



Ymddiriedolaeth GIG
Gwasanaethau Ambiwllans Cymru
Welsh Ambulance Services
NHS Trust



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6 November 2014

Mr John A Gittins
H M Senior Coroner
H M Coroner's Office
County Hall
Wynnstay Road
Ruthin
LL15 1YN

Dear Mr Gittins,

**Re: Report for the Prevention of Future Deaths
Inquest of Mr. Clive Harold Turner**

We are writing in response to your Report pursuant to Regulation 28 of the Coroners (Investigations) Regulations 2013, dated 12 September 2014.

This letter aims to confirm the actions taken by the Betsi Cadwaladr University Health Board (BCUHB) and the Welsh Ambulance Services NHS Trust (the Trust) in accordance with the three matters of concerns raised in your report (Regulation 28 notification).

1. That there were significant delays in the provision of assistance to Mr Turner by the Welsh Ambulance Service

This first concern requires a retrospective summary of the delayed response, to ensure that the Trust learn lessons from the sequence of events (SOE) relating to the 999 call made from the home of Mr. Clive Harold Turner on the 25 March 2014 at 16.01 hours.

the Trust's review of the SOE shows that the call was prioritised as requiring a face to face assessment within 30 minutes. This category of call is set by the National Ambulance Performance Standards, and is defined as a 'Green 1' call. It was quickly identified; however, there were no resources available to attend at that time.

The contact centre staff, therefore, took a number of mitigating actions to continue to manage the call. These included: continuing to search their technological system for any available resources to attend the home of Mr Turner; the contact centre staff remaining on the telephone line with the caller until the arrival of the first Paramedic; referring the call to the Trust's Nursing colleagues in NHS Direct Wales (NHSDW) for secondary clinical triage and advice; and, ultimately sending the first available resource that was able to attend the home of Mr. Turner.

The SOE also revealed that throughout the time this call was being managed, delays in handing patients over to Emergency Departments from ambulance crews were being experienced



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Mae'r Ymddiriedolaeth yn croesawu gohebiaeth yn y Gymraeg neu'r Saesneg
The Trust welcomes correspondence in Welsh or English

across the North Wales geographical area. For example, at the Wrexham Maelor Hospital, where Mr. Turner was conveyed to by the Trust, the average Patient Handover delay during this period was 164 minutes.

The mitigating actions of the contact centre staff are acknowledged as attempts to offset the delay in responding to the home of Mr. Turner, and that their effort to gain extra clinical assistance from NHSDW is to be commended. This action failed, however, due to the telephone line being engaged, as the ambulance contact centre staff were still using the telephone to keep in contact with the caller.

To prevent this break down in communication in the future, the Trust has developed a clear process for escalating calls where a delayed face to face assessment (i.e. ambulance response) is offset by gaining additional clinical assistance from NHSDW, who can undertake a telephone assessment in the absence of an ambulance response. This will be in place from 1 December 2014.

Paragraph 3 identifies further actions the Trust has taken to mitigate reoccurrence.

- 2. That the current practices in place for the handover of patients at an Emergency Department far too often results in wholly unacceptable delays with patients being kept waiting for long periods in ambulances and ambulance resources consequently being unavailable for allocation to other calls. Whilst this is a multi-factorial problem, improvements must be made so as to reduce the risk of future deaths.**

BCUHB has developed a protocol for their area to ensure a consistent approach to ambulance handover across North Wales. The Medical Director has mandated the protocol that is currently used at Ysbyty Gwynedd Hospital to be used across the Health Board for use in the interim period until a new Handover Policy for BCUHB can be formally agreed. The revised protocols are currently out for consultation and will require ratification by both BCUHB and the Trust prior to formal implementation.

The audit of ambulance handover to provide assurance in relation to patient safety during this period of care has been revised by the BCUHB Associate Medical Director for Unscheduled Care. The new process has been piloted at one of the Emergency Departments in North Wales and following some amendment will be implemented across BCUHB and reported monthly. This has already commenced in Ysbyty Glan Clwyd.

Holding areas are being established in each Emergency Department when required to enable patients to be offloaded in a safe and timely manner. Serious Incidents where there are joint issues for BCUHB and the Trust are now investigated jointly and learning outcomes shared. Senior Clinical, Nurse and Operational Management Leadership have been enhanced by the Health Board to ensure robust support for the Emergency Departments and patient flow.

BCUHB has developed an escalation protocol for their area to ensure a consistent approach across North Wales. The protocol is currently out for consultation and will require ratification by the North Wales Unscheduled Care Programme Board prior to implementation. This has included advice issued by the Medical Director to support and encourage NHS Managers and Clinicians to work closely with the Trust staff at the Emergency Departments (ED) "front doors" to jointly assess patients held in ambulances and identify patients that could either safely be transferred to the waiting room or be brought into the department without delay.

