East of England Ambulance Service NHS Trust

Your Ref:

**Headquarters**
Melbourn Ambulance Station
Whiting Way
Melbourn
Cambridgeshire
SG8 6NA

Tel: 0845 6013733

23 January 2018

Clive Lewis MP
House of Commons
London
SW1A 0AA

Dear Clive,

Thank you for your letter dated the 18th January 2018.

Firstly, I can confirm that no concerns have been raised by any employee through the line management structure, the Trust's Whistleblowing Policy or the Trust's Freedom to Speak Up Guardians.

I have set out below response or comments to your specific questions:

1. What is the normal process whereby REAP levels are escalated or stood down?

2. Will you release the decision making criteria or rubric for those choices?

3. Who has normal operational responsibility for changing REAP levels?

***Response to Questions 1, 2 and 3:***
*The Resource Escalation Action Plan (REAP) is a nationally developed plan for use as guidance by all Ambulance Trusts alongside other business continuity plans. It is strategic in nature as opposed to the Surge Capacity Plan which deals with the more acute demand and capacity matters experienced at an operational level. The REAP was developed and updated by the National Ambulance Resilience Unit (NARU).*

*The criteria within the plan relating to NHS ambulance service targets is based on the previous NHS Constitution targets. In the autumn 2017, all Ambulance Trusts were required to transition to the new national Ambulance Response Programme (ARP). The current version (attached) is the latest version available to the Trust. Consequently, the target based criteria are no longer directly relevant. Decisions on criteria for level change are therefore subjective and are considered in the context of what other information and intelligence is available and what actions can be taken.*

*It sets out the normal process whereby REAP levels are escalated or stood down, what the decision making criteria is, what should be considered and how decisions should be informed and made. Where the Joint Decision Model (JDM) identifies that REAP should be enacted, then the plan provides for the Strategic Commander available to make the declaration.*

*In normal circumstances, EEAST operates a process whereby the REAP level is reviewed in weekly Operational meetings and if necessary, a recommendation is escalated through our operational governance structures for consideration.*

4. On what date was the first request made to go to REAP 4 by an appropriately qualified member (or members) of the Trust's staff?

5. *If any such request was made prior to the 31st December, why was it not acted upon?*

6. *If the answer to Q.4 is yes, who made the decision not to act?*

7. *If the answer to Q.4 is yes, by what authority, or with reference to what decision making rubric, was REAP 4 refused?*

***Response to Question 4, 5, 6 and 7:***
*There was no formal escalation by any of the Strategic Commanders or above groups to increase the REAP to 4. There were a number of ongoing discussions in relation to wider NHS pressures, specifically in relation to Hospital Arrival to Handover Delays. On 14 December 2017, whilst on REAP 3, - the Executive Leadership Board approved a recommendation to introduce overtime incentives for various periods between the 24 December 2017 and the 2 January 2018 which our Forecasting and Planning Group were highlighting as period of expected high demand.*

*No recommendation to move to REAP 4 was made on 19th December 2017. However, senior operational leaders did discuss REAP 4 as an option but there was no formal request made at that time. Given the emerging pressures, specifically demand from 111 and Hospital Arrival to Handover Delays, the Director of Service Delivery consulted with the Executive Leadership Board on 19th December 2017 about a proposal to pre-approve escalation if deemed operationally necessary during the festive period*

*A review of REAP occurred on the 28th December and concluded that REAP 3 remained appropriate. A further review early on 31st December concluded that given the wider system issues were not improving, that a move to REAP 4 was then appropriate.*

