Ymddiriedolaeth GIG
Gwasanaethau Ambiwlans Cymru

Welsh Ambulance Services
NHS Trust

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CHAIR AND CHIEF EXECUTIVE'S OFFICE

Your Ref:
Our Ref: CDP/JK5334/et

22 May 2019

PRIVATE & CONFIDENTIAL
Mr Mark Layton
H M Senior Coroner
Coroner's Office
Town Hall
Hamilton Terrace
Milford Haven
Pembrokeshire
SA73 3JW

Dear Mr Layton

Re: Regulation 28 Report in relation to the death of Michael Davies

I am writing in response to your Regulation 28 Report issued on 25 April 2019 following the sad death of the late Mr Michael Davies. In the report you raised your concerns in relation to three matters.

Following receipt of the Regulation 28, I would sincerely appreciate the opportunity to discuss these with you as the Trust does not propose, at this time, to take any action in relation to the three matters you have raised. The reasons for which I will explain below.

Matters of concern noted in the Regulation 28 report:

1. During the course of the inquest the Welsh Ambulance Service Trust disclosed that in 2015 chest pains and related conditions were removed from the Red categorisation and placed in an Amber 1 categorisation whenever the patient is conscious and breathing. The inquest heard that in England (or in parts thereof) chest pains and related conditions remain as attracting a Category Red response.

2. The effect of removing chest pains and related conditions from Category Red is the response time, previously 8 minutes, is now up to 4 hours and often patients are advised to make their own way to hospital.

3. This puts patients' lives at risk and in this inquest may have contributed to the death of Mr Davies.

My letter dated the 18 March 2019 contains relevant information regarding the actions that the Trust is currently taking to ensure that it has sufficient resources to respond appropriately to each patient and to reduce patient waiting times more generally.

As you explored during the inquest, each ambulance service has a response model that supports the categorisation given to each call (irrespective of which prioritisation system is used). That response model and the decisions made will reflect the demographics of the population and the geography being served by that individual ambulance service. I notice that you have relied on evidence informing your view and subsequently raising the noted concerns that England (or parts thereof) have some chest pains as a red category of call, requiring an 8 minute response. I would respectfully draw to your attention to the fact that England operates a national system of response prioritisation following the introduction of the Ambulance Response Program (ARP). More information regarding the Ambulance Response Program, which reflects the Clinical Response Model used here in Wales, can be found at https://www.england.nhs.uk/urgent-emergency-care/arp/. It is therefore correct to say that England operates a universal, i.e. national system of response prioritisation and that, in line with the system operated here in Wales, only when a chest pain call is identified as being unconscious and not breathing does it attract a red response category.

With regard to point 2 of the Regulation 28 Report, I would like to take the opportunity to explain that Amber 1 calls do not attract a planned response of up to four hours within the clinical response model, nor is it correct to say that patients are often advised to make their own way to hospital. It would be right to say however that around 10% of all patients who dial 999 are offered advice by a senior clinician over the telephone which may include self-care advice or instructions to make their own way to a healthcare facility. This is only the case where it is clinically appropriate and safe to do so and supports the provision of sufficient emergency ambulance capacity being available to respond to those patients who do genuinely require such.

During the inquest, specifically the evidence provided by [redacted] you were informed that since February 2018 changes have been made to the scripts used by the call takers within our clinical contact centres. [redacted] did advise that she was unable to answer your questions in relation to what callers were now told as she did not have that information available to her.

When pressed she did advise that a worst case scenario would be callers being informed that an ambulance may take up to four hours to arrive. However, for clarity this advice was in relation to calls that were categorised as green or Amber 2 only.

I attach for your reference the Demand Management Plan and the associated scripts that are used by staff at different stages of the escalation or pressure within the plan. As you will see from these documents when the Demand Management Plan stage 1 and 2 are in use there is no scripted delay advice in relation to Amber 1 calls. When the Trust is operating in Demand Management Plan stage 3 we will advise callers, whose call has been categorised as an Amber 1, that the delay may be over an hour, and should the Trust move into Demand Management Plan stage 4, the advice given to callers in relation to Amber 1 calls is that an ambulance may be delayed for over two hours.

It would however be right to offer balance in this respect in that whilst over 50% of patients who attracted a response category of Amber 1 during 2018/19 received a response within 17 minutes there are clearly a number of patients who do regrettably wait longer that we would like.

During the winter months from December 2018 through to February 2019 there was a marked decrease in the length of time the Trust spent at the highest level of escalation within the plan;

- December 2018 - 17% compared with December 2017 - 32%.
- January 2019 – 36% compared with January 2018 – 48%
- February 2019 – 21% compared with February 2018 – 48%

Whilst the Trust in its letter to [redacted] and in the oral evidence provided at the inquest, acknowledges that there was a delay in an ambulance being allocated to Mr Michael Davies on 7 February 2018, this was an unavoidable delay. This is because at 11.25 hours when the call was received, and allocated the Amber 1 categorisation, there were no vehicles available to the Trust to send to Mr Michael Davies. This resulted in the open microphone call being made to all ambulances in the vicinity at 11.31 hours.

As you will appreciate, whilst the Trust strives to allocate a vehicle immediately to Amber 1 calls, this is not always possible especially during periods when demand outstrips supply.

In closing, I am of the view that the principle issue for us here is not one of categorisation as it is right to have a system of priority that assigns more rapidly to clinical severity but ensuring sufficient resource availability to meet demand and response within a reasonable time from to all our patients. I hope that I have been able to assure you that we remain focused to provide the best possible service for the people of Wales.

I would like to extend the offer to meet with you to discuss our response in more detail and to provide you with any further assurances you require regarding our commitment to continuous improvement.

Yours sincerely

Jason Killens
Chief Executive

[redacted]