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East Midlands Ambulance Service NHS
NHS Trust

Emergency Care | Urgent Care | We Care

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SN/BW/smb/Brown
28 August 2015

Mrs L C Brown
HM Assistant Coroner
Leicester City and South Leicestershire
The Town Hall
Town Hall Square
Leicester
LE1 9BG

Dear Mrs Brown

Re: Report to Prevent Future Deaths: George Boulton (DECEASED)

Thank you for your Regulation 28 Report to Prevent Future Deaths, dated 6th July 2015, bringing to our attention the Coroners concerns arising from the inquest into the death of George Boulton.

I would like to assure you that within the East Midlands Ambulance Service (EMAS) all matters related to patient safety are taken extremely seriously. In particular, any matters arising from Coroners Inquests from which lessons can be learnt, and this includes any Prevention of Future Deaths (PFD) notices. All PFD's involving any Ambulance Service are discussed within our Coroners Working Group and learning shared.

This process has been applied to the Prevention of Future Death notice pertaining to the inquest into the death of George Boulton:

East Midland Ambulance Service did not identify that a request to collect a stroke patient should have been escalated to a medical emergency and a 20 minute response time, rather than the actual allocated 2 hour response time

Firstly, we would like to explain the current processes that are followed once EMAS receives a call from a GP requiring urgent transfer of a patient to hospital:

1) The call from a GP or Bed Bureau proceeds as follows :
   - The non-medical call taker will ask the caller, *"Does the condition present an immediate threat to life?"* (I would like to draw your attention to the fact that in common with all other ambulance services our call takers are not clinical, and therefore cannot override a GP or bed bureau decision)

- If the answer is "Yes", the call should be immediately processed using AMPDS (Advanced Medical Priority Dispatch System) or IFT (Inter-FacilityTransfer) protocols *(priorities available are 999= 8, 20, 30 minute response or 1, 4 or 8 hour IFT)*
- If the answer is "No", the call taker will then ask for the diagnosis.

2) The following information is requested and entered into the computer system :
   - The NAME of the GP Surgery
   - The reason for the admission, (i.e. *what is wrong with the patient*)
   - If Basic Life Support is sufficient or if a qualified crew is required
3) At the end of the booking the caller will be informed "Help has been organised as requested. We will be sending an ambulance in the agreed response time.
4) Worsening instructions are given. *"If the patient's condition deteriorates in any way please call back immediately"*
5) The call is ended by the call taker repeating the booking information back to the caller for confirmation and also informing them of the Call Reference number.

Prior to this Prevention of Future deaths (PFD) order being received our senior managers and business intelligence teams have explored the possibility of implementing the AMPDS system to triage all GP and Health Care Professionals (HCP) requests for urgent transport.

Following the initial scoping, it was determined that there is a potential for between 36% and 40% of all the HCP calls that we receive will filter into the RED category of Emergency call, requiring a minimum 8 minute response. This naturally has a significant impact on our ability to deliver on our National Performance targets as we would be trying to provide an immediate 8 minute response to an additional number of incidents each day.

This additional activity has been modelled and has concluded the following;

In order for EMAS to migrate over to this protocol and using a medical triage system (AMPDS) for all GP urgent and Bed Bureau calls, we will need to uplift the response capability across the region by additional Paramedics.

Until the additional staff are in post, EMAS would suffer significant performance degradation on a daily basis by trying to meet this additional level of Red demand. This may cause an increase in delays and this may put further patients at risk.

We will be having further discussions with our lead commissioners about the additional workforce changes required to implement the AMPDS system to GP and HCP urgent calls.

As this implementation will take some considerable amount of time, as an immediate action we will communicate with our lead commissioners to disseminate the following message to all GP's and Bed Bureau.

If a patient's condition presents an immediate threat to life or relates to new symptoms of Stroke or Cardiac chest pain call 999 for an emergency response, this ideally this should be done by the clinician on scene with the patient.

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We trust that this response meets the requirements of the prevention of future deaths order, if further clarification is required, and then please do not hesitate to contact us.

Yours Sincerely

Sue Noyes

Sue Noyes
Chief Executive

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Our Ref: SM/NA/

28 August 2015

Mrs C E Mason
HM Coroner
The Town Hall
Town Hall Square
Leicester
LE1 9BG

Dear Mrs Mason

Re: George Boulton

I write further to the Report from your Assistant Coroner concerning Mr Boulton sent to us on 6th July 2015 pursuant to Regulations 28 and 29 of the Coroner's (Investigations) Regulations 2013.

On the 12 February 2015, Mr Boulton's General Practitioner (GP) rang our Bed Bureau staff to arrange the admission of Mr Boulton. The Bed Bureau is staffed by junior administrators who are not clinically trained. The role of bed bureau staff is not to provide clinical advice to GP's about the management of their patient but is to facilitate admission to hospital based on the clinical needs of the patient as identified by the GP.

Our Head of Capacity and Flow, who manages the Bed Bureau, has identified the written entries that we hold concerning the telephone call received from the patient's GP, and they indicate that at 15h14 a call was received from the GP who informed our Bed Bureau Call-Handler that she suspected that Mr Boulton was suffering from a stroke and that he was showing right-sided facial weakness. Our protocol for such patients is for our Bed Bureau staff to invite the GP to consider whether their patient ought properly to be admitted via ED and if so to remind the GP that Bed Bureau staff can only order ambulances on a non-emergency basis which can take up to two hours to arrive. This protocol appears to have been followed in this case.