8. Who made the decision to go to REAP 4 on the 31st December?

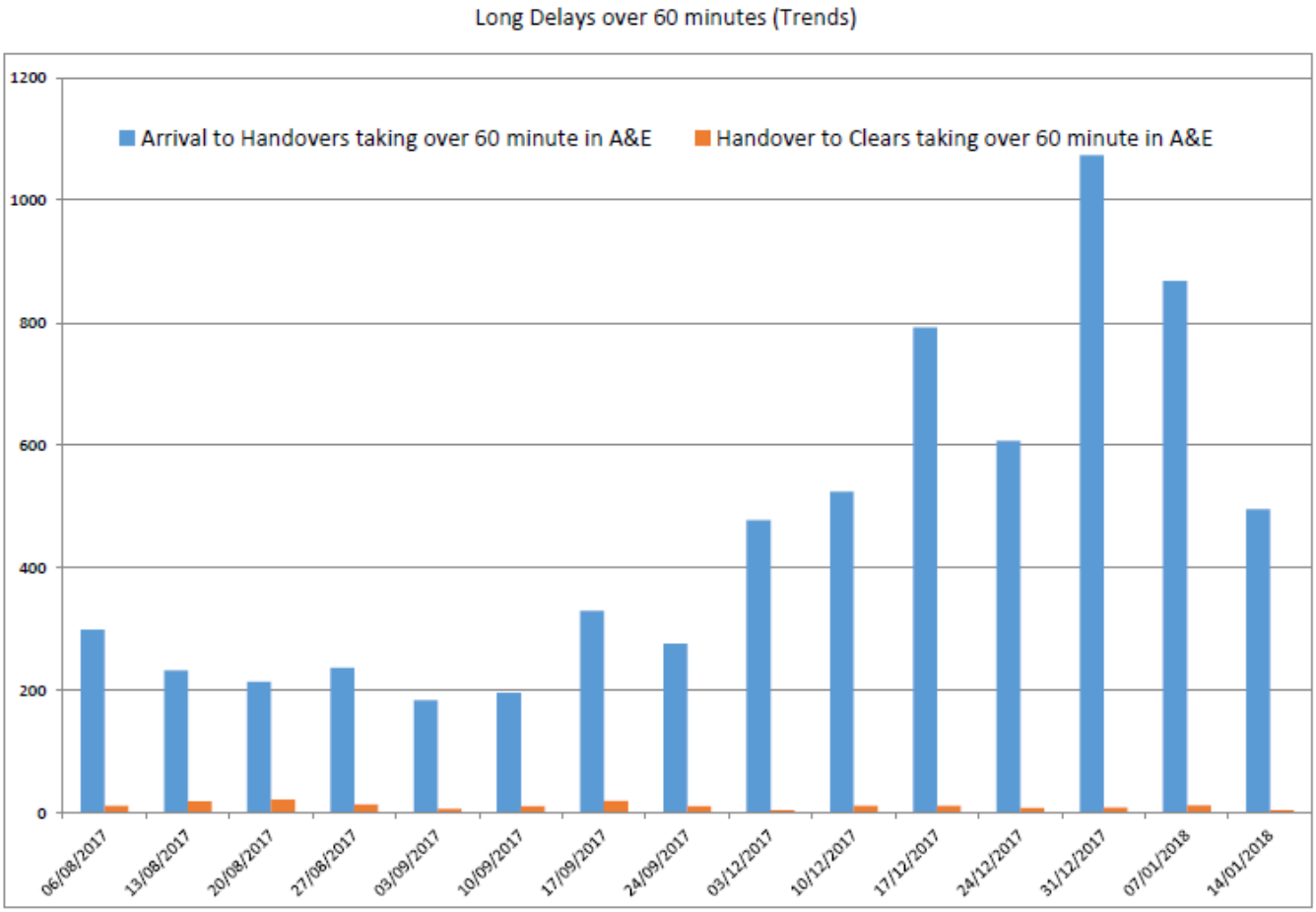
***Response to Question 8:***
*The situation was under close scrutiny daily. On 22 December 2017, the Executive Leadership Board reviewed the robustness of the Festive Plan and noted that there was a significant increase in resourcing as a result of those actions agreed earlier in the week. On that date, the Executive Leadership Board noted that REAP 4 could be enacted over the festive period if it was deemed operationally necessary.*

*The situation was under daily review by our individual Gold (Strategic) Commanders and every day members of the Executive Leadership Board were available to contribute to and support any Gold (Strategic) Commander led discussions. In tandem with system partners, the Trust kept in close contact about pressures the rest of the NHS was experiencing so as to ensure any emerging trends were being considered.*

