East of England Ambulance Service NHS
NHS Trust

Our reference : ACM /TN

Date : 11 March 2014

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Mr T Osborne
HM Coroner – Bedfordshire District
The Court House
Woburn Street
Ampthill
Bedfordshire
MK45 2HX

Dear Mr Osborne

Re: Response to Regulation 28 – Mr Albert Hand (deceased)

I write further to your correspondence of February 2014, where you advised that you were making a Regulation 28 recommendation to the Trust following the inquest into the death of Mr Albert Hand.

Following the inquest you asked the East of England Ambulance Service NHS Trust ('the Trust') to consider a number of points relating to your findings that I will highlight in my response. I can confirm that the Trust has undertaken several actions to mitigate the risk of a similar incident occurring.

I have highlighted the Trust's actions and progress under the specific headings you have asked us to consider:

(1) That a patient who has suffered a head injury has to wait for over one and a half hours to be conveyed to hospital

On this occasion a number of factors collectively contributed to the delay:

1. Initial response to original location with a solo paramedic in a rapid response vehicle (15 minutes)
2. Inability to find the patient as the incorrect location was given (9 minutes)
3. Assessment by the paramedic before requesting backup (11 minutes)
4. Waiting for an ambulance to arrive (23 minutes)
5. Re-assessment and extrication to the ambulance (22 minutes)
6. Conveyance to hospital (14 minutes)

All users of the 999 system are triaged by our Call Handlers in the Health and Emergency Operations Centre (HEOC) using the Advanced Medical Priority Dispatch System (AMPDS). The purpose of the triage is to identify the seriousness of the patient's condition by asking a series of focused questions around the chief complaint to arrive at a determined priority of call. The call priority then determines the level and type of response sent in line with Trust policies and national and government targets.

On 1 November 2013 at 13:17 hours, an emergency call was received within the Bedford HEOC from a passer-by who had seen Mr Hand fall. The Call Handler used the AMPDS system outlined above and

from the information provided during the call, the call was coded as a Red 2 as Mr Hand was described as not alert. Red 2 calls are immediately life-threatening and require an emergency response to arrive within 8 minutes irrespective of location in 75% of cases.

Three further 999 calls were received into HEOC as the location was given by three separate callers, none of whom were with Mr Hand, and caused some degree of confusion as to his exact location. On this occasion the Trust was experiencing data problems with the Ambulances and Rapid Response Vehicles (RRV) not receiving data via their Mobile Data Terminals (MDT). It is through the MDT system that the details of addresses and problem texts for patients on 999 calls are sent. When received into the vehicles this automatically activates the satellite navigation system giving the route to the address. It also automatically pages the hand held radios carried by the ambulance personnel to alert them that they have been assigned to attend a 999 call.

Due to the MDT failure, the EEAST Dispatchers were calling every resource dispatched to confirm whether they were aware they had been allocated to an incident and to confirm location details. This can cause some delays depending upon the volume of 999 calls being received in each area. The issues with the MDT are further addressed in (3) below.

The Bedford HEOC, where this call was dispatched from, had received a large volume of calls and the Trust had activated its internal Demand Management Plan (DMP) to level 1 at 13:10. This meant that there were more calls than we had ambulances for at that time and Mr Hand's call came in at 13:18, eight minutes after the DMP was activated. The DMP puts in place actions to maximise ambulance availability for life threatening patients.

An ambulance was dispatched towards the scene at 13:18 hours. Unfortunately, by the time confirmation of the incident had reached the crew they were already committed to the M1 heading back towards Bedford from Luton, with the nearest turnaround point being the junction at Flitwick. This ambulance was diverted to a different 999 call as a further ambulance had become available in Luton and this was dispatched towards the scene at 13:20 hours. An RRV was also dispatched to the scene as this was the nearest available resource.

Unfortunately, the ambulance was diverted at 13:25 hours to a further 999 call where the patient was confirmed to be unconscious with no other available resource to attend. However, the nearest available resource was still en route to Mr Hand, which we can confirm was the RRV.

At 13:33 hours the RRV contacted HEOC via the radio as she had been unable to locate Mr Hand on the original location given of Bute Street or near Lloyds Bank and was redirected by the Dispatcher to George Street where subsequent callers had given the location. At 13:33 hours a fifth call was received. This call was from a previous caller who was chasing up the ambulance. He was a shop worker who was unable to leave the shop to be by Mr Hand. The caller stated the patient had fallen and was unconscious.

