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Yorkshire Ambulance Service NHS
NHS Trust

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15 October 2014

Mr C. P. Dorries O.B.E.
HM Coroner for South Yorkshire West District
Medico-Legal Centre
Watery Street
Sheffield
S3 7ES

17 OCT 2014

Dear Sir

Inquest touching the death of Mr. Anthony Offord (deceased)
Response to Regulation 28 Report to Prevent Future Deaths dated 8 September 2014

Thank you for your report dated 8 September 2014, issued under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013. I note that your report is addressed to the Secretary of State for Health in addition to me as Chief Executive of the Yorkshire Ambulance Service NHS Trust ("the Trust"). I am aware that during the three day inquest heard on 24, 25 and 28 July 2014, you heard evidence about the actions taken by the Trust since Mr Offord's death to improve the systems and processes relevant to 'stand off' decisions. The purpose of this letter is to provide you with a full response to the concerns set out in your report of 8 September 2014, in so far as these are issues which can be addressed by the Trust on a regional basis. I appreciate that some of the concerns you raise are potential national issues and, where this is the case, I will defer to others in terms of the appropriate response.

I have responded to the concerns raised in your report in the order in which they appear namely:

1. Training for Emergency Medical Dispatcher ("EMD") staff and possible amendment to the breathing diagnostic tool,
2. The involvement of managers in 'stand off' decisions,
3. Consideration of all alternative methods of support in stand off cases,
4. The possibility of providing drivers for lone workers on late shifts,
5. Meal breaks

<u>Training for EMD staff and possible amendment to the breathing diagnostic tool</u>

Your concern:

There is (apparently) no training given to Emergency Medical Dispatch staff as to signs of respiratory difficulty including the well-known relevance of snoring in a person who cannot be roused. This may perhaps require an amendment to the breathing diagnostic tool?

Trust response:

All EMD's employed by the Trust undergo a robust training programme. This includes the following:

- Corporate Induction which includes Basic Life Support training and use of Automated Emergency Defibrillator (AED)
- A one week course on the Advanced Medical Priority Dispatch System (AMPDS) followed by a two day course on 'Medical' which is the triage tool used within the Emergency Operations Centre (EOC) with medical background information to support this. An exam is undertaken at the end of

this course whereby a minimum pass mark of 85% must be achieved and a candidate cannot progress further without this.

- A four week training course on the use of the Computer Aided Dispatch (CAD) system which is the system used within the EOC. Exams are taken throughout the course followed by a final exam. Only those that pass the exams are able to progress onto mentorship stage.
- A six week mentorship programme in the live environment, followed again by a final written exam and assessment.
- AMPDS re-certification every 2 years including evidence of continued development.

Specific training in relation to breathing difficulties is incorporated in the above programme and this particular element is heavily embedded in the triage tool. The AMPDS provides the call taker with information about ineffective and agonal breathing and how to recognise this. A breathing diagnostic tool is available to aid the EMD in making decisions about patient's breathing.

The breathing diagnostic tool (part of the AMPDS) is an internationally recognised and approved system used by Ambulance Services nationally. The Trust does not have the power to amend this system unilaterally and I note that your report has been copied to the International Academy of Emergency Dispatch with a view to exploring this issue further.

Within the Trust, a new Clinical Duty Manager (CDM) role was implemented within the EOC on 14th July 2014. A key part of the role is to actively 'floor walk' and listen in to calls to review for any changes in clinical condition. This would enable the EMD staff member to seek clinical input into a call as required.

<u>The involvement of managers in 'stand off' decisions</u>

Your concern:

That where crew make a unilateral decision to stand off there is no requirement for a manager to be informed, even when there is likely to be a delay in the provision of support.

Trust response:

The Trust is implementing a change in current practice within the EOC which is based around the Joint Decision Model (JDM). This is the standard decision decision making model used across the police service in the United Kingdom. The model seeks to bring together the available information pertinent to the decision, reconcile objectives and then enable effective decisions to be made.

The model will be applied to a wide range of scenarios, but in a stand-off situation, there will be a manager actively reviewing, assessing and building intelligence within the EOC to be able to make decisions and provide the front line clinician with robust information in order to support them to make a dynamic risk assessment of the situation.