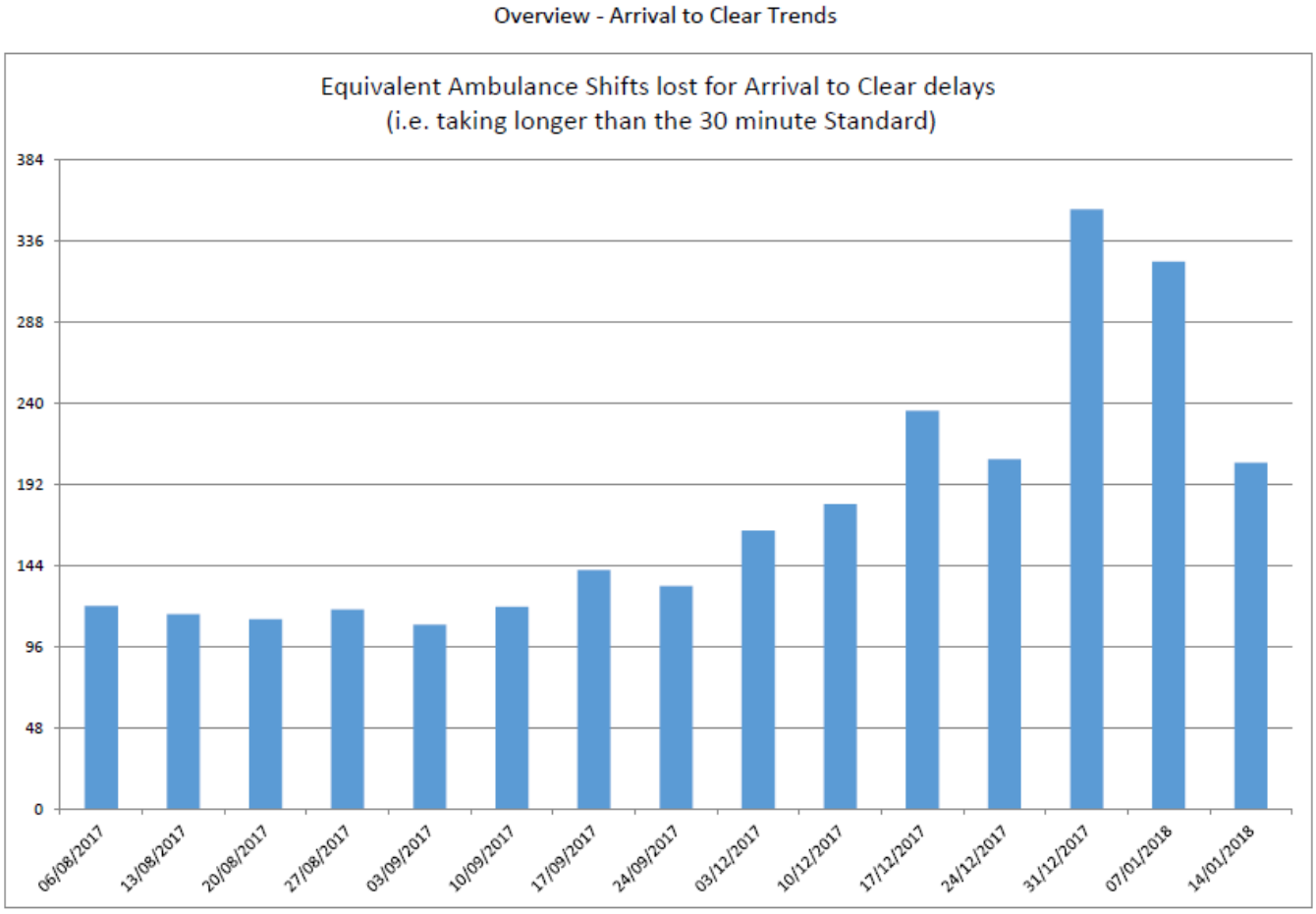
*There was a sharp rise in demand on 27 December 2017 combined with a significant increase in Hospital Arrival to Handover Delays which were impacting on the Trust's ability to respond to patients in the community. The Trust deployed Patient Safety Intervention Teams to manage Hospital Arrival to Handover Delays and release crews to respond to patients. These deployments were successful in releasing crews.*

*To continuously inform the Joint Decision Model and following regular consultation with the NHS Winter Room, regular REAP reviews were undertaken. On the 29 December 2017, the Director of Service Delivery, the Medical Director and the Director of Nursing and Clinical Quality formally escalated their concerns about the emerging trend of Hospital Arrival to Handover Delays to NHS regulators.*

