Department of Health

Steve Barclay MP
Minister of State

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Tel: 020 7210 4850

Your reference: RCG/01473-2015/LJ
Our reference: PFD-1107336

Ms Rachel C Griffin
HM Senior Coroner, Dorset
The Coroner's Office
Town Hall
Bournemouth
BH2 6DY

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18 JAN 2018

15 JAN 2018

Dear Ms Griffin

Thank you for the Regulation 28 Report to prevent future deaths issued to the Secretary of State for Health and Social Care on 17 November 2017 following the inquest into the death of Miss Kathryn Verina Richmond. I am responding as Minister with responsibility for ambulances and I apologise for the slight delay in doing so.

Firstly, I would like to say how extremely saddened I was to read of the circumstances surrounding Miss Richmond's death. Please pass my condolences to her family and loved ones.

The concerns highlighted in your report are around the staggering of shift patterns of ambulance crews to maximise resources and avoid delays in attending emergency calls where ambulance staff take meal breaks at the same time. You ask that a review is undertaken of guidance to ambulance trusts regarding rota systems and the staggering of shifts to ensure that as many resources as possible are available at any one time.

Your report was issued to the Association of Ambulance Chief Executives (the AACE), which acts as a national co-ordinating voice on issues of policy and practice for ambulance trusts. My officials have liaised with the AACE to inform this response.

I am aware that Mr Anthony Marsh, Chair of the AACE, responded to your report on 8 January. You will therefore know that the AACE provides a function that enables learning from serious incidents occurring within individual ambulance

trusts to be shared nationally. This allows action to be taken where necessary across ambulance trusts within England to avoid similar incidents occurring.

Learning lessons where things have gone wrong is essential to ensuring the NHS provides safe, high quality care. I am advised that the AACE will ensure that the learning from this incident is shared nationally to allow other ambulance trusts to review their procedures and ensure their internal control room processes are adequate.

I can confirm that the Department of Health and Social Care does not issue specific guidance to ambulance trusts on the structure of their rostering systems or meal break arrangements. Neither does the AACE have the power to mandate ambulance trusts to make changes to their operating practices. Paramedic meal breaks and shift pattern arrangements are operational matters for individual ambulance trusts.

However, I am advised that all ambulance services are aware of the need to stagger meal breaks as much as possible and to regularly review rostering systems to stagger start and finish times and therefore meal breaks. In addition, all ambulance services have arrangements in place to enable clinicians to be interrupted during their breaks in the event of a major incident, and all services have additional arrangements for crews to be disturbed during a break on a voluntary basis to respond to potentially life-threatening calls.

I am assured that all ambulance trusts are aware of their responsibilities in this area and regularly review rostering arrangements to ensure they are robust and optimised to meet current demand patterns.

The AACE will ensure that the National Directors of Operations Group is made aware of your concerns and remind them of the need to regularly review rostering arrangements. Additionally, I am advised that NHS Improvement intends to write to all ambulance trusts in England to ask them to reflect on the Regulation 28 Report and their own governance procedures, in particular to review rota management including the scheduling of meal breaks to ensure adequate operational cover is provided at all times.

I hope this reply is helpful. Thank you for bringing the circumstances of Miss Richmond's death to our attention.

Yours sincerely

**STEVE BARCLAY**

ASSOCIATION OF AMBULANCE CHIEF EXECUTIVES

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Rachel C Griffin
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10th January 2018

Dear Dr Griffin,

Thank you for your letter dated 17th November regarding your Regulation 28 report to Prevent Future Deaths Kathryn Verina Richmond.

Within your letter the area of concern you have raised is as follows:

- *Due to the non-staggering of shift patterns of ambulance crews within Ambulance Service Trusts, there could be increased delays in attending emergency calls due to ambulance staff taking meal breaks at the same time.*

- *I therefore request that a review is undertaken of the guidance given to Ambulance Service Trusts regarding the structuring of their rota system to stagger shifts which in turn will stagger meal breaks to ensure as many resources possible are available at any one time.*

In preparing our response we have also been in contact with South Western Ambulance Service (SWAST) and have reviewed their response to your concerns and the actions they have taken internally to address those concerns.

Clearly there were two main issues in this tragic incident the first involving the way in which the incident was managed internally by the SWAST Emergency Control Centre and secondly the availability of ambulances associated with crews being on protected meal breaks. These issues have been addressed internally by SWAST as part of their response to this incident.

Whilst you have indicated that you are satisfied that lessons have been learned in SWAST and changes have been made which adequately address your concerns you remained concerned that similar issues could occur in other Ambulance Trusts nationally.

Firstly, can I be clear that the Association of Ambulance Chief Executives (AACE) has no power to mandate Ambulance Trusts nationally to make changes to their operating practices which remain a matter for individual trusts and their respective Boards.

That said AACE can and does act as a national co-ordinating voice on many issues of policy and practice and importantly collates information on serious untoward incidents and the lessons learned from them. We maintain a database of such incidents and share outcomes from them widely with the National Ambulance Medical Directors Group (NASMeD) and the National

Directors of Operations Group (NDOG). This is to ensure that learning within an individual Trust which might have national implications is shared across all Trusts allowing action to be taken where necessary to avoid similar incidents occurring. This is always done when a Coroner issues a Regulation 28 report.

Turning to your areas of concern we will ensure that the lessons learned and the actions taken by SWAST are incorporated into our national database of Regulation 28 reports and that both groups take on board the learning from the incident.

The changes which SWAST have made in the way in which they managed the emergency call may have been specific to SWAST but we will ensure that those issues and the subsequent changes are shared nationally to allow other Trusts to review their procedures internally to satisfy themselves that their internal control room processes are satisfactory.

In terms of the staggering of meal breaks all ambulance services are aware of the need to do this as much as possible and regularly review their rostering systems to stagger start and finish times and hence their meal break 'windows'.

There is a balance to strike which needs to give Trusts the ability to allow emergency crews to have a meal break which they are legally and morally entitled to in order to protect their health and well-being whilst at the same time safeguarding emergency cover to ensure appropriate response times for patients.

In addition, all ambulance trusts have the ability to ask crews to interrupt their meal break to attend patients who are life threatened and whilst this is a voluntary system it will have been agreed locally in each case with ambulance staff and their trade unions. In my experience, this works well and dedicated ambulance staff will invariably interrupt their meal break to respond to such patients.

The Department of Health and NHS England do not issue specific guidance to ambulance Trusts on the structure of their rostering systems or their meal break arrangements. These remain a matter for individual Trusts to negotiate locally. That said, all Trusts are aware of their responsibilities in this area and regularly review those arrangements to ensure they are robust and are optimised to meet current demand patterns.

AACE will ensure that the National Directors of Operations Group (NDOG) is made aware of your concerns associated with this tragic incident and remind them of the need to ensure that this is done on a regular basis.

I hope you will agree that this addresses the areas of concern that you have raised.

Yours sincerely

A. C. Marsh.

Anthony C Marsh QAM SBStJ DSci (Hon) MBA MSc MA FASI
Chief Executive, West Midlands Ambulance Service NHS Foundation Trust
Chairman, Association of Ambulance Chief Executives