Ymddiriedolaeth GIG
Gwasanaethau Ambiwlans Cymru

Welsh Ambulance Services
NHS Trust

Cadeirydd
[redacted]

Prif Weithredwr
[redacted]

Swyddfa'r Prif Weithredwr a'r Cadeirydd

Chair and Chief Executive's Office

[redacted]

04 January 2024

PRIVATE & CONFIDENTIAL
For the attention of Mr Graeme Hughes
Senior Coroner
South Wales Central Area
[redacted]

Dear Mr Hughes

Re: Mrs Lynda Blackmore

I am writing in response to the Prevention of Future Deaths Report issued to this Trust on the 9 November 2023, following the inquest.

The matters of concern that you have asked the Trust to consider are:-

"The investigation focused upon the causal significance, if any, of a delay of some thirteen hours, or thereabouts in the provision of an ambulance to the deceased.

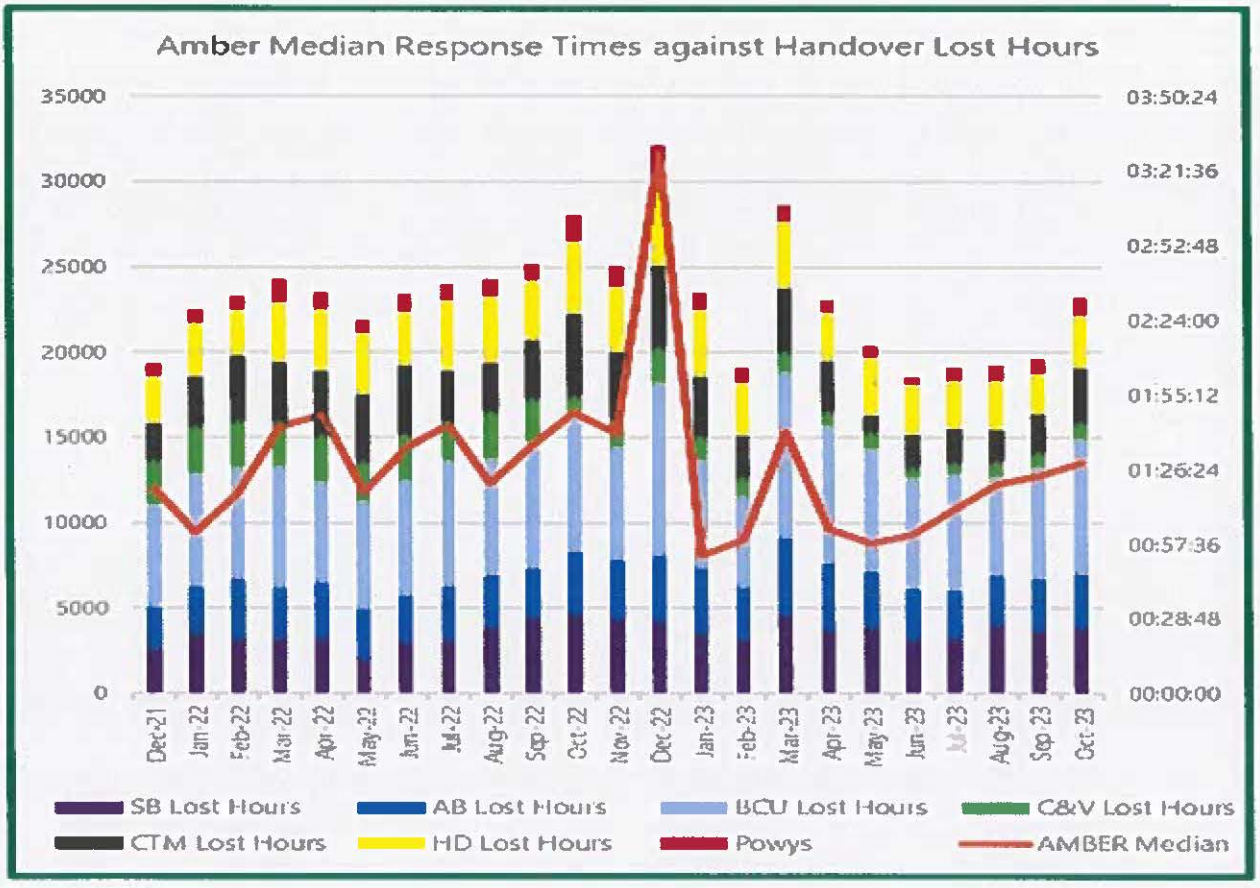
I received written & oral evidence from [redacted] *of the Welsh Ambulance Service Trust (I annex a copy of his witness statement). I refer you in particular, to paragraph's 43-49.*

My concern here is that handover delays are impacting upon response times in respect of patients requiring emergency treatment & for conveyance to hospital. As [redacted] *in his evidence at para 45, the handover delays experienced at/around the time that the deceased was awaiting assistance were well in excess of the targets enshrined in the Welsh Health Circular of May 2016.*

Such delays pose a risk to the lives of those requiring emergency treatment/conveyance to hospital."

