A joint investigation into two separate complaints by Mr S and Mrs B against Welsh Ambulance Services NHS Trust

A report by the Public Services Ombudsman for Wales

Case: 201002432 & 201002552

Contents

Introduction

This report is issued under section 16 of the Public Services Ombudsman (Wales) Act 2005.

In accordance with the provisions of the Act, the report has been anonymised so that, as far as possible, any details which might cause individuals to be identified have been amended or omitted. The report therefore refers to the complainants as Mr F who complained on behalf of his mother, Mrs S, about the care provided to his father, Mr S; and Mrs B who complained about the care provided to her husband, Mr B**.**

Summary
The Ombudsman received two separate complaints from Mr F and Mrs B who respectively complained about the care provided to their father and husband by the Welsh Ambulance Services NHS Trust. Both complained about the length of time it took for an ambulance to attend following the 999 calls they made to the service. They also complained about the manner in which the Trust had dealt with their complaints.

The Ombudsman found that ambulances and rapid response vehicles from other divisions of the service could have been deployed to both incidents, and they might have arrived with the patients sooner, but that their deployment had been overlooked. The Ombudsman was also critical of the quality of the Trust's investigations into Mr F and Mrs B's complaints, the content of its responses and the time it took to provide them. The Ombudsman upheld both complaints in full. He made a total of nine recommendations including that the Trust apologise to Mr F, Mrs B and their respective families and to pay them appropriate redress. He also recommended that the Trust should reinvestigate or review the original complaint; review the relevant policies and procedures and its management of resources and audit any changes it has implemented

The complaints

1. Mrs B complained, via her solicitor (the solicitor) about the delay that was encountered following a call for an ambulance on 27 June 2009 to attend to her husband, Mr B, who had fallen and injured his hip and was in a distressed condition. Mrs B complains that, despite telephoning the emergency ambulance service at around 23.10 hrs, the emergency ambulance did not arrive until shortly before 02.00 hrs. Mrs B is aggrieved that, despite making numerous telephone calls, the ambulance failed to arrive for two and three quarter hours, even though the call priority was raised to category A (Red) at 00:56 hrs. Mrs B also had concerns that an ambulance was not dispatched to her husband during this period despite information provided by the Welsh Ambulance Services NHS Trust (the Trust) indicating that other emergency ambulances would have been available during the period Mr B was waiting. Mrs B was of the view, that if the ambulance had arrived in a more timely manner, her husband would have stood a better chance of recovery. Sadly Mr B died four days later in hospital.

2. Mrs B also complained about the failure of the Trust to provide an adequate response to her complaint. She was also concerned about the length of time taken by the Trust to deal with her complaints. Of particular concern was

- the five and a half months it took to provide the first substantive response to her complaint;

- the further four months to respond to supplementary enquiries from the solicitor and;

- the five months to respond to Mrs B following recommendations from an independent reviewer who considered Mrs B's complaint.

The latter delay was experienced despite the solicitor lodging a formal complaint with my office and a number of interventions from my officers.

3. I received a complaint from Mr F, on behalf of his mother, about the delay that occurred on 19 July 2010 when an emergency ambulance was called to attend to his father, Mr S, who had developed breathing

difficulties. Mr F was concerned that even though his father was categorised as a Category A (Red) priority, an emergency ambulance took 51 minutes to arrive. Mr F complained that no rapid response paramedic was dispatched to attend to Mr S and that even when an emergency ambulance became available, it was not dispatched. Mr F was concerned that, if assistance had arrived within the target time of 8 minutes for such a category of call, the outcome for his father might have been different. Mr S died within three hours of being transferred to hospital.

4. Mr F also complained that despite complaining to the Trust on 1 August 2010, he did not receive a substantive response to his complaint until 19 February 2011 and that was following his contact with, and intervention by, my office.

Investigation

5. I commenced an investigation into Mr F's complaint on 13 April 2011 and into Mrs B's complaint on 6 June 2011. In my view the matters complained about by both Mr F and Mrs S involved common themes such as delays in dispatching ambulances potentially caused by failures to identify available resources and lengthy delays in responding to their complaints. For this reason, I decided that it was appropriate for both complaints to be investigated together. During the course of the investigation, I obtained comments and copies of relevant documents from the Trust in relation to both incidents and complaints. I considered these in conjunction with the evidence provided by Mrs B's solicitor and Mr F. I have also obtained advice from one of my professional ambulance service advisers on both cases. I have not included every detail investigated in this report, but I am satisfied that nothing of significance has been overlooked.

6. Mr S, Mrs B and the Trust were given the opportunity to see and comment on a draft of this report before the final version was issued. The draft of this report was also shared with the relevant department of the Welsh Government for information purposes

Relevant national and local guidance and procedures

7. In April 2003, the Welsh Assembly Government issued guidance on the handling of complaints in Wales entitled "Complaints in the NHS – A guide to handling complaints in Wales" (the guidance). Paragraph 1.83 states that :

> "A full investigation of the issues raised in the complaint should be completed within four weeks (20 working days). If it is not possible to complete the investigation within this time, the complainant should be informed of the reason for the delay and when they can expect to receive a reply."

8. The guidance also states that that the reply should aim to satisfy the complainant by assuring them that their concerns have been thoroughly investigated point by point.

9. In April 2011, the Welsh Government introduced a new complaints procedure for handling concerns about the NHS in Wales. It also issued guidance entitled "Putting it Right - Guidance on dealing with concerns about the NHS from 1 April 2011" (the new guidance). Paragraph 4.12 of the new guidance confirms that in the majority of cases, concerns should be responded to within 30 working days of their receipt. NHS bodies are permitted to have longer to respond if this proves necessary. However in any case the new guidance also emphasises that, where there might be a delay, an explanation must be provided to the person raising the concern.

10. The Trust also introduced its own complaints procedure on 18 June 2007. This says that the Trust "aims" to provide a written response within 20 working days. The Trust's complaints procedure stipulates that, if a complaints investigation cannot be completed within the set target time, the Investigating Officer must contact the complainant to inform them of the reason for the delay and also inform the National Complaints Manager / Co-ordinator and Regional Director "immediately". The procedure also requires the completion of a risk matrix[1] once the

[1] This is a tool which gives a score to a potential risk taking into account the likelihood of an event occurring and the severity of the outcome if that event in question did happen.

complaints investigation is completed. The procedure states that it is necessary for a follow up action plan to be implemented within three months if a risk score of over 8 is arrived at.

