NHS
South Western
Ambulance Service
NHS Foundation Trust

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**Private & Confidential**
Senior Coroner
Dr Elizabeth Earland
Exeter and Greater Devon Coroner's Office
Room 226,
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Topsham Road,
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EX2 4QD

Dear Dr Earland

**Prevention for Future Death Report- Colin Sluman**

We write in connection with the Inquest touching on the death of Mr Colin Sluman and in response to a Prevention for Future Deaths Report issued to the Trust in accordance with Sch 5 (Coroners and Justice Act 2009 and reg 28 and 29 of the Coroners (Investigation) Regulations 2013.

The report identified three chief concerns, which we will address in turn:

**(1) The protocol supplied by NHS Pathways to SWAST call handlers does not include reports of 'dizziness' and 'patients on their own' as important triggers for a rapid response to a report of catastrophic haemorrhage**

Upon making the call to the ambulance service, Mr Sluman explained to the Emergency Medical Advisor (EMA) that he was bleeding from the back of the leg. The EMA selected a 'Nature of Call' category, that is, they identified from a list the nature of call that best fits the description of what happened to the patient. In this case, the nature of the call was 'bleeding' and accordingly it was this that indicated the likely urgency of the call, although the final urgency was not determined until the triage was complete.

As a Pathway had now been identified, the Emergency Medical Advisor began to triage Mr Sluman using the triage tool- NHS Pathways. Depending on the Pathway selected, a series of questions devised by clinical experts and designed to assess the appropriate urgency and type of response required, is generated. The EMA is tasked with asking each question as scripted within the triage system and must select an appropriate response using the supporting information available. As non-clinicians, the EMAs are prohibited from deviating from the questions and are encouraged to ask them as they appear on the screen to ensure the clinical meaning of the question is accurately conveyed.

It is, however, the final urgency of the call that determines the category of response assigned to the incident. In this case, the full NHS Pathways triage process resulted in a disposition of 'emergency ambulance response for major blood loss' - Amber (R). This indicates that a blue light resource was needed, with a paramedic or autonomous clinician on board.

The questions generated by this Pathway did not include questions relating to dizziness nor did they prompt Mr Sluman to confirm whether he was alone. However, as Mr Sluman had informed the EMA towards the end of the call that he felt dizzy, the EMA felt this was relevant and decided to make a note of this on the system. As explained in her statement, the EMA felt comfortable that an appropriate disposition had been reached- that is, an emergency response with an indicative response time of 19 minutes. The EMA also confirmed that she knew that in the event of delay, it would be important for a clinician reviewing the records to be aware of this to ensure they could make an informed decision regarding any required escalation of the call. The EMA explained in her statement that she recognised that this call was very serious and attempted to consult a clinician once the call had ended.

At the time of the incident, an Amber (R) disposition was the second highest emergency response category and had a locally set target response time of 19 minutes. Other conditions likely to be assigned an Amber (R) disposition would include: Myocardial Infarctions, strokes and sepsis, which meant that the highest response category- Red calls would be reserved for those patients who were not breathing or conscious at the time the call was received. It is therefore important to bear in mind that the role of an EMA is to triage 999 calls before passing the responsibility for allocating a resource to the dispatching team. Whilst this does not negate their duty to alert clinicians to a call they have concerns about, it is their responsibility to ensure they answer 999 calls and so once the call had ended, the EMA in this instance would have been required to continue answering 999 calls rather than monitoring the adherence to a target response time.

Following the incident, concerns regarding the bleeding Pathway were quickly identified and escalated by the Trust's Clinical Lead to NHS Pathways for consideration. The concern as to whether a question relating to dizziness should be incorporated within the bleeding Pathway was first raised on 15th July 2016. The Serious Incident investigation report highlighting these concerns was also shared with their organisation in December 2016. It is the Trust's understanding that NHS Pathways has considered the concerns raised and do not feel that the addition of a question about dizziness would have raised the disposition level.

In terms of whether the fact that Mr Sluman was alone when he made the call was considered when triaging the call, again this is not a question that is contained within the Pathway and was not volunteered by Mr Sluman during the call. As explained above, EMAs are not permitted to deviate from the questions generated by the Pathway to ensure the required responses are elicited from the patient and an appropriate disposition is reached that is based on clinical presentation. However, in the event a patient advises an

EMA that they are alone, it would be good practice for the EMA to note this information on the log, as this might assist a Clinician tasked with reviewing the call.