*The following table sets out the scale of the challenge facing this Trust from Hospital Arrival to Handover Delays and is a clear reflection of overall system pressures at that time:*



*The following table sets out the impact of Hospital Arrival to Handover Delays on the ability of this Trust to respond to patients in the community:*




*On 31 December, it was clear that the Hospital Arrival to Handover Delays were not improving and that this would likely impact on the week ahead requiring further actions. Based on this analysis, the decision was taken to escalate to REAP 4 which was communicated at midday on 31st December 2017 by the Gold (Strategic) Commander. At that point in time, all other Trusts were on REAP 3 and two other Trusts also moved to REAP 4 meaning no opportunities existed for mutual aid. The Trust subsequently received 4,800 calls in the following 24 hour period - the first time this level of demand had occurred over the festive period.*

*The REAP does not include any use of military resources. Military Aid to Civil Authorities (MACA) may be considered under specific circumstances https://www.gov.uk/government/publications/2015-to-2020-government-policy-military-aid-to-the-civil-authorities-for-activities-in-the-uk/2015-to-2020-government-policy-military-aid-to-the-civil-authorities-for-activities-in-the-uk. All requests for military help by civil authorities are made through the MOD Operations Directorate and will require specific ministerial approval. As there are no standing military forces for these tasks, military support is not guaranteed. The timelines for securing approval and for establishing what resources are available and what is the mobilisation timeline are unknown and there is no precedent for doing so.*

9. Will the Trust release the number of Red 1/Red 2 responses that took place in an ambulance or prior to an ambulance arriving during December 2017, when the response time for that ambulance failed to meet the NHS target of 8 minutes or the R1/R2 secondary target of 19 minutes?

10. For comparison, will the Trust release the number of patient deaths on Red 1/Red 2 responses that took place in an ambulance or prior to an ambulance arriving during the Decembers of 2016, 2015 and 2014, when the response time for that ambulance failed to meet the NHS target of 8 minutes or the R1/R2 target of 19 minutes?

11. Has the Trust made any attempt to statistically correlate response times to patient outcomes on Red 1/Red 2 responses, and if so, will they release those analyses to the public?

***Response to Questions 9, 10 and 11:***
*The NHS targets referred to in the questions were retired in autumn 2017 and have now been replaced with the Ambulance Response Programme (ARP). During the transitional period, up until the Spring Review in 2018, all Ambulance Trusts are currently applying new targets on an evaluation basis. That review is expected to consider the suitability of those targets and inform when all Ambulance Trusts will be required to or be in a position to deliver against any finalised targets.*

*Throughout 2017, all MPs in the East of England have been provided with the details of ARP through regular briefings in Westminster or through written correspondence most recently on the 25 August 2017 in writing and at a Regional MP briefing in Westminster on the 18 October 2017.*

*The mandate of any ambulance service includes patients whom are critically ill or injured, terminally ill or at the end of life. In this context, ambulance services do not specifically record patient deaths. Instead, the service considers all cases, whether death has occurred or not, where an incident has occurred that could be considered as a near miss, incident or serious incident. Serious Incidents are subject to root cause analysis to determine what did or nearly went wrong and what lessons can be learnt. The full reports of these investigations are shared with patients or their families.*

*The cause of death must be certified by the patient's treating doctor or determined by HM Coroner. Therefore, Ambulance Trusts are not in a position to speculate on the cause of any death. Where a Serious Incident Investigation related to a patient whom has died is undertaken, the report is normally informed by the decision of the certifying doctor or HM Coroner prior to presentation to the family.*

*The following table sets out the number of Serious Incidents reported in the Decembers of 2014, 2015, 2016 and 2017.*

*Please note that, as the NHS criteria for declaring a Serious Incident changed to include near misses, these numbers do not provide a direct comparison between each year. Therefore, for in year comparison purposes, the numbers of Serious Incidents reported for June each year are also provided. The annual variation in Serious Incidents (which may include near misses in some years) is directly influenced by increasing demand (volume of calls) and changes to reporting criteria.*

| December | Number | June | Number |
|---|---|---|---|
| 2014 | 7 | 2014 | 17 |
| 2015 | 18 | 2015 | 2 |
| 2016 | 9 | 2016 | 9 |
| 2017 | 14 | 2017 | 7 |

