Ymddiriedolaeth GIG
Gwasanaethau Ambiwlans Cymru

Welsh Ambulance Services
NHS Trust

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CHAIR AND CHIEF EXECUTIVE'S OFFICE

Eich Cyf/Your Ref: 5152
Ein Cyf/Our Ref: JK/5152/DR

12 February 2019

14 FEB 2019

Ms W A James
Acting Senior Coroner for Gwent
Coroner's Office
Victoria Chambers
11 Clytha Park Road
Newport
South Wales
NP20 4PB

Dear Ms James,

Re: Regulation 28 relating to Inquest of Diane Greenslade

I am writing in response to the Regulation 28 Report to Prevent Future Deaths, issued to the Welsh Ambulance Services NHS Trust (the Trust) on 21st December 2018. This was issued following the conclusion of the inquest for Mrs Diane Greenslade.

The Trust acknowledges the concerns you have raised in the Regulation 28 Report. The supporting information, accompanying this letter, highlights the strategic and operational quality improvements in patient safety that have been completed or are underway. These are aimed at preventing harm by improving those areas of our service identified within your Report.

The attached action plan identifies initiatives that the Trust has implemented, and new actions, which we continue to work on. The initiatives are designed to improve our adherence to existing policies, our collaborative working with other emergency services and our staff resourcing, both operationally and within the Clinical Contact Centres (CCC). These include:

- Training of relevant Clinical Contact Centre staff
- Recruitment of clinicians within the Clinical Contact Centre
- Aligning production against demand both locally and time of day. This means ensuring we have the right levels of staff availability to meet the demand with which we are faced
- Reducing the duration of handover to clear i.e. the time it takes for our staff to become available following the handover of a patient to another care provider, generally hospital staff
- Introducing safe alternatives to responding to scene, where this is appropriate
- Reducing conveyance where safe and appropriate, and providing care in the patient's home utilising advanced practitioners
- A reduction in sickness absence

In addition to the accompanying action plan, the Trust continues with other quality improvement initiatives designed to safely release resources to respond to patients in greatest need. This includes the introduction of our Falls Framework and increasing the scope of practice for our Community First Responders. I would like to share with you some details of the Trust's Falls Framework and the recent development of a more structured response to people who have fallen in the community, as it is relevant to the circumstances surrounding the fall that Mrs Greenslade sadly experienced.

Falls Framework and Falls Response Model

During the third quarter of 2018 – 19, the Trust, working in partnership with St John Ambulance Cymru Wales, has implemented the role of the Falls Assistant across five health boards:

- Aneurin Bevan University Health Board
- Abertawe Bro Morgannwg University Health Board
- Cwm Taf University Health Board
- Cardiff & Vale University Health Board
- Hywel Dda University Health Board

Level 1: Falls Assistant Role

The Falls Assistants provide an initial response to safely lift patients where there are no injuries, or a minor injury, as a result of a fall. The Falls Assistants will be supported in their assessment of the patient by a paramedic or nurse working on the Clinical Support Desk in our CCC, who will offer clinical advice and support.

A Falls Assistant can be a member of Trust staff from our Urgent Care Service, a voluntary Community First Responder, or in partnership with other agencies, employed by another organisation such as St John Cymru Wales or the health board. There are now seven Falls Assistant schemes working across Wales providing support

across five health board areas. During October- December 2018 the teams attended 771 patients across Wales. In North Wales we have developed a model with our Community First Responders where we have 10 teams working across the region.

Level 2: Possible Injury Fall/Complexity- Falls Response Service

A Level 2 falls response is required either where it is unclear if there is an injury or not, or where the person has co-morbidities or complex needs. A level 2 response is where a multi-disciplinary team can undertake a comprehensive assessment of the person in their own home and implement an appropriate care plan according to their individual need.

Currently, within the Aneurin Bevan University Health Board, a Falls Response Service (FRS) has been operating since October 2016 and consists of a paramedic and physiotherapist operating daily. This has been supported by the Welsh Government Integrated Care Fund. The FRS has had involvement with 1961 falls incidents received via the 999 system from October 2016 up to 31st December 2018. 1475 people (75%) have remained at home following assessment and/or treatment by the team, with the appropriate care being provided by community-based services. Only 486 individuals (25%) required further treatment and/or treatment at hospital, and only 17% of individuals attended required treatment within the Emergency Department

The Trust is now engaging with UK Ambulance Services Project A, a national improvement collaboration to share the Falls Framework and Falls Response model and learn from peer organisations on how we can continue to improve our response to people who have fallen.