11. The Trust has also provided an approved "Standard operating procedure for incident logging and activating an emergency response" (the procedure) which is understood to have been operational at the time of both incidents.[2] The procedure was issued in December 2004. The procedure sets out the definitions of various types of calls and the responses that need to be made to such calls. An Emergency call which the Trust categorises as an "AS1" or "Red" call falls into two categories – A or B. A category A call is considered to be "life-threatening" and category B is described as being "non-life threatening". The answers to questions which the Trust's call taker obtains from the person making the emergency call is inputted into a computerised "MPDS" system which then provides a code which determines whether the call should be category A or B. The procedure also sets out Welsh Assembly Government performance standards for responding to the two categories of call. The procedure states that "Life threatening calls have to be responded to within 8 minutes of receipt of the 'Chief Complaint' ", regardless of the location of the call. A category B call is acknowledged as having a lower level of response and is dependent upon the location of the caller. The standards expect that 95% of calls to an urban area are responded to within 14 minutes; to a rural area within 18 minutes and to a sparsely populated area within 21 minutes. The procedure does not define such areas. It appears that there is a third category of call, not defined in the procedure document, known as Category C (Green) which is neither life-threatening nor serious but which has a target response requiring 95% of calls to be attended within 18 minutes.

12. The procedure also contains a section for allocating AS1 incidents. Included in the procedure are the following:

> "The EMS[3] controller will ensure resources are responded to meet all service standards and procedures

[2] The Trust has confirmed, following receipt of a draft copy of my report that the procedure has now been amended to reflect recommendations contained at paragraph 83 this report

[3] Emergency Medical Services

It is the responsibility of the EMS controller in charge of the incident support desk to ensure the correct emergency response is dispatched to an incident.

There is an instruction to type RES/RESG[4] as appropriate to the incident with a reference to section 12[5] of the Trust's "Training Manual - MIS Command and Control System[6]".

The category of call is to be identified and there is an instruction "if necessary alert First responders" following Section 15[7] of the Training Manual".

13. There is no reference in this section to any procedures that need to be followed if there are no resources available to respond to the incident. Section 2.18 of the procedure sets out a procedure for inter-regional arrangements. The procedure is specified as applying to emergency calls being received within the EMS controller's Regional Control Area that are in "close proximity to a boundary line". Close proximity to a boundary line is not defined in the procedure. In such cases it is stated that "the nearest emergency ambulance must be mobilised immediately..." There is also a procedure for the diversion of an ambulance responding to an Amber call to a Red call instead. This procedure again specifies that the "nearest available" ambulance should be dispatched. Under this particular section there is also a recognition that if Emergency calls are "polling" (queuing) Red category calls must be responded to before Amber calls, regardless of the length of time the calls have been polling.

14. There is also an instruction in paragraph 2.31.6 of the procedure that "When a duplicate call is of a higher dispatch category than an original call i.e. a category A call where the original was a Category B or

[4] A command that is typed into the Trust's computer aided dispatch system to highlight all available resources across the region in question

[5] This section sets out the inputs that need to be made to activate this RESG facility

[6] The MIS command and control system is a set of software tools designed to control and manage the dispatch of emergency vehicles

[7] This refers to the various types of warnings the MIS command and control system issues

C call, if a resource has not been dispatched, an appropriate resource must be sent."

The background events

Incident 1 – relating to Mr B

27 June 2009,
Late in the evening Mr B fell whilst at home.

23:10 hrs
A 999 telephone call was received by the control centre covering the area to the North West of Pontypridd, where Mr B lived. During this telephone call, Mr B's daughter explained that her father had fallen and that he could not get up and was in pain. The dispatcher receiving this call categorised it as a green response call. It is also recorded at the time of this call that there was "no RRV[8] on duty".

23:11 hrs
A separate entry made by another call room operative whilst the call was ongoing states that there was no crew available at the time of the call. No ambulance was dispatched to Mr B at this time.

28 June - 00:15 hrs
A second call was received from Mr B's daughter providing similar information, but indicating an increased level of concern and informing the control room operative that Mr B's leg was swelling and that he was in increasing pain and was asthmatic. Following the responses provided by Mr B's daughter during the call it was identified as requiring an amber response.

00:56 hrs
A third call was received from Mr B's daughter which was quickly recognised by the control room operative as being more urgent as Mr B was having difficulty breathing and was passing in and out of consciousness. This call was identified as requiring a Red category response. It appears from the evidence provided, however, that whilst the information regarding this call was added to the log of the initial

[8] rapid response vehicle

incident, no warning was activated. This meant that the control room allocator would not have been alerted to the need for a higher category of response (i.e. Red) as the incident would have remained green on the queue of waiting incidents.

01:10 hrs
A fourth call was received which was identified as a duplicate of the previous call. This call was not completed as the line was cut off and it was categorised as an amber call.

01:36 hrs
A fifth and final call was received about Mr B. During the course of this call it was identified that Mr B had deteriorated but that an ambulance identified with call sign 1527 had been dispatched at 01:37 hrs.

01:57 hrs
Ambulance 1527 arrived at Mr B's home address.

02:41 hrs
Ambulance 1527 departed from Mr B's home address.

03:02 hrs
Ambulance 1527 arrived at hospital.

Later that day Mr B underwent a hip replacement procedure because of a fractured femur.

2 July 2009
Sadly Mr B died in hospital having developed symptoms of heart failure post-operatively.

Incident 2 – relating to Mr S
19 July 2010 - 06:09 hrs
A 999 telephone call was received by the control centre covering an area to the North West of Pontypridd, where Mr S lived. During this telephone call Mrs S explained that her husband was experiencing breathing difficulties. The responses the control room operator recorded

during this call meant that it was categorised as requiring a Red response.

06:46 hrs
An emergency ambulance became available and was allocated to attend the incident at 06:46 but, as it needed to change oxygen cylinders it did not depart until 06:53.

07:00 hrs
The ambulance arrived at Mr S's home address.

07:37 hrs
The ambulance arrived at hospital.

07:45 hrs
Mr S was triaged and assessed at the hospital's Accident & Emergency Department and referred to the medical department at 08:35 hrs.

10.30 hrs
Sadly Mr S suffered a cardiac arrest and died. The medical notes state that the admitting doctor had discussed Mr S with the family following his death. He told them that they did not have sufficient time to stabilise or diagnose Mr S. A post mortem examination indicated that the likely cause of death was a "heart attack".

