Ymddiriedolaeth GIG
Gwasanaethau Ambiwlans Cymru
Welsh Ambulance Services
NHS Trust

[redacted]

Swyddfa'r Gwasanaethau Ambiwlans Cymru
Welsh Ambulance Services Office

[redacted]

[redacted]

25 April 2024

PRIVATE & CONFIDENTIAL

Mr. Aled Gruffydd

Assistant Coroner

[redacted]

Dear Mr Gruffydd

Re: Jean Thomas

I write in response to the Prevention of Future Deaths Report issued on 4 March 2024, following the inquest.

The matter of concern that you have asked the Trust to consider is:-

There was a significant delay in getting an ambulance to Jean which resulted in a pressure sore forming due to long lie. That pressure sore was exacerbated by a further long wait to be offloaded into hospital. The time taken to offload was in excess of 16 hours, when the target offloading time is 15 minutes,

I would like to focus my response to reflect two distinct issues, firstly the issues surrounding delays in responding to our patients in community and the delays at hospital, and secondly the work being undertaken by the Trust in relation to pressure damage prevention or reduction.

Firstly at this time, the Trust does not propose to take any further action or new actions in relation to the matter of ambulance delays in arriving with patients and patients delayed outside of hospitals. The Trust is taking all possible steps within its control to ensure availability of appropriate resources.

I do not propose to share with you all the historic actions that have been taken by the Trust, should you wish for more detail please let me know and the Trust will gladly share with you the actions already taken. I propose to concentrate on the actions currently being taken.

The Trust also seeks to secure full support from Welsh Government, the wider NHS and local Government to ensure appropriate clinical risk management across the urgent and emergency care patient pathways to release resources to respond in the community.

Within the enclosures I have shared the measures that are currently in place, namely the Clinical Safety Plan and the Regional Escalation Action Plan to manage resources at times of high demand. I am also attaching copies of the Real-time Mitigation Report and the Reducing Patient Harm Action Plan, along with the associated risks, all of which were presented to the Public Trust Board on the 28 March 2024. These Reports 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 for the Trust Board.

We believe we have robust plans in place which are regularly critiqued and monitored throughout the organisation. The issues arising are presented to our Trust Board and we liaise directly with the Health Boards and wider health and social care partners across Wales in order to secure their support to ensure that we respond calls in a timely way.

Secondly, I would like to share with you that the Trust has implemented a range of actions to mitigate as much as possible the effects of long community waits and the identification and mitigation of pressure damage. These include:

- E-learning programme where causes, risks and identification are explored.
- Clinical notices (04/2020, 07/2021, 10/2022) including escalation of concerns at hospital sites.
- Trust position on the use of the repose mattress which was shared as not being fit for purpose for our stretchers following review.
- Review of other services approach and search for specific pre-hospital clinical equipment
- Discussions with Stryker who manufacture the stretchers and wider NHS leads on the risks to patients and possible solutions.
- Updates of certain Medical Priority Dispatch System codes (those patients who have been on the ground for more than an hour) now include the ability to automatically dispatch our community volunteer and falls response teams.

Additionally, the focus for Trust clinicians:

- High index of suspicion/inquiry into the risk of pressure area development (frailty/immobile/long lies).
- Assessment and identification of high-risk areas.
- Repositioning.
- Escalation of concerns/risks/harm.

Despite these actions there continues to be incidents where harm through pressure damage have been reported.

I am pleased to share that the Trust has been working with an industry partner to develop and innovate around the current challenge. A company called OSKA have helped us design and test a surface that can be quickly deployed onto the Trust's fleet to help reduce the risk that we are facing of increased patient harm by way of pressure damage.

Pressure relieving devices are widely accepted methods of preventing and reducing pressure damage development. There are many different devices used across health and care system but no bespoke option has yet been developed for pre-hospital care teams.

The Trust and OSKA have been working together to develop a bespoke alternating pressure mattress that fits the Stryker stretcher. The Stryker and all ambulance stretchers are designed to support the care of a wide range of patients with differing clinical presentations, including those patients requiring cardio-pulmonary resuscitation. Due to these reasons the mattresses are not designed as a low pressure surface. The Trust has been in discussion with Stryker and there are no plans to change the current design or to adjust the specification to meet the challenge of providing a low pressure surface.

Contact through the Ambulance Paramedic Lead Group which reports into the National Ambulance Service Medical Directors (NASMED) confirms that there is no similar innovation ongoing in any of the UK's ambulance services. Trusts who provided their guidance on pressure area management were similar to the education packages developed in the Trust (as shared above) but also included other protocols such as immediate 'offload' for patients at risk.

A number of meetings with Trust leads have informed the development of the device and it has been discussed with colleagues from various forums such as Health and Safety, Infection, Prevention and Control (IPC) and the Vehicle Working Group members who have identified how the device can be operated and stored on the Trust's vehicles.

Although there has been significant development there are still a number of steps to be finalised by the manufacturer and ourselves before we begin a pilot of the new mattress.

I hope this offers you reassurance that the Trust has considerable ongoing work to address the concerns you have shared within the Prevention of Future Deaths Report. If you have any further questions please do not hesitate to contact me, this can be done by writing to the address shown on this letter or by email to [redacted]

While writing I would like to offer my sincere condolences to Mrs Thomas's family on their sad loss.

Yours sincerely

[redacted]

[redacted]

Chief Executive

Enclosures:

- Clinical Safety Plan
- Regional Escalation Action Plan
- Real-time Mitigation Report
- Reducing Patient Harm Action Plan
- Associated risks