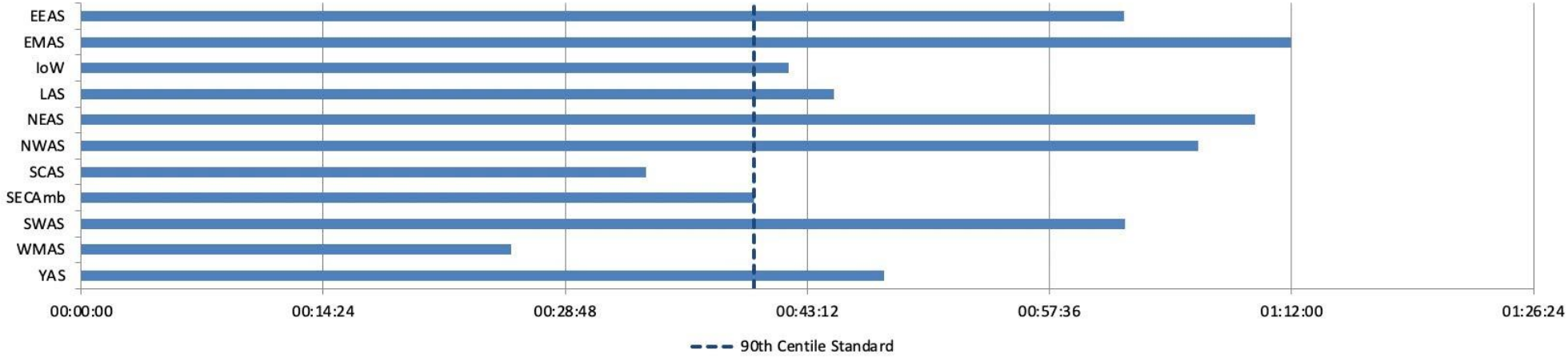
Appendix 1

Visual representations of performance achieved nationally by ambulance trusts in the week in which the incident occurred.





Category 2 90th Centile Response Times for week commencing 18 November 19



Appendix 2

NWAS & GM Staffing levels for Sunday 24th November 2019

Hour of Day	0600	0700	0800	0900	1000	1100	1200	1300	1400	1500	1600	1700	1800	TOTAL
GM Rostered	59.8	59.0	78.0	84.8	100.5	105.5	116.0	121.0	122.5	123.5	120.5	120.3	124.7	1,336.1
GM Planned	58.3	60.4	77.0	83.3	97.5	102.5	111.0	116.5	118.0	118.8	115.3	115.3	116.7	1,290.4
GM VAS / PAS	1.0	1.0	2.0	3.0	5.0	7.0	8.0	8.0	8.0	8.0	8.0	8.0	8.0	75.0
Difference	-0.5	2.4	1.0	1.5	2.0	4.0	3.0	3.5	3.5	3.2	2.8	3.0	-0.0	29.4

Hour of Day	0600	0700	0800	0900	1000	1100	1200	1300	1400	1500	1600	1700	1800	TOTAL
NWAS Rostered	181.8	189.0	236.5	245.3	278.0	294.5	313.5	322.5	338.0	339.0	335.0	335.8	337.7	3,746.6
NWAS Planned	172.6	183.5	229.4	238.3	268.5	286.0	302.0	310.4	325.5	326.8	322.3	323.3	319.8	3,608.2
NWAS VAS / PAS	2.0	1.0	2.0	3.0	8.0	13.0	15.0	15.0	15.0	15.0	15.0	15.0	15.0	134.0
Difference	-7.2	-4.5	-5.1	-4.0	-1.5	4.5	3.5	2.9	2.5	2.7	2.3	2.5	-2.9	-4.4

Rostered = Covering every shift for the full length of the shift. I.E. 100% staffing.

Planned = This level is Rostered minus the following: Vacancies, abstractions (such as Annual Leave, Sickness, any training or stand downs), shift swaps or any other reason why a member of staff is not on their shift for that day.
Then Plus the following:

Relief staff to back fill abstractions (such as Annual Leave, Sickness, any Training, etc.), plus Overtime, plus Private and Voluntary ambulance vehicles.
This level is the Planned level and is the best that the rostering teams as able to produce with the staff available to them. This is the final level that is provided to EOC in advance.

Actual - This is the Planned level minus any last minute ("On the Day") downtime or changes, such as: Lateness, no vehicle available, late notice sickness, meal / rest breaks, etc. This level is only available from the CAD systems and is not in this report.

The planned data for this report has been taken from GRS using the attached SQL. The Rostered level was taken from the Second script. These are both long standing scripts for calculating Planned and Rostered levels. Calculating a historical Rostered does mean that it can be affected by any changes made by the Rostering staff.

The information in this report is reliant on the accuracy of the information entered into GRS and is accurate to GRS as at 09:00 14/04/2021.