*The Trust has undertaken high level analyses of all these cases which will be the subject of Serious Incident investigations. The subsequent individual reports are presented to families and clearly it would be a breach of patient confidentiality to put these reports into the public domain.*

*What is publicly reported and available are the trends and themes that emerge from these reports. For example, the most recent analyses of Serious Incidents identified the leading causative factor of a delayed ambulance response as Hospital Arrival to Handover Delays.*

*In recent weeks, there has been much publicity about the challenge that Hospital Arrival to Handover Delays present to Ambulance Trusts across the country which result in delayed responses to patients in the community where ambulances are not released within the expected timeframe. This issue has been a key focus area for all parts of the NHS to improve over the winter period. The following link may be helpful: https://www.england.nhs.uk/publication/addressing-ambulance-handover-delays-letter-from-professor-keith-willett/*

12. In light of the resignation yesterday of your Medical Director, Dr. Mark Patten, can you confirm that Dr. Patten's resignation is unconnected with the whistle-blower revelations and secondly can you please provide written evidence in the form of meeting minutes or emails etc that Dr. Patten did – as has been reported in the press – announce to the Board in November of last year that he had decided to leave?

***Response to Question 12:***
*I can confirm that Dr. Patten's resignation is unconnected with what the whistle-blower shared. Dr. Patten notified me of his resignation by letter dated the 10 November 2017 with a notice period of 12 weeks which is due to end next week. I do not have permission from Dr. Patten to release a copy of that letter and to do so in the absence of such permission would represent a breach of his personal and sensitive data.*

*Dr. Patten's resignation and the subsequent interim arrangements pending a formal recruitment process are in the public domain through the Chair's Report contained within the Trust's publication in advance of it's Board papers https://www.eastamb.nhs.uk/about-us/papers-2018/24-01-18-Trust-Board-Public-Session-Papers.pdf*

13. HSJ allegations – Can you make the contents of this review public?

***Response to Question 13:***
*The Trust has undertaken a high-level overview of cases over a 30-day period across December 2017/January 2018. In summary, the review notes that during this period:*

| | |
|---|---|
| Total Responses | 96,000 |
| Significant Cases | 48 |
| Serious Incidents Declared | 21 |
| Number of SIs relating to Hospital Arrival to Handover Delays | 16 |
| Patients Deceased* | 12 |

**Cause of death has not been certified by the patient's treating doctor or HM Coroner and no link with any delayed response has been established.*

*The 21 cases declared as Serious Incidents will be the subject of full Serious Incident Investigations. The first to know about these reports will be the patients or families and clearly it would be a breach of patient confidentiality to put these reports into the public domain.*

*In due course, the trends and themes will be publicly reported through Trust Board papers on our website.*

*The Trust also notes that these allegations refer to the release of a list containing patient details by a senior employee of the Trust. The Trust also wishes to put on record that robust information governance processes exist to protect all patient details. However, no process can prevent the deliberate act of an employee.*

*In this regard, it is important that the Trust also put on record the fundamental breach of patient confidentiality that has occurred as a result of this release. The magnitude of the seriousness of this breach is compounded where the employee is a senior manager and/or a registered healthcare professional. The Trust has a statutory duty to report such a breach to the Information Commissioners Office, notify any affected patients and where relevant, the appropriate professional registration body.*

I hope you will find this information helpful in addressing any public concern which has been brought to your attention.

By separate cover, I will also be writing to all MPs about recent events. I know you will agree that in the interest of transparency, we should also share your questions and these answers with them.

We will also be sharing information about the Independent Service Review of the East of England Ambulance Service NHS Trust, commissioned by both NHS England and NHS Improvement. The subsequent report has identified a significant gap in our capacity and recommends the necessary investment to enable our Trust to implement additional capacity and further improvements.

This represents some potentially very good news for both our staff whom continue to work under extraordinary pressure every day and our patients whom deserve the best possible service.

If you would like to learn more about the Trust, we would be happy to arrange for our senior manager covering your constituency to meet with you.

Best regards,

**Robert Morton**
**Chief Executive**