The records go on to suggest that the GP was to arrange admission via our Emergency Department (ED) and that the GP was to inform our ED that Mr Boulton would be arriving there. At 15h15 a member of our Bed Bureau Staff contacted our ED staff to inform them that Mr Boulton would be attending ED.

I consider that what happened in this case demonstrates that we do have a system for identifying calls from GP's that should be rerouted to an emergency admission.

Since the conclusion of your Investigation, our Head of Capacity and Flow has ensured that all bed bureau staff continue to be aware of the process to be followed should a GP seek to admit a patient via Bed Bureau when a stroke is suspected.

With a view to making our processes even more robust, by the end of September 2015 our Head of Capacity and Flow, supported by our Chief Operating Officer, will have designed a flow-chart to be used within the Bed Bureau to further support our junior administrative staff in prompting a GP to consider emergency admission should a GP seek to admit a suspected stroke patient via the Bed Bureau.

In our view it remains a matter for the GP to identify when emergency admission is required for their patient.

However in taking the actions that we describe above I trust this provides you with the assurance that we also take this matter seriously and are keen to support our colleagues in best delivering patient care.

If you wish to discuss this further with me, please do not hesitate to contact me.

Yours sincerely

John Adler
Chief Executive Officer

NHS England

Bruce Keogh
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H.M. Coroner for Leicester City and
South Leicestershire
Mrs Catherine E. Mason, LL.B, BSc
HONS; RGN
The Town Hall
Town Hall Square
Leicester
LE1 9BG

28th August 2015

Dear H.M. Coroner,

Re: George BOULTON

I am writing in response to your report under Regulation 28 and 29 regarding the sad death of George Boulton. Before I set out my response to the questions in your report I would like to express my deep sympathy to the Boulton Family.

NHS England has addressed your matters of concern as follows:

1. Response to potential stroke symptoms should be on an emergency basis, in accordance with FAST criteria. The GP attempted to arrange admission but accepted delays via bed bureau rather than convert to a 999 call and obtain immediate ambulance transfer.

All recent guidelines for stroke, NICE (2008) and the Intercollegiate Stroke Guidelines (2012) state that suspected stroke should be treated as a medical emergency with immediate admission to hospital and that it should elicit an urgent response. The NHS 111 services also have pathways that should lead to an urgent ambulance response. NHS England propose to make contact with GP practices through their membership organisations to reiterate the message, as has been the focus of FAST campaigns, that all suspected strokes should receive an urgent 999 response or that if the patient or carer first contacts the GP practice with a suspected stroke, the patient or carer should dial 999.

2. The Bed Bureau did not appear from the evidence available in court to have a system for identifying calls that should have been re-routed to an emergency admission, and not be dependent on a bed, as early scanning was essential for proper diagnosis.

Bed Bureau Services are local and variable in their organisation; however such services are guided by the opinion and requirements of the referring GP. As stated above, NHS England proposes to engage with GPs through their membership organisations so that all suspected strokes receive a 999 response.

3. East Midlands Ambulance Service did not identify that a request to collect a stroke patient should have been escalated to a medical emergency and a 20 minute response time, rather than the actual allocated 2 hour response time.

In terms of ambulance response there is an expectation that such a call should elicit an urgent response. My recent review of NHS waiting-time measures recommended that the ambulance service should test a series of changes to their current way of working. NHS England are undertaking a clinical review of the response protocols, which will lead to recommendations on changes to national ambulance service standards by autumn 2016. There is evidence to suggest that this would reduce operational inefficiencies currently experienced, whilst focusing on clinical need to maintain a very rapid response to the most seriously ill patients.

4. This culmination of events in this particular case allowed for the unexpected intervention of the District Nurse: while this is very case specific, similar delays, in another patient's care may allow further deterioration and the loss of treatment options.

In terms of national work, in January 2013 NHS England launched a review of urgent and emergency care services in England. The new urgent and emergency care system will ensure that those people with more serious or life threatening emergency needs receive treatment in centres with the right facilities and expertise. We have developed guidance which summarises practical design principles that local health communities should adopt to deliver faster, better, safer care. This will help front line providers and commissioners improve the flow of patients through the urgent and emergency pathway, increasing the availability of resources.

The review is now within its implementation phase and a key aspect of this is the establishment of urgent and emergency care networks (UECNs). UECNs will ensure that patients with more serious or life threatening emergencies receive treatment in centres with the right facilities and expertise. UECNs will also ensure that individuals with less serious conditions have their urgent care needs met locally by services as close to home as possible.

In particular, UECNs will focus on creating effective, joined-up pathways of care and working across traditional boundaries to ensure that all patients are managed using agreed pathways, that mutual trust is developed in the system and that no clinical decision is made in isolation. NHS England has been working hard with partners and experts from across the system to provide support and guidance for these emerging UECNs. Advice on the formation and operation of UECNs was published in June 2015.

We have set up an urgent and emergency care vanguard programme for

Strategic Resilience Groups and urgent and emergency care networks to help accelerate delivery of the principles envisaged in the Urgent and Emergency Care Review and to ensure the right care is delivered in the right place, first time.

I hope that this response containing details of the action proposed provides assurance.

Yours sincerely,

Bruce Keogh KBE, MD, DSc, FRCS, FRCP
National Medical Director
NHS England