NHS
Derby and Derbyshire
Integrated Care Board

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Date 17 January 2025

Dear Sophie Lomas,

Subject: Regulation 28 with respect to the death of Mrs Vera Spencer

Thank you for raising your concerns with us on this important matter.

Derby & Derbyshire ICB extend our sympathies to the family and friends of Mrs Vera Spencer over their loss. Secondly, we have examined the issues you raised in the regulation 28 notice.

The Regulation 28 Notice identified:

At times when the ambulance service is under extreme pressure, individuals who have fallen at home can wait many hours on the floor before paramedics can attend. This is usually because falls are given a lower categorisation by the ambulance service because it is not a life-threatening situation. Resultant long lies can increase the risk of pneumonia, pressure damage and Rhabdomyolysis. The court heard evidence that other than the ambulance service, there is no local falls service or team operating out of hours to assess patients and assist them off the floor following a fall.

Derby & Derbyshire ICB response:

At the time of Vera's fall, the Team Up falls service was resourced to support non-injurious falls, so an individual with a fractured hip would not have been suitable for that type of response.

We are aware that some areas have since progressed into supporting injurious falls, and the plan is for all others to follow suit.

Action 1: Derby & Derbyshire ICB will seek to accelerate the development and roll out of a falls prevention service that is available to all residents in Derby & Derbyshire that includes consideration of an injurious falls service. This will be considered through in the local NHS planning & prioritisation process for 2025/26.

Long lies are variable in their effect on an individual, this is usually based on their co-morbidities/frailty prior to the fall. If an individual is not able to be retrieved from the floor, then the main concerns are hypothermia, dehydration, immobility, severity of pain and acute kidney injury.

In exceptional circumstances, next of kin or responders from the above options could attend on scene and support to confirm the need for ambulance, or recover if able, and manage symptoms and risks e.g. pain relief, temperature regulation, hydration, safe movement/pressure care, if a long wait for an ambulance is incurred. However, we are aware that in periods of severe strain upon acute & ambulance services that this approach may not always be successful in mitigating the risk of harm to patients. Therefore, the ICB recognises the need to look at further actions that may be put in place to mitigate the risk of harm.

Further options that the ICB will consider for alternative ambulance response out of hours:

Option A: DHU have staff trained in falls recovery as they provide some cover for the Team Up / UCR provision. Their falls response provision could be extended to cover 20:00-08:00, and Team Up and step-up virtual wards would provide the continuation of clinical support next day. If this was in situ, this individual could have been responded to by a team, observations completed, ambulance need confirmed through on-screen head to toe assessment, perhaps an urgent visit arranged from DHU medic for pain relief. It is likely that with a hip fracture suspected, the responders would not be able to safely lift the individual off the floor (teams only have seated lifted equipment). This option would offer the person in person support, confirmation of need and pain and other symptom management, but not remove the need for ambulance attendance in this case.

Option B: EMAS have a community first responder network who are volunteers and trained in falls recover, deployed exclusively by EMAS EOC. The provision can be variable in the hours available, and geographies covered However we can explore the possible extension of this service for the people of Derby & Derbyshire. Again, these teams would be limited to providing on scene support/monitoring but would likely not be able to recover the individual as they only have access to seated lifting equipment.

Option C: ICB to consult with technology enabled care providers to ensure they consider the provision of community-based response as an integral part of their services. Where TEC services do not provide in person response, there is an increased dependence/reliance on ambulance services for attendance to pendant alarm alerts. However, like the above option, if the TEC provider had attended in person, and confirmed the individual was significantly injured, the team would not recover, keep the individual safe, and escalate to the ambulance service to attend.

Option D: The district and borough technology enabled care providers that we have commissioned as part of the Team Up Enhanced falls response; all operate as 24/7 responding services for their main service provision (fee paying TEC services). Therefore, they could be commissioned by the ICB to extend this enhanced offer to cover 24/7, maintaining similar processes we have in place now for UCR. The provision offered by these providers is limited to Derby City, High Peak (excluding Glossop currently), Chesterfield, South Derbyshire, Bolsover, and parts of NE Derbyshire and therefore DHU would potentially offer a solution for the remainder.

Action 2: Derby & Derbyshire ICB will seek to implement options that further mitigate the risk of a long lie following a fall that is available to all residents in Derby & Derbyshire.

Derby & Derbyshire ICB recognise that there are times when the East Midlands Ambulance Service (EMAS) is under extreme pressure. These situations lead to unacceptable response times for severely ill and injured people within our community. Indeed we have just come out of an unprecedented EMAS critical incident due to such pressures.

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In this critical incident the local NHS worked together with the local authorities and the voluntary sector to reduce the response times for patients in the community. In the short term we will continue to work as a multi-agency group to try and minimise response times by EMAS. In the medium term we recognise that we will need to identify ways in which the demand for healthcare and healthcare beds can be reduced. This will require a blended approach that looks at:

1. Reducing the flow of people into our urgent & emergency care services through prevention
2. Improving flow through our acute sector and reducing length of stay in hospital beds. In the short term we have the local roll out of a technology known as Optica that has a proven ability to reduce length of stay in hospital settings
3. Continued working with social and voluntary care services to improve the speed of discharge of people when they are well back to their usual home setting.

Yours sincerely,

[redacted]

[redacted]
Chief Medical Officer