Complaint handling

Mrs B's complaint

15. A family member initially complained to the Trust on **3 July 2009** on behalf of Mrs B about the length of time it took for an ambulance to arrive to attend to Mr B. A full investigation was requested so that no other family would have to suffer in the same way. The Trust wrote to the family member on 7 September, 9 October and 27 November 2009, confirming that the investigation was ongoing but providing no explanation for the delay in responding. The letter of 9 October noted that Mrs B was now being legally represented.

16. On 9 December, the Trust's Chief Executive wrote to the family member apologising for the delay in responding but providing no

explanation for the delay. The Chief Executive's letter set out the events which took place following the initial 999 call to the Ambulance service at 23:10 hrs. Whilst it was acknowledged that two of the calls received were below standard, it was stated that this would not have impacted on the response time. The letter also explained that, at the time of the call, the service was experiencing a 50% greater volume of calls than average. The Chief Executive also indicated that all of the emergency ambulances in Mid Glamorgan were unavailable (responding to emergencies or on non-disturbable breaks) at the time of the call. It was also stated that seven out of thirteen emergency ambulances and two out of six rapid response vehicles that should have been operational at the time of the call were not available because of staffing shortfalls. The Chief Executive said that the shortfall in staff adversely affected the Service's ability to respond in a timely manner. The Chief Executive indicated that recruitment measures had been taken to address the shortfall. The Chief Executive concluded by apologising to the family for any anxiety or distress caused by the Trust's failure to respond to the emergency in a timely manner.

17. The solicitor wrote to the Trust on 17 December. In his letter the solicitor queried the number of telephone calls that had been made to the ambulance service on Mr B's behalf and sought an explanation as to why the handling of the two of the calls had been below standard. The solicitor also asked the Trust to explain the "Green" category of call and to provide more information about the volume of calls being experienced. The solicitor also asked in his letter:

> "Given that the target is to respond to 95% of "Green Calls" within 18 minutes, your response does not explain why it took over 3 hours to attend to [Mr B]. Our client requires to be satisfied that her husband's case was given proper priority in the system and that otherwise available ambulances had not been despatched to deal with later calls involving cases of equal or lesser severity..."

18. The solicitor also asked the Chief Executive to explain how the situation was allowed to arise whereby 9 out of 19 emergency response vehicles were not available.

19. On **23 April 2010** the Chief Executive responded to the solicitor. However I have seen that, during the intervening period, three reminder letters were sent and at least one telephone call was made by the solicitor. I have seen no evidence of the Trust providing an explanation for the delay during this period. The response was provided to the solicitor by a Regional Director (the Director). There was no explanation provided for the delay in responding, but the Director confirmed that a further review of all the evidence had taken place. The Director set out the categorisation of emergency calls. The Trust explained that the two below standard calls mentioned in the Trust's previous letter related to a failure by the call taker to stay on the line. The call volume was explained as being 50% higher that day than it had been for the same period the four preceding weekends. The Director also stated that "All of the emergency units on duty at the time of [Mr B's] call were dispatched to other emergency calls ... None of these units were dispatched to lesser categories of call."

20. With regard to the operational deployment of resources, the Director confirmed that a series of daily operational conferences were held to review any issues that arise. He explained that the resource department would then provide a staffing plan for the period. The Director confirmed that the service did have staff shortages that day, across the Mid Glamorgan area, which affected the service's ability to deploy ambulances. The Director indicated that the resource department would have attempted to fill vacant shifts but commented that overtime is voluntary. The Director also confirmed that the service was recruiting staff and that the staffing levels would be fully established in 2010.

21. Because of Mrs B's dissatisfaction with this response, the solicitor requested an Independent Review in May. The independent reviewer sought independent professional advice from an ambulance service adviser during his review. In order to do so, his adviser was provided with a copy of the Trust's investigation report. On 12 August the Lay Reviewer wrote to Mrs B providing a copy of the advice he had received. The reviewer asked the Trust to respond to six recommendations contained in his adviser's report. Whilst the recommendations in the main related to the provision of further information, it also contained a

specific recommendation that the Trust explain whether a failure to activate a red warning following the change in category from a green to red led to a delay.

22. On 27 January 2011 the Trust wrote to the solicitor responding to the lay reviewer's recommendations. It should be emphasised however, that this response was received following a number of reminders by the solicitor and the involvement of my officers on more than one occasion.

23. In its response, the Trust acknowledged for the first time that there was a failure to display a warning on its Advanced Medical Priority Dispatch System (AMPDS) of a change in category for the call to attend Mr B. The Trust said however that this was not the reason that a resource was not activated sooner because their records indicate that the allocator frequently accessed the call demonstrating their awareness of its status. The Trust said that the failure to dispatch a resource to Mr B was because the allocator had not looked outside the allotted divisional boundaries. The Trust stated that this was routine practice at the time of the incident. The Trust went on to state that "As a result of lessons learned from incidents such as this, the Trust has recently introduced new processes which allow resources from surrounding localities to be allocated to emergency calls."

24. The Trust also confirmed that there were 6 emergency ambulances and 4 rapid response vehicles operational in the Mid Glamorgan area which included Caerphilly, Rhondda Cynon Taf and Merthyr localities. The Trust also confirmed that alteration in working practices since this incident meant that the organisation had moved away from working within a defined geographical boundary with resources being deployed across the entire region.

25. As she had outstanding concerns Mrs B complained to me via the solicitor.

Mr F's complaint

26. Mrs S complained to the Trust on 1 August 2010 about the length of time it took for an ambulance to attend to Mr S following her 999 call on 19 July 2010. She was concerned that the ambulance took 51

minutes to arrive and questioned whether the outcome would have been different if it had arrived earlier.

27. The Trust acknowledged her complaint on 3 August 2010. It sent her update letters on 1 September and 1 October. Both letters indicated the Trust was awaiting the investigating officer's report before responding. Having heard nothing further, Mr F contacted my office on 15 February 2011 on Mrs S's behalf. One of my complaints advice officers contacted the Trust and a letter dated 16 February 2011 was sent to Mrs S.

28. Whilst an apology was provided in this letter for the delay in responding to her complaint, the Trust's Chief Executive did not provide a reason for that delay.

29. The Chief Executive explained that the Trust had undertaken an audit of all available ambulances within the timeframe of Mrs S's 999 call to ensure that none had been overlooked. The Trust confirmed that an audit had shown that at the time of the call (06:09hrs) there were no ambulances available. However the Chief Executive confirmed that, at 06:13 hrs, an emergency ambulance became available in Blackwood and that this ambulance should have been dispatched. The Chief Executive apologised for this oversight. The Chief Executive confirmed that the staff involved had undergone a case review.

