**East of England Ambulance Service NHS Trust**
Whiting Way
Melbourn
Cambridgeshire
SG8 6NA

HM Coroner Darren Stewart OBE
Area Coroner for Suffolk
By email

4 March 2024

Dear Mr Stewart

I am writing further to the inquest into the death of Dennis John William King, which concluded on 29 November 2023. I understand that the Trust were not Interested Persons and no Trust witnesses were required to give evidence at the inquest to provide further information in relation to our action plan.

Following the inquest, you made a Regulation 28 Preventing Future Death report on 15 January 2024 outlining your concerns for the availability of ambulances to respond to transfers and 999 calls; lack of clarity between ambulance and hospitals in relation to transfer requests; the adequacy of the action plan provided by the Trust; and the appropriateness of centralising care in regional centres. I have not commented on the latter concern as it is outside the scope of the ambulance service.

**Availability of ambulances to carry out transfers in a timely manner**

The Trust has a range of specific actions in place to improve response times to patients which include:

- Additional recruitment with the aim for there to be over 300 more frontline clinicians in place by March 2024.

- Additional recruitment of clinicians within our control environment, allowing for greater volume of clinical triage to improve patient safety and to transfer patients to alternative services where appropriate. This is supported by the establishment of an Unscheduled Care Coordination Hub within Suffolk where we are working with the Integrated Care Board, the 111 provider and community services to increase referrals of appropriate patients to alternative services and to provide remote support to crews on scene.

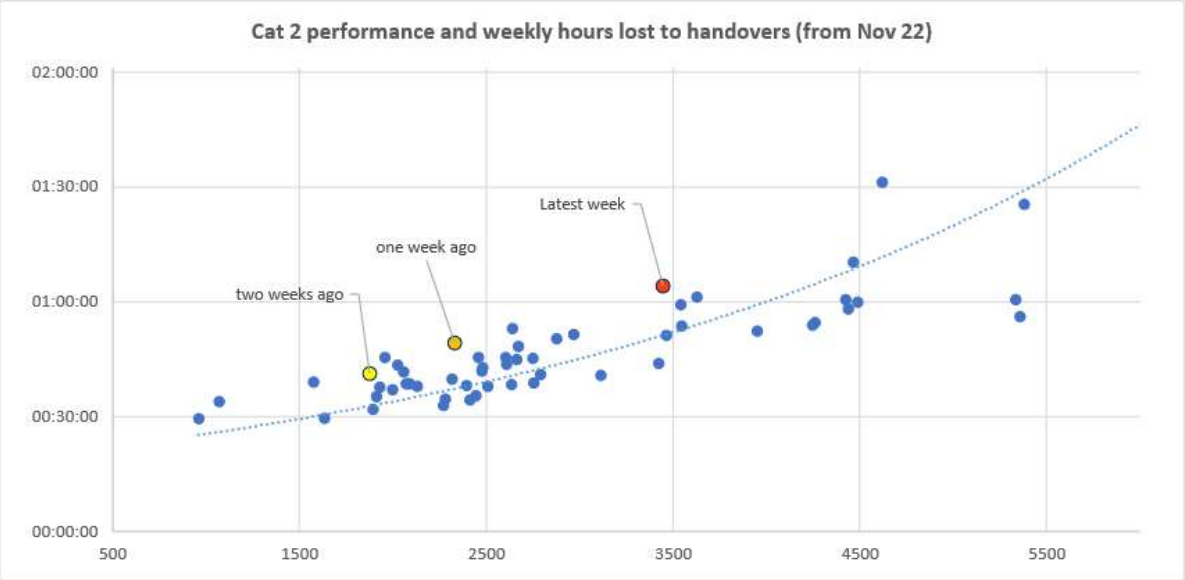
- The implementation of our Operational Performance and Improvement Plan, which is our plan to improve our own efficiency as an organisation and to maximise ambulance availability. I attach a presentation on OPIP with this letter to provide an update on this work.

Meeting the C2 response time has been a challenge for all ambulance services. Modelling by NHS England (NHSE) demonstrates there is a strong relationship between hospital handover delays and the ambulance C2 performance. NHSE's regression model indicated that based on previous performance, in order to reach an average response time of 30 minutes for C2 patients,

[redacted]

a maximum of 1,500 lost hours per week should not be exceeded (see graph below). Equally if more than 1,500 hours are lost per week, the C2 response time is unachievable.

The Regional NHSE oversight meetings have been formed to support this important maximum standard. Currently levels exceed this significantly and in Q2 weekly lost hours exceeded 2,582 hours per week.




Specifically in Suffolk, we have been engaging with the local Acute Trusts to reduce delays, which has started to have a positive effect on the number of our vehicles delayed at hospital. The Trust is also working with our ICB colleagues in Suffolk and across the region to implement the 'Call before you convey' programme. This allows frontline clinicians to speak with senior clinical advisors before making a decision on conveyance and check the most appropriate pathway for the patient is being followed. In the past month, the Trust has implemented the same-day emergency care team at West Suffolk Hospital to ensure patients are attending the right facility at the right time to avoid unnecessary handover delays in the Emergency Department. In addition to this, in Suffolk, a mental health joint response car has recently been implemented jointly with the Norfolk and Suffolk Foundation Trust and a 24/7 advanced practice paramedic car is also now live in the Suffolk area.

**Confusion as between ambulance and hospital staff and a lack of clarity in the purpose of and process for the categorisation of transfers**

The National Framework for Inter-Facility Transfers is produced by NHS England and we will endeavour to review this framework with NHS England in light of Mr King's death.

I can confirm that the call has been reviewed and at no point was the hospital matron informed that the patient was at a place of safety when she challenged the timeframe. The call handler gave appropriate information during the call in relation to call categories and delays. I am happy to share this call recording with you if required.

[redacted]

**Adequacy of the action plan provided to the court in addressing the concern at (a) above and that of ambulance attendances to 999 calls the plan is generalised, lacking detail and any means of measurement of progress.**

The action plan disclosed to you is an information sheet shared with families where a Serious Incident (as they were referred to at the time) is declared and the aim is to provide a high-level overview of the actions the Trust is taking to tackle the demand challenges we face. The plan provided to you was an existing version and has been updated a number of times since this incident. It is currently under review and, once approved, we will share an updated copy with you. The OPIP (as outlined above) is the more detailed action plan that the Trust has had in place to improve response times.

In light of your comments on this matter, the Legal Services Team is reviewing the information we share with Coroners when the initial request for records is received to ensure we are providing the most appropriate and up-to-date information to support the coronial process.

We are continuing to work with NHSE and our other healthcare partners to improve our response times to our patients. Please do not hesitate to contact me should you require any further information.

Yours sincerely,

[redacted]

[redacted]
**Chief Executive**

[redacted]