South East Coast Ambulance Service NHS
NHS Foundation Trust

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26 June 2017

Miss Gilva Tisshaw
Assistant Coroner
The Coroner's Office
Woodvale
Lewes Road
Brighton
BN2 3QB

Dear Miss Tisshaw

Re: The late Mr Ronald Bennett

I am writing further to your report, written under Paragraph 7, Schedule 5 of the Coroners & Justice Act 2009 and Regulations 28 and 20 of the Coroner's (Investigations) Regulations 2013.This was in relation to the sad death of Mr Ronald Bennett.

The concern you raise about hospital handover delays is a high priority, not just from the ambulance service but the whole healthcare system, as each component part has a role in resolving the problem. I will focus here specifically on Brighton & Hove, but the issues I highlight are consistent across Sussex, Surrey and Kent; indeed, across most of the country.

In recent years, the delays at hospitals for ambulance crews has continually increased, to the point where they are impacting on the Trust's ability to respond to emergency calls in the community. During 2015, in response to this ever growing problem, we introduced an Immediate Handover Policy. However, due to the challenges at the Royal Sussex County Hospital this was difficult to implement. A special Handover Workshop was facilitated last year in Brighton by Professor Matthew Cooke who had previously been National Clinical Director for Emergency & Urgent Care for the NHS. This was organised by Emergency Care Improvement Programme to seek solutions as the delays at Brighton & Sussex University Hospitals NHS Trust had been rising.

Towards the end of 2016, NHS England and NHS Improvement organised a number of strategic region-wide meetings There was a resultant understanding at a strategic level of the need to think differently about how to address this problem. It has become a standing agenda item at both the Local Accident & Emergency Delivery Board and the two Urgent Care Operational Resilience Groups.

In March 2017, a new joint Standard Operating Procedure was developed in partnership with BSUH providing more clarity around the process and responsibilities, including how and when to escalate. Since its implementation, there has been a marked improvement in overall performance in handover delays, although it is still the case that many hours continue to be lost.

There is a commitment from system partners to ensure continual improvement and I have attached the improvement plan for your information.

Although I cannot give you assurance that this complex and multi-factorial problem is fixed, I am confident that the matter is now being given sufficient priority by our acute, community and primary care partners. Its impact on our services is significant, and we are doing all we reasonably can to ensure improvement is sustained.

I hope this information is helpful and I can confirm that the Trust would be content should the Chief Coroner wish to publish a copy of this response.

Yours sincerely

D S Mochrie

Daren Mochrie QAM
Chief Executive