At this time and in specific response to this Prevention of Future Deaths Report, the Trust does not propose to take any further action or new actions in relation to this matter, but rather continue with the actions in place. There has been a noticeable improvement in Cardiff & Vale University Health Board's handover lost hours linked to an organisational focus, with other Health Boards reporting that they are seeking to learn lessons.

The table below illustrates the improvements that have been made by the Health Board and Trust in order to reduce hours lost whilst ambulances are delayed at hospital. The table is extracted from the Monthly Integrated Quality & Performance Report and was presented to the Trust board on 23 November 2023.



Whilst these improvements have been seen with hospitals in the Cardiff & Vale University Health Board area the Trust is aware that ambulances delayed at hospital in neighbouring Health Board areas can also have an effect on those resources in the Cardiff & Vale University Health Board area.

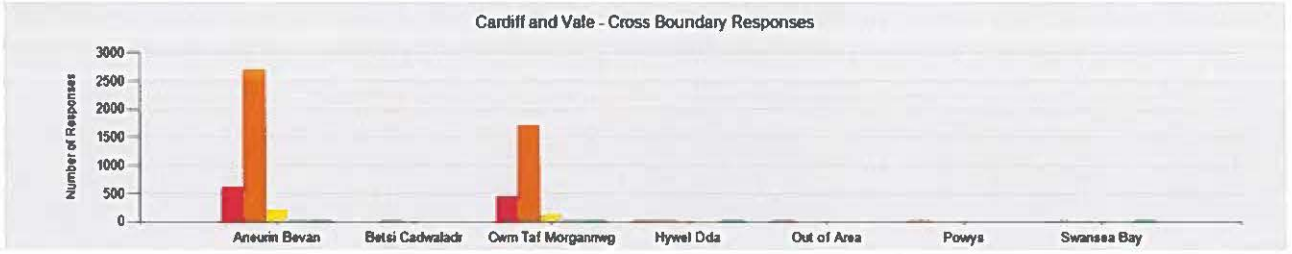
This is because the Trusts Clinical Response Model adheres to the dispatch principle that we seek to send the nearest most appropriate resource in time waiting order. Therefore, if because of ambulances delayed at hospital, the nearest most appropriate resource is in a neighbouring Health Board area, then this resource will be dispatched.

The details illustrated below shows the total number of cases where resources based in the Cardiff & Vale University Health Board area have responded to patients outside of the Health Board area due to ambulances delayed at hospital. A total of 5865 between Jan '23 and Nov '23. This is broken down to 3542 resources going into Aneurin Bevan University Health Board area and 2284 into Cwm Taff Morgannwg University Health Board area.

EMS Cross Boundary Responses

Report By: Station LHB	Cardiff and Vale	Date Period:	01/01/2022	to	30/11/2023
Vehicle Type:	EA				

MPDS Priority Type	Location LHB							Total Responses
	Aneurin Bevan	Betsi Cadwaladr	Cwm Taf Morgannwg	Hywel Dda	Out of Area	Powys	Swansea Bay	
RED	606	-	437	2	1	3	10	1061
AMBER1	2703	1	1700	6	-	-	14	4423
AMBER2	216	-	122	1	-	-	-	339
GREEN2	7	-	4	-	-	-	-	11
[illegible]	8	-	21	1	-	-	1	31
Total	3542	1	2284	9	1	3	25	5865

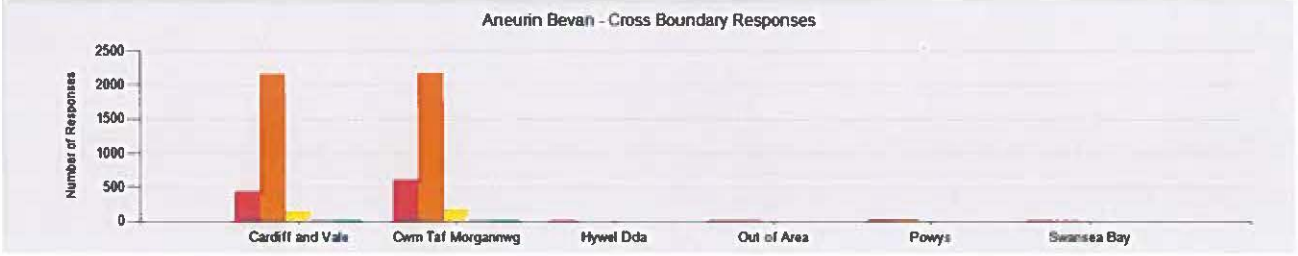


The details illustrated below shows the total number of responses returning into Cardiff & Vale University Health Board area from Aneurin Bevan University Health Board area (2747) and from Cwm Taff Morgannwg University Health Board area from Aneurin Bevan University Health Board area (2284).

