



GIG  
CYMRU  
NHS  
WALES

Ymddiriedolaeth Brifysgol GIG  
Gwasanaethau Ambiwylans Cymru  
Welsh Ambulance Services  
University NHS Trust



## Swyddfa'r Prif Weithredwr a'r Cadeirydd Chair and Chief Executive's Office

---



27 March 2026

### FAO John Gittins

Senior Coroner North Wales



Dear Mr Gittins

### Prevent Future Death Report relating to Heather Louise Parkhill.

I am writing in response to the Regulation 28 report to prevent future deaths, that you issued on 2 February 2026 and wish to share again my sincere condolences with Mrs Parkhill's family.

*"For many years, myself and other coroners have raised concerns regarding so called "ambulance delays" and I recognise that the challenges faced by WAST around the availability of resources are the result of multifactorial issues, however problems regarding the unavailability of resources persist. I have a mandatory statutory responsibility to raise concerns where they exist and it is clear that lives continue to be lost as a result of this problem.*

*Despite all of the multi-agency efforts to improve the availability of resources and hence response times, nothing appears to change I therefore remain concerned that lives continue to be at risk."*

Mae'r Ymddiriedolaeth yn croesawu gohebiaeth yn y Gymraeg neu'r Saesneg, ac na fydd gohebu yn Gymraeg yn arwain at oedi

The Trust welcomes correspondence in Welsh or English, and that corresponding in Welsh will not lead to a delay

[www.ambulance.wales.nhs.uk](http://www.ambulance.wales.nhs.uk)

Pencadlys Rhanbarthol  
Ambiwylans

Regional Ambulance  
Headquarters

Beacon House  
William Brown Close  
Llantarnam, Cwmbran  
NP44 3AB

Ffôn/Tel  
01633 626262

## **WAST response to your concerns**

The concern you express about the continued impact and harm resulting from extensive community waits for ambulances is shared by myself, the Executive team and our Trust Board at WAST. Over the years, the Trust has shared with you all the measures that have been taken in an attempt to manage and address the changes in the pressures both within the Trust and across the wider NHS Wales landscape. These actions include:

- Increasing our remote clinical support to ensure we are prioritising our available resources effectively based on the presenting needs of patients and also to improve safety netting when we are under significant pressures
- Minimise the number of patients being transported to already busy hospitals by enhancing staff knowledge, skills and competencies and the alternatives available to them
- Increase resources available for use, completing roster changes to increase resource availability and improving levels of attendance levels
- Offering more treatment at home, or away from the hospital environment in partnership with Health Board colleagues

You correctly identify that current challenges are multi-factorial in cause and the Trust continues to work tirelessly with system partners to achieve the changes that our population deserves.

### Managing 999 ambulance demand

In July 2025, a new emergency ambulance performance framework was introduced in Wales, supporting a move away from time-based targets towards a more clinically driven, outcome-focused approach, with an emphasis on responding quickly to people with time-sensitive conditions.

Two new categories of call were initially introduced in July – a new purple category for people suffering a suspected cardiac and respiratory arrest and the red category for people at high risk of cardiac and respiratory arrest, including where this is a result of injury or illness.

As part of the framework, all 999 calls to WAST, which are not classified as either purple or red, go through rapid clinical screening to ensure everyone receives a more tailored approach. This means the ambulance service takes account of their symptoms and where the incident occurred to determine what sort of response they receive. Every person receives a tailored response but not everyone will need an ambulance – they may receive a different clinical response, which is appropriate to their needs. An additional 28 clinical advisers – new posts – were recruited to support this new process to ensure people get the right response the first time.

The next phase of the framework was introduced in December, following a clinical review of the amber and green categories of call. A new orange – time-sensitive response category was introduced. This was designed to ensure people with conditions such as suspected stroke or STEMI are identified earlier through enhanced clinical screening in the 999 contact centres to receive a faster, more appropriate ambulance response, and rapid transport to specialist care.

The new framework also increases opportunities to better understand patient outcomes and experience by broadening measurement beyond initial response times to include more clinically meaningful metrics, such as call-to-door times. The intent is to enable clearer insight into the timeliness and quality of care delivered to patients with serious and time-sensitive conditions, including stroke, to drive quality improvement.

The changes are being tested for 12 months and will be thoroughly evaluated.

I understand that Mrs Trish Gaskell, the Trust's former Solicitor, had made the offer to you to attend the Clinical Contact Centre now located in St Asaph, to observe firsthand the changes that have been made to our response model.

#### Improving ambulance patient handover performance

All health boards are expected to deliver the *Ambulance Patient Handover Guidance*, published by the Welsh Government. This was updated in January 2026 and issued to health boards for immediate delivery. I enclose a copy of that guidance for your reference.

This reinforces that ambulance patient handover is a whole system responsibility, requiring co-ordinated action across all parts of the NHS and aligned to existing escalation arrangements. It also expects a more consistent approach to monitoring, assurance, and accountability, enabling system leaders to identify and address the underlying causes of handover delays rather than managing the symptoms alone.


Last year the Cabinet Secretary for Health and Social Care set up a clinically-led National Handover-45 Taskforce to support delivery of a recommendation made by the Ministerial Advisory Group on NHS Performance and Productivity to eliminate ambulance patient handover delays of more than 45 minutes. The taskforce has brought together senior clinical, operational and system leaders from across NHS Wales and has overseen focused improvement activity, shared good practice, and provided national clinical leadership on safe and timely handover.

Its work has helped to strengthen understanding about why handover delays happen, reinforced the importance of whole-system flow, and supported measurable improvements in handover performance across a majority of hospital sites in Wales.

I enclose a copy of the *Ambulance Handover Accelerated Design Events Integrated Thematic Summary*, which provides more detail and context regarding the National Handover-45 work.

I appreciate that these broad system-based actions will not diminish the loss experienced by Mrs. Parkhill's family. I am genuinely sorry that we were not able to deliver the service I am committed to offering to them.

If you wish to take up the offer of visiting our clinical contact centre (now based at St Asaph) please contact [REDACTED] Legal Services Manager, who will be happy to arrange this. I understand that the Trust's Executive Director of Nursing, [REDACTED] has also offered to meet with you recently, and this can also be arranged via [REDACTED]



Yours sincerely



CHIEF EXECUTIVE

Encl: Ambulance Patient Handover Guidance

ADE integrated thematic summary report