30. Because Mr F and his mother remained dissatisfied with the response and the explanation provided, Mr F complained to me about the delay in the Trust responding to the emergency call to attend to his father.

What the complainants had to say

What Mr F had to say

31. Mr F complained about the length of time it took for the ambulance service to attend to Mr S and questioned why a "first response" paramedic was not despatched. They also questioned whether, if assistance had arrived in a timely manner, the outcome would have been different. Mr F and his mother were also dissatisfied with the manner in which the Trust dealt with their complaint and in particular, the

length of time it took to provide them with a substantive response to their complaint.

What the solicitor had to say on behalf of Mrs B

32. The solicitor originally complained to me in October 2010. However, since at that time a response from the Trust was promised within a fortnight, my office considered that it was appropriate to await such a response. The final response to the solicitor, responding to the lay reviewer's recommendations was eventually sent by the week of 14 February 2011.

33. In addition to overall concerns about the delay in the ambulance attending to Mr B and the delay in the complaint response from Trust, the solicitor also queried:

- The precise nature of the non-compliances referred to in the Trust's letter of 9 December.

- The significance of the Trust's reference to having received a volume of calls 50% higher than the average.

- An explanation of how a situation was allowed to arise where 9 out of 19 emergency vehicles were non-operational because of insufficient staffing levels.

- Whether the Trust's assertion that no lesser priority call was responded to before that of Mr B, since Mrs B considers that the information provided to her by the Trust does not bear this out.

What the Trust had to say in relation to Mrs B's complaint

34. On 6 June 2011 my investigator wrote to the Trust initiating the investigation into Mrs B's complaint. In the letter the Trust was asked to respond to the complaint in general terms and to respond to a number of specific questions. I have included elements of the Trust's responses below.

35. The Trust was asked to explain the time it took for an ambulance to attend to Mr B following a category C call, later reclassified as a category A (Red) call. It explained that its investigation report identifies

that during the timeframe of the incident there was a significant increase in emergency calls within the South East Region. It said that, between 23.00 hrs and 01.59 hrs on 27 and 28 June 2009, there were 140 calls registered in the South East Region which was 80% higher than the average call volume for the same period during the preceding three weeks. It should be noted that this information relates to the South East Wales Region as a whole and not Mid Glamorgan specifically.

36. The Trust also suggested that its ambulances were also delayed at two local hospitals at the time of the call, citing delays of 23 and 36 minutes during this period. However, no information was provided as to the normal handover interval for this period, although I understand that normally such handovers are expected to take 15 minutes.

37. The Trust also said that their resource logs indicate that all their resources were utilised on other emergency calls or non disturbable rest breaks at the time of the call to attend Mr B. They also commented that Rapid Response Vehicles (RRV's) were conveying patients to hospital due to the volume of calls in the Mid Glamorgan area.

38. The Trust confirmed that an ambulance was allocated at 01.36 hrs to attend to Mr B and that it arrived at his address at 01.57 hrs, two hours and forty six minutes after the initial call.

39. The Trust was asked to explain what resources would have been available if the allocator had looked for a resource outside of the allotted divisional boundaries. It said that between 23.00 hrs and 01.57 hrs, there were a total of eleven resources in neighbouring divisions which potentially could have been allocated to this incident.

40. The Trust also commented on the failure to look for resources outside the divisional boundaries. It said that it would have expected these resources to have been considered, however the Control Centre was experiencing a very high demand, coupled with reduced resources, at the time of this incident. The Trust also said that, because the procedure does not refer to divisional boundaries, it would have expected the allocator to have considered resources outside of their particular division.

41. Because the Trust had referred in correspondence with the solicitor to “lessons learned from incidents such as this, the Trust has recently introduced new processes which allow resources from surrounding localities to be allocated to emergency calls”, it was asked to provide details of such incidents. It confirmed that, in the period January to May 2009, it identified five incidents during which resources which had been available across divisional boundaries were not allocated to the incidents causing delay. The Trust confirmed that new processes were introduced on 1 November 2010. It explained that the reason the process took as long as it did, was due to the need to undergo staff consultation, technical re-configuration of information communication technology (ICT) systems, duty roster reviews and to inform staff of the changes to their roles.

42. The Trust said that these new processes have not been incorporated into the procedure. It commented that these new processes refer to the organisation of divisional desks within Ambulance Control in the South East Region. It explained the nature of the changes as follows:

> “Prior to November 2010 the South East Region operated 3 divisions. These were Cardiff and Vale, Gwent and Mid Glamorgan. Each division functioned with an allocator and dispatcher managing the Emergency Ambulance fleet. An additional allocator managed Rapid Response Vehicles and Community First Responder’s.
>
> As of November 2010, 5 divisions were created. These being Cardiff and Vale, West-Mid covering Rhondda Cynon Taf, East-Mid covering Caerphilly and Merthyr, North Gwent covering Monmouth, Blaenau Gwent and Blackwood and South Gwent covering Newport, Torfaen and Chepstow. All the resources of Emergency Ambulances, Rapid Response Vehicles and Community First Responders are managed by an allocator and dispatcher on each of these divisional desks.

> The aim of this reorganisation is to ... provide focus with regard to the resources available to the allocator in their particular division, making it easier to identify and dispatch resources to emergency calls as they present with the dispatcher providing a supporting role to the allocator. This enables quicker allocation of resources and easier monitoring of the demand in the particular area.
>
> The divisional desks are also organised in close proximity to one another, enabling better communication to take place between the divisional desks in order to ensure that resources are used to their maximum potential within region."

43. The Trust was asked to comment on whether it considered there were any common factors between the cases of Mr S and Mr B. It said that, whilst in both cases resources were overlooked from adjacent divisions, it believed that the reasons for doing so were different. It considered that, in Mr B's case, there were other contributory factors such as high demand, operational shortfalls and ongoing delays with hospital handovers. It felt, however, that Mr S's case was of a different nature since this was an omission by an allocator to perform an "RESG" which would have identified all available resources at the time.

44. The Trust was also asked to comment on any risk assessments undertaken in respect of reduced resource availability and a higher than expected level of emergency calls together with any mitigating actions to be instigated. It said that there is a daily planning meeting that uses forecasted activity and operational knowledge to plan for changes in activity and ensure that its resources meet expected demand. It confirms that a "dynamic risk assessment" is undertaken both for the current day, the next day and future dates. It explained:

> "We manage our resources through something we call unit hour production (UHP). This is the total amount of ambulance hours available to meet the demand each day. UHP is affected by numerous factors such as planned staff absence for training, annual leave and maternity leave and so forth. This can be planned well in advance. However UHP is also affected by staff

sickness and short term leave requests. This means that we need a certain amount of flexibility to cover these short notice absences and also compensative (sic) for times of higher anticipated activity such as bank holidays and seasonal impact. To facilitate this we use unfilled vacancies to provide additional overtime hours that allow us to flex our resources if UHP drops or activity increases but without impacting financial budgets.

