Professor Chris Jones
Dirprwy Brif Swyddog Meddygol
Deputy Chief Medical Officer

Llywodraeth Cymru
Welsh Government

Ms Rachel Knight
HM Assistant Coroner
South Wales Central Area

September 2018

Dear Ms Knight,

Regulation 28 Report to Prevent Future Deaths – Richard Thomas Peter Barrett

Thank you for your letter enclosing the above Regulation 28 report following your investigation into the death of Richard Thomas Peter Barrett. I'm responding on behalf Vaughan Gething Cabinet Secretary for Health and Social Services.

The Welsh Government expects the Welsh Ambulance Services NHS Trust (WAST) to plan and deliver a safe and timely service to the people of Wales, based on an assessment of demand, ensuring there is sufficient staffing and resource cover in its clinical contact centres and in the community to meet demand, and to flex capacity at times of increased pressure.

WAST has reported that at times of increased demand, capacity to undertake welfare calls is reduced and it is currently considering options to increase capacity on its clinical support desk which provides support and advice over the telephone, as well as opportunities for third sector organisations and other agencies (e.g. Police, Fire and Rescue Services) to support the delivery of welfare checks, particularly for patients who have experienced a delayed response.

In April of this year, the Cabinet Secretary for Health and Social Services commissioned the Chief Ambulance Services Commissioner to conduct a clinically-led review of the 'Amber' category, which includes serious, but not immediately life-threatening calls and accounts for around 65% of call volume to the Welsh ambulance service. The review is being undertaken alongside ongoing work to improve ambulance responsiveness, clinical outcomes and patient experience in order to make sure patients continue to get the most appropriate and best level of care and treatment for their needs. It is due to be completed at the end of this month and the Cabinet Secretary will be making a statement to inform Assembly Members on how its findings and recommendations will be taken forward in October.

A key part of the review is an examination of patient risk across the pre-hospital patient pathway. This includes analysis of patient-level linked information across the pathway as well as serious incidents and Coroners' reports to identify opportunities for learning to be applied to inform the review's recommendations.

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The review is also looking at expectations and experiences of the public, staff and the wider service around ambulance response. This will include the extent to which members of the public are supported and kept informed when making a 999 call. In this respect, the review may deem it necessary to make recommendations around continuity of care through increased welfare checks for all relevant calls and other options to reduce anxiety of those waiting for an ambulance to arrive.

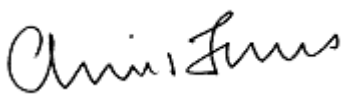
The Welsh Government recognises the challenge caused by lengthy handover delays at emergency departments, which we know can impact not only on patient experience, but also on the ability of the ambulance service to respond to subsequent urgent calls in the community.

We expect health boards to monitor all patients, especially those with time-critical and acute conditions or injuries to ensure they are handed over to the care of specialist staff as soon as possible, in order to improve patient outcomes and manage the associated risk. The Cabinet Secretary has also been clear with health board chief executives that they must take responsibility to reduce and eradicate patient handover delays by working with the Welsh ambulance service and partner organisations to improve patient flow through hospitals and receive patients from ambulance crews in a safe and timely manner. In addition they must explore alternative pathways and be able to divert demand to other unscheduled care services to reduce pressure at emergency departments during busy periods.

It should be noted that there is no time-based target for the handover of patients from ambulance crews to emergency department staff. However, the Welsh Health Circular on NHS Wales Hospital Handover Guidance, published in May 2016, sets out good practice for patient handover, including an expectation for patients to be handed over within 15 minutes. Officials continue to monitor patient handover delays closely on a daily basis and challenge health boards where appropriate.

I do assure you that Welsh Government will keep this case and the learning that arises under ongoing review.

Yours sincerely



PROFESSOR CHRIS JONES