There is engagement at all levels between the Trust and BCUHB, with conference calls arranged to agree joint action plans to address ongoing delays. Duty Control Managers from the Trust will initially contact the Hospital Clinical Site Managers if ambulances are delayed. The escalation process will continue with the Trusts Locality Managers contacting the Senior Site Operational Managers in BCUHB and then the Trusts Head of Service engaging with the Chief Operating Officer within BCUHB Out of hours as there is an 'On Call' system Bronze to Bronze, Silver to Silver and Gold to Gold engagement between both organisations to ensure that a seamless escalation process exists.

- 3. It is of considerable concern to me that item 2 above is a direct repeat of a concern which I raised in a previous Regulation 28 report following the death of Mr Frederick Pring in March 2013, twelve months before that of Mr Turner, the joint response of the Trust and BCUHB being received exactly one week before Mr Turner's death.**

We would like to take this opportunity to provide you with assurance that BCUHB and the Trust are committed to working together to deal safely and effectively when there are circumstances of patients experiencing delays during handover. In addition, there are a number of improvements and initiatives that have been implemented between both organisations since the death of Mr. Pring. The following points provide more detail of these actions:

Alternative Transport

An initiative to promote alternative transport to convey low acuity patients to hospital has been implemented. It has been identified that there are a number of low acuity patients that are clinically safe and suitable to travel to hospital by alternative means, either with family, friends or in a taxi. The aim is to ensure that the Trusts resources are more readily available to attend immediately life-threatening calls. This practice was implemented in North Wales on 1 September 2014.

Paramedic Pathfinder

Paramedic Pathfinder is a field guide (decision tool) to support on-scene decision making in relation to the most appropriate point of care for the patient. This is being tested in Conwy and Denbighshire since September 2014. The testing involves developing and introducing alternative care pathways to provide patients with the treatment and care they need, and thereby, potentially reducing the number of patients needing to be transported to Emergency Departments. Paramedic Pathfinder will be implemented in the remaining localities of North Wales during the next three months.

Rest Breaks for Trust Staff

the Trust further updated its Rest Break Policy in August 2014 to facilitate staff taking their breaks at the nearest suitable location. These locations include base stations, other ambulance stations, stand-by points or NHS locations which has fully functioning canteen/catering facilities (e.g. at hospitals).

This change has resulted in a reduction in the time that resources are unavailable due to stand down rest breaks, in turn improving the level of time that on duty crews are available to be tasked with calls. Staff are now more likely to get their break in a timely manner and arrangements are still in place in all three District General Hospitals to utilise its facilities in support of mandatory breaks

Improvement to Call Prioritisation

Like many other UK ambulance services, the Trust uses the international accredited Medical Priority Dispatch System (MPDS). This is a unified system for consistent call handling of

emergency calls, with the outcome being a priority code assigned for an appropriate ambulance (or other clinical) response.

To ensure the Trust sustains and delivers best practice when utilising MPDS, the dispatch codes in Wales have recently been reviewed. Subsequently, the Trust has now aligned its prioritisation of the codes to the other UK ambulance services that also use MPDS. This enables the Trust to benchmark with other services, and at all times ensures patient safety.

The changes have further reinforced the Trusts desire to provide a more clinically effective and appropriate service, and have been in place since 21 October 2014.

Clinical Desk

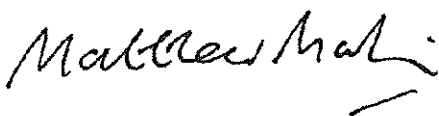
The Trust is introducing a Clinical Desk into the Clinical Contact Centre in Vantage Point House, Cwmbran, which will be in operation for the whole of Wales. This will comprise of Paramedics and Nurses providing further early triage of calls using the Manchester Triage System to ensure the correct and most appropriate response is sent to meet the clinical needs of the patient. This will be implemented by the Trust in December 2014 and provides:

- Clinical support for patients who are waiting for a response to arrive in excess of 8 minutes, especially those challenged by geography or access;
- Application of the product by Paramedics and Nurses;
- Clinical support for Clinical Contact Centres and responder colleagues.
- A potential improvement on the A&E performance standard of 1.5% – 2% by reducing the number of Category A calls by at least 10 per day, this figure could increase dependent upon the category of codes received on a daily basis;
- A clinical screening of Category A and Green 1 calls for secondary triage following MPDS assessment.

In conclusion, we hope that this joint response from BCUHB provides you with the assurances you require in response to the content of your Regulation 28 letter dated 12 September 2014. Both organisations are committed to learn lessons from this difficult case and ensure that patient outcomes are improved with more effective clinical care without delays. The necessary improvements are being implemented as quickly as possible, and both organisations will continue to monitor these actions as a part of their assurance/performance management arrangements. This will include Board level review of progress reports.

Please contact us if any of this report is unclear, or if there are still areas of concern. We commit to keep you informed of progress with respect to the key initiatives occurring in North Wales as well as those with an all Wales impact. Thank you once again for your letter regarding these very important issues.

Yours sincerely



Matthew K Makin MA MD FRCP (Edin)
Executive Medical Director



Tracy Myhill
Chief Executive (Interim)