Cannock Chase Clinical Commissioning Group
South East Staffordshire and Seisdon Peninsula Clinical Commissioning Group
Stafford and Surrounds Clinical Commissioning Group

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Your Ref: MJJ/JS/89713/2016

Our reference: MW/TLR/33881

29 March 2018

Ms M Jones
HM Assistant Coroner
Coroner's Chambers
547 Hartshill Road
Stoke-on-Trent
ST4 6HF

Dear Ms Jones

**The Late Reginald George Key**

Thank you for your letter dated 30 January 2018 informing us of your concerns regarding the transport home of the late Reginald George Key. Firstly I was saddened to hear of Mr Key's passing and would like to thank the Coroner for informing us of their recommendations from the inquest which was concluded on the 24 January 2018. In accordance with your request under paragraph 7, Schedule 3 of the Coroners and Justice Act (2009) and regulations 28 & 29 of the Coroner's Investigation Regulations (2013) I will outline the investigation undertaken by my team under my direction as the Accountable Officer for the Staffordshire Clinical Commissioning Groups. I assure you we have taken your report seriously and have dealt with the Provider of the service directly in all aspects of our investigation to enable us to respond in line with the Regulations.

The area covered in my response pertains to Section 5 of your Regulation 28 Report- Preventing Future Deaths dated 24 January 2018 and addresses the first two points you raised under your concerns. These were as follows:

- The deceased had undergone surgery and was apparently discharged from the Royal Stoke University Hospital at 6pm on 1 December 2016. He was collected by patient transport. Clinicians tell me he was well on discharge. He was apparently delivered home at 10pm some four hours later when he was described as being very unwell with paramedics commenting that he should not have been discharged and that they had to carry him into the house. Family noted there were other patients in the transport vehicle awaiting return home.
- Family and clinicians raised concerns about the length of time it had apparently taken to deliver him home and whether or not his deteriorating condition was or could have been spotted and whether there was an option for paramedics to return him to the hospital. He was returned to hospital very unwell on the 04 December 2016.

Investigation Summary
Under the leadership of my Director of Nursing and Quality [redacted] we have asked the PTS Provider to conduct a full investigation of this case. As part of their investigation they have reported to us they have conducted interviews with all staff concerned, however one half of the PTS crew no longer works for the provider so can't be questioned regarding whether there were any concerns about Mr Key's health. The provider has spoken to the other half of this crew but they were unable to re-call this transfer. There are no incidents logged for this journey. Without recall or documentary evidence reporting any concerns we cannot confirm or clarify Mr Key's condition when he arrived home.

We can confirm that Mr Key was transferred home by our commissioned Patient Transport Service (PTS) on 1 December 2016. Their records have recorded his journey as 'ready for discharge' at

17:16 and show that he had been collected by the crew at 17:50. The PTS crew had left the hospital at 18:09 and Mr Key arrived back to his home address in Hednesford at 19:15. We have confirmed that the crew consisted of two patient transport assistants and that these were not paramedics. The PTS service have no record of any concerns being raised by their crew under their deteriorating patient policy and no indication that the journey deviated from the plan as indicated by their transport monitoring system.

We have confirmed that the level of skill and knowledge of the PTS crew is of a first aid standard and they were not qualified to administer assistance above this level of training. We have also confirmed that the service has a deteriorating patient policy which is applicable for both during the journey and at the point of discharge from their care. This policy instructs staff, in the event of deterioration or concern, to seek assistance from the ambulance service by dialling 999, to administer first aid as necessary and to inform their control room of any incidents and actions undertaken when enacting the policy.

Investigation Findings

The PTS provider has interrogated their reporting system and clarified our challenges around the timings of transport and Mr Key's condition. They have re-confirmed the times and have reviewed their GPS vehicle tracker to confirm their recorded timings are accurate. They have confirmed their records indicate that when they arrived at Mr Key's house they had one individual on board who was awaiting onward transport. There are no reports of Mr Key being unwell on pick up or when they arrived at his abode. The vehicle was booked as a patient transfer in a chair requiring two PTS crew to take him safely home. There is no indication in the records of any deviation from the planned transfer route and records confirm he was transferred to his home in a chair.

We have discussed the level of skill and escalation procedure with the PTS provider. They have reported all staff are aware of the deteriorating patient policy and they expect staff to enact this when they have any patient concerns. Staff are instructed at times of a medical emergency and/or concerns around the patients' health, that they are to stop the vehicle and inform the ambulance service of the nature of the emergency and await the service to respond. It is important to highlight that they are not allowed to transport a patient to hospital and are required to seek professional help via the 999 service.

Should transfer to hospital be required this would be conducted by the 999 service. Their level of training is to administer first aid where needed and to commence interventions such as cardio-pulmonary resuscitation in emergencies should this be required. They are not allowed to diagnose or assess the patients' health above their first aid skill level. If they have concerns under this policy they are to record this with their control room and log their actions undertaken. However, without recall or documentary reporting they were unable to establish what was discussed with Mr Key's family. We are assured that our commissioned PTS provider discourages their non-paramedic staff from assessing a patient's condition other than as would be expected from their first aid training and to promptly discuss their concerns with the 999 service to ensure no delays in receipt of assistance.

Assurances Undertaken to Prevent Future Deaths

To address the Coroner's concerns we have instructed the provider to act upon the findings and include in their action plan the following:

- To review their deteriorating patient policy.
- To expect commissioners to monitor any reported elongated journey times at both the contract and quality meetings.
- To undertake a deteriorating patient policy awareness campaign with staff utilising a variety of mechanisms including one to one awareness, staff group awareness and a promotional campaign.
- To reinforce their first aid training to identify a deteriorating patient and appropriate escalation.

- To review their incident recording mechanism from crew to control room and to establish a measuring process to assure that this remains consistent.
- To establish a procedure to cross check journey times against their vehicle tracking systems to assure that patients are not being transferred or delayed for protracted periods.
- To identify specific actions to identify good practice in communicating with patients and relatives.

We have instructed the provider to produce an action plan to address these matters. This plan will be reviewed in detail at the next provider contract and quality meeting in April 2018 by my commissioning and quality teams and will be monitored at this meeting until all actions are concluded and agreed between the provider organisation and the CCGs.

We expect these actions to be expedited and we have requested measurable outcomes to be reported. From this action plan we expect the provider to have embedded the identified learning from the Coroner's concerns. We hope these actions will enhance the patient experience of our commissioned PTS service and will reinforce the safety of our patients being transferred home.

I would like to thank the Assistant Coroner for bringing their concerns to my attention. I hope that we have demonstrated our commitment to preventing future deaths in this case. Should you require any further information in relation to this response I would urge them to contact me without hesitation.

Yours sincerely

[redacted]

**Accountable Officer**