The RRV arrived at the new location at 13:41 hours. Once a clinician arrives on scene it is usual to undertaken an assessment and determine the care plan for the patient. The clinician undertook an appropriate timely assessment and requested ambulance back up as a HOT 2 response to convey the patient to hospital. A HOT 2 response is divertible under emergency conditions, meaning that allocated ambulances can be diverted for a Red 1/Red 2 priority incident or a higher priority back-up request, such as a HOT 1.

An ambulance became available to attend Mr Hand at 14:06 hours and was immediately dispatched to the scene arriving at 14:15 hours. This was 57 minutes from the time of the first 999 call and nine minutes from the time of the ambulance back up request. At this point, Mr Hand was able to communicate with the RRV as he was able to tell the Paramedic what had happened and to give her all his personal details. This was why the clinician had made the request as a HOT 2 back-up request rather than an HOT 1. The patient would have been moved into the ambulance and re-assessed as well as being attached to monitoring equipment; in this case it took 22 minutes which is not unusual.

In summary, the delay in this case was caused by a number of factors including a technology failure, increased demand and the wrong location being given by the callers.

The Trust is absolutely committed to ensuring the Trust can consistently respond in a timely manner to all calls. The Trust commissioned a Clinical Capacity Review in 2013 which clearly showed that we did not have enough ambulances to enable the Trust to meet its call demand in certain areas. The findings of this review have been shared with the Clinical Commissioning Groups as additional funding is required.

(2) That there are insufficient ambulance crews in the Luton and Bedfordshire area to meet the emergency needs of the community.

The Chief Executive Officer, Dr Anthony Marsh, joined the Trust on 1 January 2014. Dr Marsh has six key priorities for the organisation which include recruiting 400 more staff and providing more ambulances across the whole service. It is recognised that the Trust has had historic staffing problems due to a national shortage of paramedics to recruit to the vacancies, but the Trust has in place a significant recruitment drive which will enable more ambulances to be on the road over the next two years. As such, it is envisaged that patients will receive a timelier and more appropriate response to their 999 calls.

Notwithstanding the priorities set out by Dr Marsh designed to increase resource availability across the whole area covered by the Trust, Luton and Bedfordshire consistently achieve their commissioned target and regularly exceed it across all Clinical Commissioning Groups within the county. The Trust is commissioned regionally to reach 75% of all its life-threatening emergencies within eight minutes. This is in line with the national targets set by the Department of Health. Clearly, due to the events described previously, the Trust was not able to meet this target on this particular occasion.

Luton and Bedfordshire continue to produce results that are above the commissioned targets. The county has a mixture of ambulances and Paramedic response cars which enable the patient to receive clinical care in a timely manner and patients are transported to hospital where appropriate to their clinical needs.

Bedfordshire has a full complement of staff and Luton has some Paramedic vacancies which are actively being recruited to as part of the current recruitment programme by the Trust. The key priorities of Dr Marsh will ensure that front line staff capacity will remain the critical focus of the Trust.

To address the issue of response availability in general, the Trust is taking internal action against the six key priorities set. These are:

1. Recruit 400 Student Paramedics in 2014/15
2. Up-skill ECAs to technicians and EMTs to paramedics (staff development)
3. Maximise clinical staff on frontline vehicles
4. Reduce response cars and increase ambulances
5. Accelerate fleet and equipment replacement programme
6. Reinvest corporate spend in frontline delivery

(3) That the Protocols in place for dealing with emergency calls are putting patients at risk and may result in future deaths.

The organisational priorities outlined above will continue to be augmented with the clinical coordination function within the HEOCs. This function maintains a robust clinical review for those patients that require further interrogation via the telephone in order to gain a more detailed clinical picture of the patient's condition. This enables the Trust to change the priority assigned to a call based on any significant changes in the patient's condition. The clinical coordinators will continue to play a key role within the HEOCs to provide senior clinical presence within the rooms.

The Trust's Demand Management Plan referred to in (1) above has been reviewed and an updated version has been approved and is now in use. This will enable earlier escalation to senior managers during excessively busy periods of demand.

To support our staff further we have commenced issuing a clinical manual. The clinical manual has been developed by the Trust and is the first in the country. It supports the national guidelines by providing further details on assessment, interventions and procedures.

The Trust is currently commissioning an upgrade to the Computer Aided Dispatch (CAD) system which should see less technology failure. This is part of the on-going commitment of the Trust to ensure patient safety against a backdrop of increasing demand on our services.

I trust this information will show that the Trust has implemented significant changes following this tragic incident. Our thoughts remain with Mr Hand's family and friends.

Should you require any further information or clarification then please do not hesitate to contact me and I would be more than happy to come and meet with you.

Yours sincerely

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Director of Patient Safety and Clinical Standards / Consultant Paramedic