The Trust does, however, operate a Welfare Call Standard Operating Policy (SOP), whereby if it is not possible to allocate a resource to a patient within the indicative response time, a call is made to check on a patient's welfare and reassess their clinical condition if necessary. At the time of the incident, the Welfare Call SOP in place, 'Ensuring patient safety at times of high demand' required a call following an Amber (R) disposition to be made at the time the incident breached its waiting time and for a Clinician within the Clinical Hub to endeavour to contact the patient every 60 minutes until a response arrived on scene. In this case, the time of breach was 01.56. No welfare call was made at that point due to the workload demand in the Clinical Hub. At 02.40, a Clinical Supervisor became available and attempted to make a Welfare Call to Mr Sluman. Sadly there was no response, and so the Clinical Supervisor made the decision to upgrade the call to a Red/Amber, which means it would be prioritised over other outstanding amber calls.

The Trust has carefully reviewed the Welfare Call Standard Operating Procedure (SOP) and is developing a new process tailored to meet the needs of the patients waiting for an ambulance to arrive. The focus of the new process moves away from a standard time based approach to making welfare calls which are patient centred and clinically driven. The new procedure starts with an early review of calls by a registered clinician who will, if indicated by the information gained through the triage, or if demand is likely to cause a delayed response, contact patients to conduct a more thorough clinical review. This will, in turn, inform any decisions to adjust the disposition and the timing of any further welfare calls required.

**.2) Call handlers are not clinically trained and are completely reliant on the protocol for categorising responses**

The Emergency Medical Advisors (EMAs) answering calls for the 999 service are not clinically qualified. They do, however, receive intensive training in the operation of the triage tool utilised in the Clinical Hub in which they are based. In this instance, the EMA was working from the South Clinical Hub in Exeter, where NHS Pathways is the triage tool utilised. Before the EMAs are permitted to take 999 calls, they are required to engage in a twelve week induction programme. The course materials are designed by NHS Pathways and although the course is delivered by facilitators employed by the Trust, these individuals are also trained by NHS Pathways.

The twelve week induction programme commences with three weeks of classroom learning, during which time there are three written assessments that must be completed. If these assessments are not passed, the candidate cannot continue with the training. On completion of the classroom learning the trainees will progress on to an eight week mentorship of supervised call practice, taking 999 calls. These calls are taken with either the training team or experienced Pathways 'coaches'. In the final week of the mentored call taking, the trainee will need to pass call audits undertaken by the Quality and Improvement team. These audits need to be passed for the candidate to continue with the training. On completion of these audits the trainee will need to complete a final classroom



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based assessment. Failure to pass this assessment will result in the candidate failing to pass the training. After successfully passing the induction training, the EMA's performance will be regularly audited and furthermore, they are required to complete all NHS Pathways updated training modules.

In terms of whether EMAs are completely reliant on NHS Pathways to reach a disposition, as the Pathways are meticulously devised by a panel of clinical experts, EMAs are for the most part, able to rely on the disposition reached. However, there are occasions where the Trust does not consider a particular disposition (as would be generated by NHS Pathways) for a specific patient presentation to be appropriate despite being clinically safe. On those occasions, the issues are escalated to NHS Pathways for review. Although the Pathways may be revised as a result, if change is not felt to be clinically necessary, it is for the Trust to determine whether local guidance or SOPs should be implemented to govern a particular situation and accordingly any policies would need to be ratified through internal governance procedures.

EMAs and EMDs (Emergency Medical Dispatchers) are able to access any guidance or SOPs affecting their working practices on their administrative computers, together with guides to explain any particular practices to be utilised.

Furthermore, in the event an EMA identifies a call as being complex, that is where a patient is presenting with multiple symptoms or the EMA feels the scope of the call is outside their experience level, the EMA can refer the call to a clinician for advice. A clinician is then able to review the call and the disposition reached to determine whether it is appropriate. A clinician is permitted to exercise their clinical judgement to upgrade the disposition where necessary and may decide to undertake an enhanced triage, that is a further consultation to inform their decision. In the event a clinician is not available to review a call, an EMA should escalate their concerns to more senior members of staff and ultimately to a Duty Manager, who is also able to upgrade a call.

Local guidance is also disseminated to EMAs with a view to educating them regarding any topical issues or red flags associated with particular conditions that may arise during a telephone triage. This enables EMAs to be alert to the clinical significance of symptoms raised, which may prompt them to seek clinical support during a call.