...the availability of staff (UHP) was reduced due to short term sickness. The resource departments would have attempted to cover these shifts but it is not compulsory that staff work overtime. There is a balance between having enough staff in post to meet the core requirement and having vacancies that allow flexibility through overtime."

45. The Trust also said that, in February 2011, it introduced an escalation plan and provided staff training in its use. It has provided me with a copy of this escalation plan.

46. The Trust confirmed that in June it had 44 vacancies in the South East Region. The Trust confirmed that an additional 24 Emergency Medical Technicians and 15 High Dependency Service staff were trained in 2009. It also confirmed that 26 graduate paramedics were also employed by the region in 2010.

47. In relation to time taken to respond to the initial complaint and the solicitor's letters the Trust said:

"It is recognised by the Trust that processes were not followed in a robust and timely manner. In acceptance of this, the Trust has identified key areas for improvement in the overall management of concerns. As such, the Trust is continuing to work to ensure that investigations into concerns and subsequent letters of response improves, whilst also capturing organisational learning aligned to the Welsh Assembly Governments Putting Things Right'."

What the Trust had to say in relation to Mr S's complaint

48. On 13 April 2011, my investigator wrote to the Trust initiating the investigation into Mr S's complaint. In the letter, the Trust was asked to respond to the complaint in general terms and to respond to a number of specific questions. I have referred to elements of the Trust's response below.

49. The Trust was asked to explain precisely why a category A call took 51 minutes for an ambulance to attend. It said that its investigation report identified that, at the time of Mrs S's call, there were no resources available in the locality. It acknowledged, however, that its report identified that a resource did become available some 15 miles away in a different locality, but was not dispatched. The Trust added:

> "Unfortunately in light of your request for information, we have reviewed the incident and identified another resource that was available again in a differing locality. A significant cause of this was due to the control allocator not undertaking a 'Resource Geographically' (RESG) which would have highlighted all available resources across the region."

50. The Trust was also asked to comment on any lessons learned from this incident. It responded in a similar vein to that of its response to Mrs B's complaint by stating:

> "As a result of lessons learnt from this case in question and others, the configuration of the control room has been altered to ensure a more even distribution of work amongst call takers and allocators. Furthermore all staff have been communicated with reiterating that a (RESG) is to be done for every 999 call which would then identify the nearest available resource for all calls requiring an emergency response. Additionally staff receive regular case reviews when it is identified through audit or concerns raised that performance falls below expected standard."

51. The Trust was asked to explain why it took over six months for it to respond substantively to Mrs S's complaint. It again stated that it recognised that processes were not followed in a robust and timely

manner on this occasion by some managers. It added that the Trust had identified key areas for improvement in the overall management of concerns. However, the Trust provided no details as to the areas in question. The Trust said that it was continuing to work to ensure that "investigations into concerns and subsequent letters of response improves, whilst also capturing organisational learning aligned to the Welsh Assembly Government's 'Putting Things Right'."

Common complaint handling concerns

52. Following the concerns raised about the handling of both Mrs B and Mr S's complaints and its initial responses to my Senior Investigator, the Trust was asked to clarify the measures it had taken to improve the overall management of concerns. It said:

> "...It was identified that the quality of investigations undertaken did not always meet the required standard; this resulted in letters of resolution being provided to complainants that did not answer all the questions raised within their complaint. In order to address this issue the Patient Safety Team, which managed adverse/serious adverse incidents, were tasked with providing support for investigating managers when requested; this included overseeing the completed report if the investigator requested assistance. While this offered support to individuals investigating officers when requested it was recognised that further support was required.
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> In discussions with the [Welsh Government] training was arranged for lead managers and investigating officers. This training involved Root Cause Analysis training, Being Open Training and a session by Welsh Health Legal Service about Redress. This all took place during January, February and March 2011.
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> To support investigations a quality assurance process was put in place. This involved all investigations and letters of resolution being reviewed by the Regional and Clinical Director prior to submission to the Chief Executive to sign the letter.
>
> The South East Region of the Trust identified two individuals to be seconded as dedicated investigating officers. As a result it has

been noted that there has been a steady improvement in the quality of investigation, additionally as they have become more experienced they are able to respond to complainants in a timelier manner.

This can be clearly evidenced by the dramatic reduction in outstanding investigation presently ongoing within the region. Additionally the response time for complaints within the region has also reduced..."

Professional advice

Advice of the Ombudsman's ambulance services adviser

53. As I indicated in paragraph 5, I appointed a professional adviser to advise me on these complaints. My Professional Adviser (the Adviser) Simon Harding, is an Ambulance Operations Manager of over thirteen years' experience in a busy urban ambulance service in England with a further ten years' experience in the ambulance service before then. I am satisfied that he is appropriately experienced to advise me on these cases.

54. The Adviser has been asked to address specific concerns in relation to both incidents and about how the Trust responded to the two 999 calls to its service.

55. The Adviser considered the five calls to attend to Mr B on 27/28 June 2009 separately. He told me that the first call made at 23:09 hrs was correctly triaged as having a green response level and was fully compliant in terms of AMPDS.

56. The second call received at 00:15 hrs was correctly triaged as requiring a response level of Amber as opposed to Green. The Adviser pointed out that this call was correctly identified as a duplicate of the first call. However he is of the opinion that there was an error made during this call, in that the information about a duplicate call was not entered into the appropriate log at this time. The consequence of this was that the information about the higher priority of call was not entered in accordance with paragraph 2.31.6 of the procedure.

57. The Adviser confirmed that the third call received at 00:56 hrs was correctly triaged, identifying that it required a Red category response. The Adviser confirmed that the information regarding this latest call was added to the log of the initial incident correctly. However, the appropriate warning notification was not activated. The Adviser concluded that this would have meant that the allocator would not have been alerted that the call now required a higher Red category response on the stack of waiting incidents.

58. The Adviser confirmed that a further call was received which was identified as a duplicate of the previous calls. This call was not completed since the line broke up. The Adviser did identify a discrepancy between the sequence of events which shows a different determinant from the Medical Dispatch Case Review. The Adviser confirmed that this was a very short call which broke up before it could be fully completed.

