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Mr Russell Caller
HM Assistant Coroner for Inner West London
Westminster Coroner's Court
65 Horseferry Road
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5th September 2018

Dear Mr Caller

Regulation 28; Prevention of Future Deaths Report arising from the inquest into the death of Olive Nutt

Thank you for your Regulation 28 Report received on 24th July 2018 bringing to my attention matters of concern.

I would like begin by offering my sincere condolences to Mrs Nutt's family and I hope that this reply will be helpful in confirming the actions taken to demonstrate how the matters of concern have been addressed and the ongoing work to make improvements within the London Ambulance Service NHS Trust (LAS).

I will address your concerns as follows:

The LAS failed to make a relevant and proper note of the symptoms of the deceased when these were phoned through to the LAS and as a result the clinicians at LAS made an incorrect priority decision which caused significant delay in a timely attendance being made on the deceased.

LAS acknowledge and apologise for the regrettable delay in Mrs Nutt receiving an LAS resource. As set out in the evidence of [redacted] Senior Quality Assurance Manager at the inquest on 26th June 2018, the Emergency Medical Dispatcher (EMD) for CAD 3620 did not apply the Medical Priority Dispatch System (MPDS) protocol correctly. MPDS is an internationally recognised and utilised system of 999 call triage and dispatch of ambulance resources.

The error on the part of the EMD resulted in a potential under triage of the call, although as [redacted] set out in her evidence, we are unable to say whether the call would have received a higher priority as we will never know what the answer would have been if an additional question about whether the patient was alert, as opposed to being confused or disorientated, had been asked.

The EMD handling call CAD 3620 on 29th January 2018 has recognised their error and received prompt feedback on the incorrect application of the MPDS system and LAS protocols for call handling and triage. The EMD has reflected on this and learning points have been taken to reduce the risk of this situation, where an opportunity to record information given by a caller is missed, and to ensure best practice is achieved in the use and application of the MPDS protocol.

In addition, our most recent Core Skills Refresher course for Control Services staff which began on 2nd August 2018 and will run until the end of March 2019, includes refresher training on call handling and the application of the MPDS protocol. This refresher course will also specifically include an anonymised case study of the issues highlighted in the management of CAD 3620 as a 'learning from experience' example. All EMD staff are required to attend the CSR training and this case study is designed to provide EMDs with an example of best practice in applying the appropriate protocols when faced with this type of situation, to improve service delivery to patients.

The LAS breached its own pre-set time guidelines in failing to return a call to the deceased's home to take further details of her medical conditions.

Resourcing

During the afternoon of 29th January 2018 demand in the service was above that predicted and staffing levels both operationally and in the Clinical Hub were below the below the planned level.

For a day shift the minimum staffing level on the Clinical Hub is eleven members of staff, the level set by a matrix devised in 2013. Work is currently being undertaken to reassess the minimum staff levels in light of the changes within the new national response standard (ARP) and given that demand on the service has continued to increase since 2013.

As [redacted] set out in her evidence, by 17.00 hours around 150 calls were being held across London and this had reached more than 200 by 19.00 hours. Staffing for the Clinical Hub was challenging due to the volume of calls with one staff member above minimum levels to 19.00 hours and then one below minimum levels for the next hour. The Clinical Hub was holding 20 – 25 calls in the dispatch ring back group with only 3 – 4 clinicians available to ring back Category 4 calls which were on hold within the Clinical Hub dispatch group. A Category 4 call should be called back for a telephone assessment within 90 minutes and regrettably this did not happen on this occasion.

Due to the fact that demand for operational staff was high and operational staffing was also a challenge, it was unfortunately not possible to call clinical staff in from the front line to work on the Clinical Hub to increase staffing numbers on this day, which is an option if demand and staffing allow.

Resourcing is an ongoing challenge for LAS and we continue to work to address this, including securing funding for additional recruitment. I am very sorry that these difficulties resulted in a delay in ringing back Mrs Nutt to undertake a telephone assessment in a timely way.