**3) There not being enough Clinical Supervisors available to call handlers for advice at all times nor do they have constant oversight of emergency calls.**

It is acknowledged within the Trust's Serious Incident report that Mr Sluman stated he was feeling dizzy towards the end of the call and that it would have been appropriate for the

EMA to seek advice from a Clinical Supervisor, as this symptom is not covered within the Pathway questions.

In her statement, the EMA explained that following the termination of the call, she looked on the internal telephony system to see if a Clinical Supervisor was available, in order to make them aware of the call but explains that none were available. In this circumstance, the expectation would have been for the EMA to have documented this on the incident log. Furthermore, options such as placing a 'warning on' alert with her concerns to a non-clinically qualified dispatcher were not utilised by the EMA. The aim here would be for the warning to be considered by the dispatcher, who could then consult a Clinical Supervisor. The EMA has reflected on this incident considerably and has explained in her statement that she would ensure this is documented in the future.

One of the actions recommended following the completion of the Serious Incident report was to increase the clinical support within the clinical hubs to meet the increasing demand. In response, funding was put in place to recruit an additional ten clinicians. A review of the clinicians' rota has also been undertaken to ensure clinician availability is proportionate to the time of day etc.

In terms of whether there is sufficient clinical support available to EMAs, South Western Ambulance Service Foundation NHS Trust operates its 999 service from two clinical hubs- one in Bristol (North Hub) and one in Exeter (South Hub). In addition to call handling staff employed to answer the 999 calls and dispatching staff, the Trust also employs registered Health Care Professionals including: nurses, paramedics, General Practitioners and midwives to support call handling and dispatch functions. The Trust has a minimum of four clinicians on shift per hub but averages between 6 and 10 clinicians in each Hub, excluding GP and midwife support. The exact number depends on the time of day and the day of the week.

Clinicians based within the Hub are tasked with: reviewing calls awaiting a response, providing telephone consultations and advice to patients, support to operational staff and are also pivotal in the management of frequent callers. Clinicians within the Hubs will be designated to certain work-streams during their shift to ensure as far as possible, an oversight of emergency and non-emergency calls. For example, in the South Hub, the core clinical staffing requirement is four. Of the four, one will be assigned to support the dispatchers. They are responsible for looking through the waiting emergency calls to identify those that may be of particular concern and those that may require alternative care pathways. They will then add those calls into the Clinical Support Desk queue, where they are then prioritised according to a timer so that the clinicians working from this queue will know which are the most urgent to review and upgrade where required. Another clinician will be assigned to Category 1 calls (the highest category response) to provide emergency pre-arrival advice and two clinicians will work on the Clinical Support Desk queue and log in to be available for EMA/EMD support. Any additional clinicians on duty will also work from the queue.

The Clinical Hubs utilise different triage tools (which was a consequence of the acquisition of Great Western Ambulance Service in 2013); the South Hub using NHS Pathways and the Bristol hub using MPDS for call handlers and PSIAM for clinicians. The Trust is, however, currently looking to implement a single triage system to align the working practices of both hubs.

In response to continual increases in call volume, the Trust has implemented a virtual telephony system to ensure an available call handler, irrespective of location, will take a 999 call on either NHS Pathways or MPDS. To further ensure accessibility of clinical support for EMAs, a 'hunt group' was introduced in November 2016 whereby EMAs are able to seek clinical support from available clinicians irrespective of their hub location, thereby maximising the clinical support available to call handling staff.

A further system utilised by clinicians within the hub is the Escalation Report. This is a tool on the administrative computers on each Clinical Supervisor's desk and is designed to assist clinicians to identify incidents that have been triaged to an 'Amber' disposition but may be in need of a higher level of urgency. It only includes those incidents where an ambulance has yet to be allocated and relates to those categories of call that have the potential to be life-threatening, as in this instance. A Clinical Supervisor can then review the incidents highlighted by this report and decide whether to call the patient for further triage and upgrade the call where required. Before this incident, 'major blood loss' (without other symptoms) did not appear as a category identified on the Escalation report. However, as a direct result of this incident, 'major blood loss' (without other symptoms) has been added to the Escalation Report and is also joined by other 'major blood loss' categories including ' major blood loss, non-trauma and shock'.

In providing you with a comprehensive response to the points raised within the report, we hope we have been able to provide both you and the family of Mr Sluman with assurance that the issues raised have been taken very seriously and acted upon. If we can be of any further assistance, please do not hesitate to contact me or the Claims and Inquests team.

Yours sincerely

**Ken Wenman**
**Chief Executive**