59. During the course of the fifth call at 01:36, an Ambulance (identified as call sign 1527) was activated. The Adviser pointed out that the call was incorrectly triaged and, as a result, the incorrect AMPDS determinant code was produced. However, he has confirmed that, even if the correct determinant code had been produced, it would not have increased the response level.

60. The Adviser told me that these calls were mainly handled well. He confirmed that there were indeed issues identified in the Medical Dispatch Case Evaluation relating to some areas of the calls handled, such as interaction with the person making the call. However, the Adviser assures me that these would not have increased the response level and would therefore not have impacted on the time taken for the ambulance to attend to Mr B.

61. The Adviser has also told me however, that there was an omission during the second call, in that the information about this call was not appended to the log of the first incident, which meant the information about the higher priority Amber call was not highlighted. The Adviser also confirms that there was a failure to activate a Red response flag following receipt of the third call, which meant that the response

category of the call on the stack of queuing incidents remained Green. The Adviser agrees however, that this, in itself, does not appear to have had an impact upon the attendance time as there is evidence the dispatcher accessed the call frequently demonstrating their awareness of its status.

62. The Adviser is of the view however, that there were earlier opportunities to dispatch an ambulance than the one which was eventually dispatched (call sign 1527). These alternative ambulance resources could have been dispatched from outside the Mid Glamorgan area, and the information provided by the Trust suggests that these alternative resources are likely to have arrived earlier than call sign 1527. The Adviser is of the overall view that it was not reasonable, even with the mitigating factors set out by the Trust, for the response to Mr B to take 2hrs 46 minutes. This is because, despite any external pressures on the service, there were, by the Trust's own admission, eleven resources available which could have been dispatched earlier.

63. The Adviser told me that ambulance services in England have produced capacity plans to deal with capacity issues that can arise at any time. Within such capacity plans there is a resource escalation action plan which is used to identify the level of pressure the ambulance service is under at any given time and to provide a range of tactical options to deal with over-capacity situations. The Adviser has told me that the Trust's comments suggest that it has moved towards a more robust system of capacity planning. The Trust has provided a copy of its escalation procedure and the Adviser is of the view that this procedure appears to be reasonable and addresses the concerns identified in this case appropriately.

64. The Adviser has said that the information provided by the Trust indicates that its staff operated within a culture of covering calls in their own area before considering whether there were other emergencies outstanding in neighbouring areas. This is indicated by the audit of the emergency response vehicles provided by the Trust in its response. This includes comments such as "Call same time and in different divisional area" and "different divisional area". The Adviser has also told me that it is reasonable to expect that when a Red call cannot be

covered by the normal divisional resource that enquiries are made to find an available resource from elsewhere within the Trust. The Adviser commented that, while he was not personally familiar with the Trust's command and control system, generally there are functions available on CAD[9] for a supervisor to have sight of all resources and all incidents that are awaiting allocation. As stated above, the Trust has indicated that one of the shortcomings identified in the cases of Mr B and Mr S (in addition to other identified cases) is that the allocator concerned failed to consider resources outside their own divisional boundaries. The Trust also suggested that because there is no mention of divisional boundaries in the procedure, it is incumbent upon the allocator to identify the nearest resource. The Trust confirmed that a duty manager has overall responsibility of the control room and they should have intervened if there was a closer vehicle available. The Adviser has told me that he is surprised by a lack of intervention by the managers in these two cases, given the length of time the calls in question had been stacking on the system. Furthermore, the Adviser has also pointed out that the procedure does not detail the action to be taken if resources are not available to be deployed.

65. The Adviser has also highlighted the fact that the procedure does not refer to divisional boundaries. In view of the apparent culture of operating within divisional boundaries, the Adviser considers that the issue of ensuring the nearest available ambulance response from any divisional or operational area should be stipulated and not simply implied.

66. The Adviser has noted the changes the Trust has implemented in relation to the number of divisions and the proximity of divisional desks and is of the view that this appears to be a good step forward.

67. In relation to Mr S's complaint specifically, the Adviser has told me that again he is of the view that the time to taken to attend to Mr S was not reasonable. This is because once again, as in the case of Mr B, there were resources available which could have been dispatched earlier.

[9] CAD – computer aided dispatch is a method of dispatching emergency services assisted by computer

The information provided suggests the following:

- an ambulance (call sign EA1005) apparently became available at 06:13 hrs which is likely to have arrived at Mr S's address before 06:45 hrs;

- Ambulance (call sign EA1512) apparently became available at 06:26 and was dispatched to a lower category call which is likely to have arrived before 06:50;

- Ambulance (call sign EA1530) was also en route to a lower category call at the time of the call to Mr S and should have been diverted to respond to his higher category call;

- There was also an RRV immediately available in the Pontypool area at the time of the initial call by Mrs S which conceivably could have attended to Mr S between 06:35 and 06:45 hrs. Whilst this RRV was not in Mid Glamorgan, there is nothing in the procedure which prevented the use of this resource;

- It appears that a rapid response vehicle was available at Bargoed from 06:32 hrs.

68. The Adviser commented that the failure to activate an ambulance earlier appears to have occurred as a result of an error by the allocator who apparently failed to use the RESG facility to locate resources outside their divisional boundary. The Adviser commented however that this would have involved more than one "error" as there were a number of opportunities missed to activate an ambulance response. He queried why an appropriate supervisor did not intervene as the call response became extended. The Adviser told me that in general, in his experience of UK ambulance services, when a call such as Mr S's cannot be responded to, a supervisory officer is informed. Such officers generally have functions available to them to see any un-allocated incidents and to check that appropriate actions have been taken to activate a resource. The Trust has not provided any evidence to indicate that this happened in Mr S's case.

69. The Adviser was also asked to comment on other specific areas of concern which appear to feature across both complaints. The first relates to the length of time taken by the Trust to learn lessons and implement change from repeatedly identified failures to identify resources out of division in the period January to June 2009. It is clear that, even at the time of call made to the Trust to attend to Mr B, a significant number of incidents involving failures to identify resources from outside divisional boundaries were noted. It is not known when the Trust initially became aware of these problems but, presumably, the investigations into these incidents would have highlighted such concerns. It is also unclear when this information triggered action by the Trust to address the risk to patients. These problems were identified initially in January 2009; the changes to address these problems were implemented in November 2010, nearly two years later. The service provided to Mr S was also compromised during this period because of this particular problem. Accordingly, the Adviser was asked whether he considered the time taken to implement the new processes were reasonable. The Adviser told me that, while the time taken to implement the changes is considerable, it is understandable in his experience given the nature of the changes being implemented. That said, the Adviser agrees that, from the perspective of patient care, the time taken to implement the changes was not reasonable or acceptable.