Clinical assessment

The Clinical Hub clinician called Mrs Nutt at 19.37 hours, 2 hours and 6 minutes after the initial call. The Clinical Hub clinician who made the call back to Mrs Nutt had been due to finish her shift at 19.00 hours however due to the large volume of calls being held she continued to work well over the end of her shift on this day. Mrs Nutt spoke to the Clinical Hub clinician but a full Manchester Triage System triage could not be completed due the communication difficulties between Mrs Nutt and the Clinical Hub clinician. As such the Clinical Hub clinician correctly upgraded the call to a Category 3 response at 19.46 hours and also safety netted her decision by contacting Anchor care line to check Mrs Nutt's history.

Of note, evidence of good practice was demonstrated by the clinician on the Clinical Hub on this occasion in that she made a note on the log of the reason for the delay in ringing back Mrs Nutt. It is not mandatory to do this but it is recognised that to record this information is very helpful and enables other staff members to see where an issue has arisen and the cause of it.

Inclusion of this information is also recognised as helpful for data capture and identifying learning. This example of best practice will now be included in the next Manchester Triage System update which is provided regularly to Clinical Hub clinicians and it will also be included as a 'learning from experience' update which is run regularly for Clinical Hub staff to identify areas of learning and promote best practice.

Expansion of the LAS Clinical Hub

LAS are always striving to improve our service to patients and a significant amount of work is currently underway to expand our use and availability of the Clinical Hub. We currently have a Clinical Hub based at both our Waterloo and Bow sites. A planned expansion of the Clinical Hub facility involves the introduction of three additional Clinical Hubs in Kenton, Barking and Croydon which are planned to be in use by March 2019.

We are also planning to introduce a further Clinical Hub in New Maldon by the end of 2020. This will be a total of six Clinical Hubs for LAS with a view to covering each of our operational sectors.

The premise of this expansion is to allow for greater and more flexible staffing on the Clinical Hub and to assist with our winter resilience plan. LAS clinical staff have indicated it would be a more flexible option for them to book on to shifts more locally to their station rather than having to travel to sites at Waterloo and Bow. This will result in a larger pool of staff available to work on the Clinical Hub. The additional locations will also allow for the shift patterns to be more flexible with the option for staff to booking on to shift on the Clinical Hub for 2- 3 hours or half a shift either before or after working the rest of their shift on front line duties.

All staff working on the Clinical Hub are fully trained in the Manchester Triage System and they must undertake a minimum of one shift per month on the Clinical Hub to maintain their licence.

The LAS recruitment drive is ongoing for operational staff and a specific recruitment programme for the Clinical Hub is taking place in September 2018 with a view to increasing the pool of staff trained in the Manchester Triage System and with specific Clinical Hub training.

Improvements in accessing patient medical history

LAS have access to Summary Care Records, Co-Ordinate My Care and Adastra Electronic Patient Management system for all patients across London. These systems enable clinicians in our Clinical Hub to check a patient's medical notes and history. In addition, we will shortly have the benefit of a new version of Adastra, which will allow further access to records in CCGs which have signed up to this system. It will search five to six systems including NHS111 records, GP notes, mental health care plans, special patient notes and child protection plans and will continue to increase its range. This system will be of enormous benefit to LAS clinicians and will bring about a greater consistency in decision making for patient care.

Ambulance Response Times

I understand you expressed an interest in the response times assigned to call priorities. A national review is currently being undertaken, led by the Association of Ambulance Chief Executives (AACE) in the process of ringing back patients and safe systems and LAS will respond to any actions and outcomes from this. LAS are playing a significant role in this national review by submitting our data which is being used, in conjunction with other ambulance services, to identify areas for improvement and learning and also to identify and promote areas of good practice.

Yours sincerely

Garrett **Emmerson**

Chief Executive, London Ambulance Service NHS Trust