Professor Dirprwy Brif Swyddog Meddygol Deputy Chief Medical Officer



Llywodraeth Cymru Welsh Government

Eich cyf/ Your ref:AB/CE/

Andrew Barkley Senior Coroner South Wales Central Area Rock Grounds First Floor Aberdare CF44 7AE

24 April 2017

Dear Mr Barkley,

## Regulation 28 Report to Prevent Future Deaths – Ceriann Richards

Thank you for your letter to the Minister for Social Services and Public Health regarding the regulation 28 report following your investigation into the death of Ceriann Richards. I am responding on behalf of the Minister. I would also ask that you please pass on our condolences to the family of Mrs Richards.

You raised concerns regarding significant hand over delays within two district hospitals in the Aneurin Bevan University Health Board areas, resulting in the delay of an ambulance being dispatched. We recognise lengthy handover delays are clearly unacceptable as they can impact not only on the ambulance service's ability to respond to subsequent calls in the community, but also on patient's experience. Handover delays are often symptomatic of pressures elsewhere within the unscheduled care system and should not be viewed in isolation which is why work is being undertaken nationally and locally to support improvements across the patient pathway through reducing inappropriate admissions to hospital, improving patient flow through the hospital system and enabling greater capacity in the community to support timely discharge.

The Welsh Ambulance Services NHS Trust has made progress in limiting conveyance rates to hospital through the development of a five-step ambulance patient care pathway and focus on initiatives that help patients who have dialled '999' to remain at home or to access a more appropriate service for their needs. This has included:

- the enhancement of its clinical desk, where paramedics and nurses provide secondary triage to patients who may be safely discharged over the telephone or advised to make their own way to hospital (known as 'hear and treat');
- establishment of alternative pathways for a number of conditions;
- a falls response service; and
- a frequent callers project which has significantly reduced unnecessary call demand



The NHS Wales Ambulance Availability Protocol, published in March 2016 is also subject to review by the Emergency Ambulance Services Committee (EASC) in light of concern raised in relation to its effectiveness.

The Welsh Ambulance Services NHS Trust (WAST) and local health boards have shared responsibility for ensuring the safe and timely handover of patients from ambulance crews to hospital teams and I expect health boards and WAST to continue to work together to reduce handover delays and to divert demand around the system during busy periods as well as improving patient flow through hospitals

Yours sincerely

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PROFESSOR