In the interests of clarity, the Trust was not informed that Mrs Greenslade had fallen and the coding given to her call by MPDS did not identify her as a lady who had fallen and subsequently, therefore, the call was not considered for either a level 1 or level 2 response under the Falls Framework. One of the issues that the Trust is now exploring is the value that Falls Assistants can add to our responses when patients are known to be on their own, including engaging with careline companies to help improve the information shared with the Trust.

The Trust uses the Resource Escalation Action Plan or REAP to provide services during periods of increased demand or other NHS wide system pressures. The REAP is a UK agreed document used by all 13 NHS ambulance services, with some key actions and locally agreed operational tactics.

One of the aims of REAP is to ensure that we have a resource available for a cardiac arrest or other high priority RED calls. In order to ensure this, the Trust reserves rapid response units for RED calls in REAP level 3 and 4. Whilst this means that some lower priority calls may wait longer for a response, it does ensure that we are always able to respond immediately to RED calls. I would like to assure you that we have reviewed

our REAP to prepare for winter 2018/19 and we now have a more dynamic approach to managing rapid response vehicles within each health board area.

I would like, whilst writing, to respond to some of the specific matters of concern that you highlighted in your correspondence of 21 December 2018.

1. **The initial call was categorised as Green 3 without any contact being made with Mrs Greenslade or her family and without clinical assessment.**
   This is consistent with processes used across Wales and the United Kingdom, in that all 999 calls are initially assessed based on the information provided to the call handler by the caller. Increasingly, and in cases where an ambulance response may not be appropriate, a clinician based in one of our CCC will make direct contact with the patient, where possible, to clinically assess the patient's condition and provide advice over the phone (where this is appropriate).

2. **After failing to make contact, no consideration was given to either upgrading the call category or to contacting Police to ask them to carry out a welfare check.**
   Whilst we have set out in this correspondence that we are reviewing our policies and procedures around establishing contact with a patient or caller at scene, we are of the view that it would not be appropriate to request police attendance to undertake welfare checks for 999 calls to the ambulance service, as police officers are not suitably trained to make a clinical assessment. However, we are working collaboratively with our Police Force colleagues to develop a Memorandum of Understanding regarding this issue.

3. **Demand for ambulances was high compounded by excessive delays at hospitals.**
   Unfortunately, this was the case and often has a material impact on our ability to respond in a timely and reasonable way to calls that are not immediately life threatening. As set out in the accompanying action plan, we are shortly to commence an all Wales demand and capacity review to establish exactly what operational capacity is required to ensure we respond in the majority of cases within set waiting time and quality standards. This work will also assess current demand for services and what we can expect to see in the next five years.

4. **A rapid response vehicle had been based only eight minutes away from Mrs Greenslade's home since at least 0630 hrs and had not responded to any calls as it was ring-fenced for red and amber 1 calls.**
   Rapid Response Vehicles are assigned to ensure that we can respond quickly as we can to immediately life threatening situations and life threatened patients.

5. **The delay in medical intervention must have played a significant role in Mrs Greenslade's death.**
   I do accept that the delay in responding to Mrs Greenslade was excessive and fell well short of that which we set out to provide.

As the Trust has not received a concern or claim in relation to any impact the delay in medical intervention may have had in Mrs Greenslade's death, we are unable to comment on this element of your Report as an investigation into this specific matter has not been undertaken. That being said, the Trust will now undertake a concerns investigation to address whether the delay did have any impact. The investigation will be undertaken under the National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011.

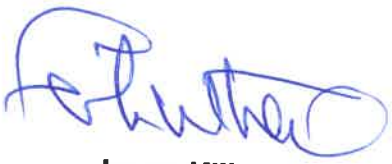
Unfortunately, the Trust does not hold the details of Mrs Greenslade's next of kin or representative and would welcome an opportunity to meet with the family, to ensure that we can investigate fully.

I would like to reassure you that the Welsh Ambulance Services NHS Trust and Aneurin Bevan University Health Board continue to work in collaboration to drive forward the improvements. We continue to strengthen out of hospital alternative pathways to improve efficiency and effectiveness of care for our patients and make best use of our resources.

We hope that we have been able to assure you that we remain focused to improve our services together, and that actions taken to date have had an impact in relation to all of the areas identified within this Regulation 28 Report.

I would like to extend the offer to meet with you to discuss our response in more detail and to provide you with assurance of our commitment to the continuous improvement of our service provision. I would also like to extend this invite to meet with the family of the late Mrs Greenslade and to offer our sincere condolences at this very sad time.

Yours sincerely



Jason Killens
Chief Executive
Welsh Ambulance Services NHS Trust

Enc: Action plan
Training plan