70. The Adviser also commented on the quality of the investigation reports. In the cases of both incidents involving Mr S and Mr B, the Adviser considered that the investigation reports were inadequate. A critical flaw of the original investigation report into Mrs B's complaint was that there was no consideration or recognition that resources out of the division were available and that a failure to identify these was a contributory factor to the delay. The Investigation report into Mrs B's complaint also had numerous omissions in other key areas:

- The investigating officer's name was excluded and the report was not signed.

- The "Outcome" section of the report was left blank.

- The risk log section was left blank.

- The “Lessons learned” section was left blank.

- There is no action plan included in the report.

The investigation report into Mr S’s case was better in terms of the report’s completion although the “lessons learned” sections were omitted. The risk log was completed and it appears from this that the risk was considered to be 9. There is also concern, however, about the accuracy of the Trust’s evidence which it used as the basis for the report. There is conflicting information contained within the investigation report about resource availability. For example, page 14 of the Trust’s investigation report contains a “supporting evidence” section which identifies an ambulance (call sign EA1005) available in Blackwood at 06:13 hrs and remaining so until 07:00 hrs. This is the information provided by the Trust in its formal responses. However it is also claimed elsewhere in the supporting evidence that this same ambulance (EA 1005) was available in Newport from 06:10 hrs until 06:51. This, in the Adviser’s view, casts doubt on the robustness of the Trust’s investigation. Subsequent enquiries of the Trust have confirmed that the latter information was incorrect and that the ambulance was in fact available in Blackwood for the period identified. Furthermore, the Adviser commented that the length of time taken to undertake the two investigations was excessive in view of the reports produced. The Adviser also commented that the investigations appeared to be focussed on identifying individual errors rather than on trying to address organisational issues.

71. Turning finally to the responses provided to the complainants, the Adviser said that the Trust failed to mention, in its initial responses to Mrs B, the fact that other resources did become available elsewhere in the region which could have been dispatched to attend to Mr B. The Trust also failed to mention in its response to Mrs S, and based on the information it held, there were two rapid response vehicles which could also have been dispatched to Mr S but were not utilised. It is likely that the shortcomings identified in the Trust’s response to the complaints are a reflection of the inadequacies of the investigation reports upon which, presumably, such responses were based.

72. The Adviser also made a number of specific recommendations. These include:

a. The Trust should review its "Standard Operating Procedure for incident logging and activating an emergency response" to specifically stipulate the need to ensure that the nearest available resource is deployed from any divisional or operational area.

b. The procedure should also detail the action to be taken if resources are not available to be deployed. It should detail at what stage the supervisory officer is alerted, and what actions the supervisory officer should take to ensure all available options for response are investigated. This should also include an option for looking outside of the Trust's operational borders, if necessary.

c. The Trust should look to introduce robust systems and checks to minimise the number and impact of human errors.

Advice of the Ombudsman's Accident & Emergency Adviser

73. I have also appointed a professional adviser (the A&E Adviser) to comment specifically on the concerns expressed by the families of Mr B and Mr S that, if more prompt treatment and transfer to hospital had occurred, the outcomes may have been different. The A&E Adviser, Dr Simon Ward, FRCS Eng MRCP UK is an Accident and Emergency consultant of 9 years' experience with a further 14 years' experience of working in the NHS in England. The A&E Adviser was asked to address the same questions in relation to the care of Mr B and Mr S, namely whether, if the ambulance had arrived on time, would the outcome for the patients have been different and would it have impacted on the patients' likelihood of survival?

74. In relation to Mr B, the A&E Adviser has told me that, on the whole it appears from the information available that Mr B sustained a fractured hip after a fall. This injury led to him being admitted to hospital. The patient was a heavy smoker, had chronic obstructive pulmonary disease (COPD) and hypertension. He considers that Mr B underwent an

operative fixation of the fracture in a timely manner. Although the operation apparently progressed uneventfully, Mr B developed post-operative complications. The A&E Adviser considers that these were most likely to be secondary to his underlying pre-morbid lung and cardiovascular conditions. The A&E Adviser concluded that it is not possible to directly link the delays in the untimely arrival of the ambulance and his death a few days later.

75. In relation to Mr S, the A&E Adviser told me that, overall, it appears from the clinical notes that Mr S developed worsening acute heart disease. He then deteriorated catastrophically in A&E and died shortly after arrival. The A&E Adviser said that it appears clear that the progression of Mr B's disease was developing quickly and unexpectedly and any further treatments were likely to have been unsuccessful. As a result of this well recognised, but uncommon progress of Mr S's disease, in a patient with other pre-existing conditions, the A&E Adviser is of the view that it was unlikely that an earlier ambulance would have materially altered the sad outcome for Mr S. He added that, in particular, the blood gas analyses showed that the extreme worsening of Mr S's condition occurred in A&E, as the first blood gas results were not very abnormal but quickly became so over the ensuing hour in A&E. The A&E Adviser concluded that, in Mr S's case it was not possible to directly link the delay in arrival of the ambulance and the sad outcome later that same day.

Analysis and conclusions

76. In both of the cases considered, it is clear to me that the Trust failed to deploy ambulance resources to the patients in a reasonable time-frame. It is also evident that there were pressures on the service the Trust was able to provide because of staffing issues and high demand. However, it is equally evident that opportunities to deploy resources to both incidents were missed, which meant that Mr B and Mr S did not receive the timely treatment they could reasonably have expected if these failings had not occurred. The Adviser has highlighted a number of concerns about the manner in which the Trust managed its resources in these cases and I appreciate that the Trust has, albeit rather belatedly, taken action to address some of the concerns raised by these cases. On the basis of the information it has provided, the steps

taken appear to be reasonable. However in view of the above failings, I uphold the complaints made by both Mr F and Mrs B in their entirety. I should emphasise however, that, based on the comments of my A&E Adviser, I have not found evidence to suggest that the delays that occurred in responding to the 999 calls to attend to Mr B and Mr S had any impact upon the sad outcomes for them on these occasions. This, however, does not in any way diminish the failing since, in other cases, such delays might have been critical to a patient's survival and I would encourage the Trust to carefully consider the lessons which stem from these cases.

