GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

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Mr John Gittins
Senior Coroner for North Wales (East and Central)
Coroner's Office, County Hall
Wynnstay Road
Ruthin
Denbighshire
LL15 1YN

Ein cyf / Our ref: GD/CB/3405/777
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Dyddiad / Date: 25th April 2017

Dear Mr Gittins,

RE: Emergency Care Access Performance

I write in response to the Regulation 28 of 14th March 2017 highlighting performance issues relating to Ambulance handover delays.

Matters of concern:

1. *That there were significant delays in the admission of Ms Evans to hospital and the medical treatment was consequently not commenced in a timely manner.*

2. *That despite changes having been made previously the current practices in place for the handover of patients at an Emergency Department far too often results in wholly unacceptable delays with patients being kept waiting for long periods in ambulances and ambulances resources consequently being unavailable for allocation to other calls. Whilst this is a multi-factorial problem, improvements must be made so as to reduce the risk of future deaths.*

I will detail below the improvements we have made or are in the process of making to improve waiting times in our ED but in terms of performance we have made improvements in what is our busiest time of year. Comparing January to March 2017 to the same period last year shows improvements in every indicator (e.g. 4 hours, twelve hours, and response times for Red ambulance calls. For ambulance handovers taking more than an hour, the number has improved substantially - a reduction of 786 instances which is a 23% improvement.

Unscheduled Care Plan
The latest version of the Unscheduled Care Plan included within our 2017/8 Operational Plan submission is attached. The plan covers all areas of the Unscheduled Care System and has been developed to ensure improvement in emergency access, as measured by the 4 hour and 12 hour target.

The plan addresses the main causes of Unscheduled Care pressure through reducing admissions (demand), reducing DTOCs and length of stay (supply) and addressing flow

at the front of hospitals to protect minors from long waits. It also includes reducing ambulance handover delays.

The overall plan is supported by a set of metrics which will demonstrate improvement on the underlying position which will lead to improved 15minute ambulance handover.

The work in these areas is showing improvement in reducing admissions and DTOC. There is clearly a great deal more to do, but I can assure you that these improvements are a key priority for the Health Board.

Engagement at an Executive Level
I have taken steps to strengthen the level of visible Executive input to the management of escalation out-of-hours and nominated Morag Olsen as our lead Exec to link with the Welsh Government Delivery Unit to explore areas where further improvements.

The use of information within Unscheduled Care decision making
There is extensive use of predictive tools and modeling within our overall approach to Unscheduled Care. The overall capacity and demand model developed by the planning section has informed the scale of improvement required to achieve a bed occupancy level of 85%. The metrics within the overall plan are calibrated at a level which has been calculated to enable the 4 hour target to be achieved and improve ambulance handover.

On a daily and weekly operational level, there is extensive use of demand and flow information in Unscheduled Care decision making. In particular, predictive demand analysis is used to drive resourcing decisions within each week. The following is a sample, but not a complete list of the information routinely used:

- Daily and weekly 4 hour/12 hour performance
- Daily and weekly activity trends
- Ad –hoc trends for holidays and peak periods
- Time spent in ED
- Heat maps of arrivals and ED occupancy
- Frequent attenders
- Review of ambulance performance against quality standards

The majority of the above is held on the main information system (IRIS), which is in extracted to support weekly decision making on Unscheduled care.

The following are examples of operational decisions which have been influenced by the above information specifically in relation to improving performanceat YGC and YMH:

1. **Medical Rotas**; WMH has increased Emergency Department Consultant presence overnight on the shop floor. YGC has a second ED Consultant on the shop floor until 10 pm. These rota changes are set against a challenging workforce recruitment and sustainability backdrop

2. **Nursing Rotas**; Since YGC opened the new Emergency Department in June 2014 the nursing staff have been significantly increased to ensure staffing meets demand especially in the evening, weekend and over night. WMH have increased twilight shifts to meet evening demand. Both WMH and YGC Emergency Departments have increased their Health Care Support Workers capacity and increased Physician Assistant roles to meet demand and improve timeliness.