All Duty Managers within the EOC have undertaken a five day training course in the model. The next phase of the rollout will be to provide all the CDMs and team leaders with the training. All other staff within the EOC will be provided with an awareness session so they understand the changes that are taking place. This is a phased implementation of the model and is estimated to be completed by May 2015.

Where there is concern for the patient in stand off scenarios, these are escalated via a Team Leader to the Duty Manager within the EOC. The Duty Manager and the CDM are seated together in the EOC, this means they are able to work together effectively when incidents such as this occur, and together use the JDM model to provide additional intelligence to the attending crew to assist their decision making at scene.

All Red 1 and Red 2 incidents (whether this relates to a stand-off situation or not) where the estimated time of arrival is greater than the response are actively listened to by clinicians within the clinical hub. Where these delays have been identified they are now escalated to a CDM for further clinical assessment.

Consideration of all alternative methods of support in stand off cases

Your concern:

That there is no system to ensure that all alternative methods of support are automatically considered when a stand-off occurs, not simply a double crewed ambulance.

Trust response:

An information bulletin has been provided to all staff within the EOC to remind them to consider all alternative methods of support in a stand-off situation, including all forms of responders, not just double crewed ambulances, and also, where applicable, other emergency services, such as the police.

The implementation of the JDM and the improved escalation processes, as described above, will also ensure that all alternative methods of support are considered.

The possibility of providing drivers for lone workers on late shifts

Your concern:

Consideration might be given as to whether drivers could be provided for lone responders on late shifts. This would be similar to the system used by many 'out of hours doctor' services and would provide some security for the lone responder thus lessening the need for stand-offs.

Trust response:

The above concern has been noted within the Trust. The Trust's Accident and Emergency Operations Workforce Model is based on the resources currently available in terms of the number of different response vehicles. These response vehicles consist of both lone worker and double crewed resources. To implement a system suggested would require significant numbers of extra staff across the region or alternatively, in the absence of additional staff, would lead to many responder vehicles being unused. This would not be practicable or manageable on the basis of current resources and funding arrangements. The introduction of additional funding to enable such a system to be implemented is not within the powers of the Trust.

The Trust has, however, reviewed and updated the Safety and Security Policy, which covers the process relevant to lone responding. Training and education about the dynamic risk assessment process for frontline responders has been strengthened and awareness about the JDM being implemented in EOC is planned prior to its implementation. Using the JDM will ensure a standardised framework is utilised for all stand-off decisions. Where stand off decisions are made they will be based on dynamic assessment relating to that individual incident with appropriate escalation as required.

Meal breaks

Your concern:

With some diffidence, the point should also be raised that apart from the other lone responders who were available, as referred to in 'Circumstances of the Death' above, there was another double crewed ambulance nearby which could very likely have reached the scene as early as 2310 -- a point at which Mr Offord might have been saved. Unfortunately at 2302 this vehicle had become 'unavailable out of meal break window'. I recognise that this is a difficult subject, with valid arguments on both sides. I appreciate that it is a national issue, much debated in the past, and I do no more here than record the position as regards that vehicle.

Trust response:

The Trust is continuing to review the meal break policy to ensure it meets the needs of both staff and patients in order to provide a safe, effective and quality service.

Additional matters

I am aware that you raised a concern during the inquest hearing, which is also referred to in your report, regarding incident reporting within the Trust. I take this opportunity to confirm that alerts have been issued to staff to remind them of the importance of incident reporting and detailing what constitutes an incident, near miss or issue/concern. From June 2014 the internal incident reporting line has run on a 24/7 basis to make it easier for staff to report incidents. Staff have been reminded, by way of an alert issued in August 2014, to specifically report any delays in response which they believe may have resulted in harm to a patient.

I hope that this letter provides you, and Mr Offord's family, with assurance that the Trust has taken this case extremely seriously, has carefully considered the concerns raised in your report and taken steps to improve the quality of the service the Trust provides to patients.

If I can provide any further information to you please do not hesitate to contact me.

Yours faithfully

[redacted]

David Whiting
Chief Executive Officer
Yorkshire Ambulance NHS Trust

[Cc Secretary of State for Health and the cc recipients of the Coroner's original report dated 8.9.14]