77. I also have ongoing reservations about the manner in which the Trust provides its services to patients. Clearly the Trust has now recognised failures to identify out of area resources and reminders have been issued to the staff involved. However, I am more concerned that this failure to look outside divisional boundaries is representative of a wider organisational culture of operating within divisional areas. This is evidenced by the fact that, apparently, the duty managers who had overall responsibility for the control rooms at the time of these incidents also apparently failed to identify the availability of nearer resources. This culture is further evidenced by the fact that the investigation into Mrs B's complaint also failed to recognise the availability of resources from outside the divisional area. Whilst the measures taken by the Trust to address these shortcomings, as outlined in paragraph 42, go some way to addressing this problem, I would suggest that the Trust needs to monitor the use of out of division resources very carefully to ensure that the changes it has implemented are working effectively.

78. It also concerns me that the Trust has apparently sought to lay the blame for the failure to identify available resources outside Division areas on individual officers. This to me seems unfair. The Trust's protocols specifically refer to the need to allocate the "nearest" resource without reference to Divisional boundaries at this point. However, given that Divisional boundaries do exist, I am of the view that it would be appropriate for the Trust to stipulate in its operating procedures that allocators need to identify the nearest resource regardless of Divisional boundaries. The procedures, as currently set out, are clearly inadequate, as evidenced by the other five incidents identified by the

Trust (paragraph 41). These other incidents strongly suggest that other operators and potentially other control room duty managers also failed to appreciate the implied need to identify available resources outside divisional boundaries. There is an organisational duty to clarify operational requirements rather than rely on "custom and practice". This is a systemic failing and is the responsibility of the Trust and not its individual officers.

79. It is also evident that the manner in which both of these complaints were handled by the Trust was woefully inadequate. The quality of the investigations undertaken by the Trust, the substance of the responses provided and the time taken to provide these responses to the complainants was entirely unacceptable. It is clear that the investigations undertaken were flawed, in that important sections of the reports were left blank, including, crucially, the risk log (in the case of Mr B) and the "lessons learned" sections were not completed. Such shortcomings indicate to me that the Trust did not treat complaints with sufficient seriousness, nor, apparently, did it endeavour to learn from the complaints presented to it. My view on this matter is reinforced by the lack of urgency demonstrated in responding to Mr F and Mrs B's complaints. The complainants had to wait over six months for their substantive responses (often without any contact from the Trust for prolonged periods). I do not consider that the substance of the responses provided justified such lengthy delay, particularly given that that they contained inaccuracies and omissions which cast doubt upon their reliability.

80. Both complaints had raised their concerns about the possible impact that the delays in the ambulances' attendance might have had on Mr B and Mr S's chances of survival. The Trust made no attempt to address these concerns in their responses even though in both cases they acknowledged that the response times to the incidents were not within the set timeframe for such calls. My own investigation has concluded that the delay in the ambulances' attendance is not likely to have affected the outcome. Be that as it may, the Trust should have taken steps to establish the impact of these delays and addressed these matters in its responses to the complaint. I consider that such a failing demonstrates a basic lack of empathy bearing in mind that the

complainants were recently bereaved widows who would have been trying to come to terms with their husbands' deaths. Accordingly, in view of the dilatory manner in which the Trust dealt with Mr F and Mrs B's complaints, **I uphold** these aspects of both their complaints in their entirety.

81. I appreciate that the Trust has recognised its shortcomings in these cases and has stated that it is continuing to work to ensure that investigations into concerns and response letters improve, whilst also capturing organisational learning in line with "Putting Things Right". However I now need to see evidence that these measures are having the desired effect, particularly in light of other complaints involving complaint handling which I have reported upon previously.

82. In view of the issues which this report has highlighted and bearing in mind previous concerns about the Trust's performance which I have reported upon previously, I consider it appropriate to share my report with the relevant department of the Welsh Government and Healthcare Inspectorate Wales. This will give them the opportunity to consider whether any further action needs to be taken to address the shortcomings identified.

Recommendations

83. In view of the failings identified in this report I recommend:

A. Within 1 month, the Trust provides Mrs B and her family and Mr F and his family with fulsome apologies for the failings identified in this report and writes to them, providing a full explanation of the actions they have taken to address the concerns I have highlighted.

B. Within 1 month, the Trust should pay Mrs B and Mrs S £2000 each for the distress and worry that would have been caused as a result of the protracted and inadequate manner in which the Trust dealt with their concerns. The Trust should also reimburse any reasonable costs incurred by Mrs B as a result of the solicitor's involvement in pursuing her concerns with the Trust.

C. Upon receipt of this report, the Trust should amend its "Standard Operating Procedure for incident logging and activating an emergency response" to specifically stipulate the need to ensure that the nearest resource is deployed from any divisional or operational area.

D. The Trust should also immediately ensure that the procedure details the action to be taken if resources are not available to be deployed. It should detail at what stage the supervisory officer is alerted, and what actions the supervisory officer should take to ensure all available options for response are investigated. This should also include an option for looking outside the Trust's operational borders if necessary.

E. Within 6 months, the Trust should look to introduce robust systems and checks to minimise the number and impact of human errors. In doing this, the Trust should investigate the feasibility of automating the RESG function.

F. Within 3 months, given the inaccuracies identified in the investigation report, the incidents concerned should be re-investigated or fully reviewed so that a definitive unambiguous report is provided to Mrs B and Mrs S.

G. The Trust undertakes an audit within six months into the allocation of resources across division boundaries to ensure that the changes it has implemented are working effectively. I expect the Trust to provide me with a copy of this audit when complete.

H. Within 6 months, the Trust ensures that all policies and procedures which were relevant at the time of these incidents are reviewed in light of this investigation to ensure that lessons learned are incorporated. This is particularly important in light of the reconfiguration measures which the Trust has implemented.

I. If it has not done so already, that the Trust audits the effectiveness of the escalation arrangements introduced in February 2011 as soon as possible.

J. Given that these cases are two of a series of cases whereby the primary underlying causes of delays in responding to calls appear to be resource availability, a whole service review for each region of funding resources is undertaken, ideally, in conjunction with the Welsh Government.

K. The Trust should formally review the effectiveness of the changes which were set out in paragraph 52 and conduct a survey of those people whose concerns it investigates in order to establish their level of satisfaction. I expect the Trust to provide me with the outcome of the review and any survey undertaken within six months.

L. The Trust provides me with a copy of its monthly report on complaint management performance to the Management Board. This information should also include information on the monitoring of quality in relation to complaint responses and be accompanied by any other submissions relevant to complaint handling. I expect to be provided with this information until 1 April 2013.

84. I am pleased to note that in commenting on the draft of this report the Welsh Ambulance Services NHS Trust has agreed to implement these recommendations.

Peter Tyndall
Ombudsman 7 March 2012