EMS Cross Boundary Responses

Report By: Station LHB	Aneurin Bevan	Date Period:	01/01/2022	to	30/11/2023
Vehicle Type:	EA				

MPDS Priority Type	Location LHB						Total Responses
	Cardiff and Vale	Cwm Taf Morgannwg	Hywel Dda	Out of Area	Powys	Swansea Bay	
RED	429	609	1	4	32	8	1083
AMBER1	2154	2169	-	1	27	7	4358
AMBER2	146	170	-	2	1	1	320
GREEN2	7	7	-	-	-	-	14
[illegible]	11	15	-	-	-	-	26
Total	2747	2970	1	7	60	16	5810

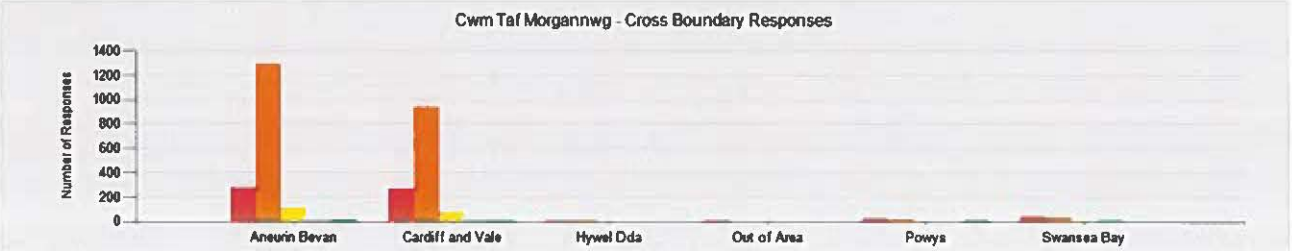


This final table and graph show the number of resources from Cwm Taff Morgannwg University Health Board into Cardiff & Vale University Health Board area (1688) and Cwm Taf Morgannwg University Health Board area into Aneurin Bevan University Health Board area (1278).

EMS Cross Boundary Responses

Report By: Station LHB	Cwm Taf Morgannwg						Date Period:	01/01/2022	to	30/11/2023
Vehicle Type:	EA									

MPDS Priority Type	Location LHB						Total Responses
	Aneurin Bevan	Cardiff and Vale	Hywel Dda	Out of Area	Powys	Swansea Bay	
RED	279	266	1	1	20	40	607
AMBER1	1292	935	1	-	14	32	2274
AMBER2	100	70	-	-	2	1	179
GREEN	4	1	-	-	-	1	6
	7	6	-	-	1	-	14
Total	1688	1278	2	1	37	74	3080



This clearly shows a higher proportion of vehicles going out of the Cardiff & Vale University Health Board area into the other Health Board areas.

Aneurin Bevan University Health Board have nearly double the Emergency Ambulance capacity at peak, than Cardiff & Vale University Health Board, with Aneurin Bevan University Health Board having 22 Emergency Ambulances at peak against 13 in the Cardiff & Vale University Health Board area at the same time.

The Trust is taking all possible steps within its control to ensure availability of resources to respond to Red and Amber calls. The Trust also seeks to secure full support from the Welsh Government, the wider NHS and the local Government to ensure appropriate clinical risk management across the urgent and emergency care pathways to release resources to the Trust. The Trust has evidenced this work through the comprehensive details of all the actions that we have taken to date.

I attach for your reference copies of the Real-time Mitigation Report, Reducing Patient Harm Action Plan and the Associated Risks, all of which were presented to the public Trust Board on 23rd November 2023. These documents are regularly presented to, and reviewed by, the Trust Board and I hope this offers you assurance that this matter continues to remain a significant risk and a matter of attention to the full Trust Board.

Whilst the Trust fully supports the need to issue a Prevention of Future Deaths Report under Paragraph 7, Schedule 5 of the Coroners & Justice Act 2009 and Regulation 28 and 29 of the Coroners (Investigations) Regulations 2013, we do not believe that we are the authority with the "power to take such actions". Notwithstanding the authority to act, I have recently held executive level meetings with Aneurin Bevan University Health Board colleagues and as a result of these, we have agreed some additional measures that we will be implementing in January 2024. These measures are expected to reduce the number of conveyances to The Grange Hospital through direct admission to alternative sites and the introduction of a new temporary facility that can be used for patients who are often those that experience the longest delay in handover. We expect both these measures, in addition to those outlined in our responses to date, to offer additional support to the release of ambulances back into the community for response.

To reaffirm my earlier comment, we believe we have robust plans in place which are regularly critiqued and monitored throughout the organisation. The issues arising are presented to our full Trust Board and we liaise directly with the Health Board and wider health and social care

partners across Wales in order to secure their support to ensure that we respond to Red and Amber calls in a timely way.

While writing I would like to offer my sincere condolences to Mrs. Blackmore's family on their sad loss. I would also like to extend an offer to meet with you and leaders of key organisations to discuss our response in more detail, and to provide you with any further assurances you may require regarding our commitment to continue improvement to support prevention of harm and future deaths.

Yours sincerely

[redacted]

[redacted]
Chief Executive

Enc: Real-time Mitigation Report
Reduced Patient Harm Action Plan
Associated Risks