3. **GP Out of Hours; both YGC and WMH** have worked to create an integrated platform to deliver services that support patients moving from ED to GP Out of Hours to reduce demand on the minors ED streams. This redirection continues to evolve with further work supporting satellite GP Out of Hours facilities co-located with Minor Injury units for example at Llandudno Hospital.

4. **Emergency Departments and WAST**; WAST locality Leads are engaged on both sites supporting non-conveyance options for EMS activity. This includes the formal Minor Injuries Units Stand Operating Procedure to redirect suitable clinical cases to MIUs.

5. **Alternative Healthcare Professional provision**; Both Emergency departments have responded to the Musculo-skeletal demand attending the departments by appointing Extended Scope Physiotherapists. YGC has also employed through seasonal plan funding GP support to ED to stream suitable patients away from the main emergency department pathways.

6. **Emergency department Capacity**; both EDs have reviewed the demand profiles and commissioned additional clinical capacity. WMH have opened two additional examination rooms for minor attendances to protect the minors stream. YGC have converted one minors trolley space to a four chair ambulatory area to increase minors stream capacity.

7. **Operational site management**; WMH have employed twilight site managers to support evening bed pressures. All three acute hospitals in the Health Board are moving towards a new out of hours site management clinical rota to support flow and response to escalation. This includes additional night sisters to support core site management. WMH also provide a Senior Manager of the day who works till 8pm to support decompression of acute problems affecting flow.

8. **Ambulance Conveyances**; YGC has engaged with Public Health Wales to understand the higher 999 demand experienced at YGC. This work is informing a number of plans including the development of a minor injuries unit within the north Denbighshire project at the Royal Alexandra hospital site.

9. **Frequent service Users**; data on both Emergency Department attendances and acute admission into medicine from frequent service users (more than 4 attendances / admissions in a rolling 12 months) has resulted in resources being

allocated to clinical Psychology to lead a multi-disciplinary response to the most frequent service users. This results in a multi-agency action plan. Benefits are felt within the acute hospitals, WAEDT and north Wales police.

10. **Senior Manager Bronze and Silver on call arrangements**; a formal review of Bronze and Silver on call manager rotas in recognition of the demands of unscheduled care pressures has informed the development of a new model. This includes

    a. Dedicated Silver on call for 24 hours
    b. Development of complimentary clinical rota to support sites de-escalation and risk management
    c. Strengthened site management resilience with additional night Sisters to support flow

11. **Evening / Overnight Capacity**; all sites have developed surge capacity options to meet periods of peak demand during the evening and overnight. This utilizes physical capacity that would not normally be staffed overnight, therefore increasing capacity and utilization of core clinical estate.

12. **Development of Medical Fit to Discharge data**; WMH and YGC have used data extracted specifically from WPAS and local data collection to identify patients fit for discharge but delayed due to factors outside of the acute hospital control. This has resulted in the development of new escalation pathways and teams, such as the Step Down Team at YGC to secure alternative discharge / transfers options for MFDs contributing to bed blockages and bed turn over.

13. **Patient Navigators at YGC Emergency Department**; learning from Salford Hospital has been implemented at YGC through using patient navigators to help redirect and expedite patient care of walk in attenders.

14. **Roll out of treatment escalation plans (TEP's)**; a completed pilot of treatment escalation plans for palliative/terminally ill patients in Nursing and residential homes has resulted in a 50% reduction to referral to the emergency department and is now being rolled out across BCU.

15. **Regular Review of Patient delayed in Ambulances;** to help prevent recurrence of the issues you raised relating to Rebecca Evans a system of regular checks, diagnostics and treatment, has been put in place to ensure patients experience the minimum delay.

16. **Ambulance Red Release;** in partnership with the Welsh Ambulance Trust (WAST) they co-ordinate with emergency department to ensure that ambulances can be released to respond to potentially life threatening calls through immediate offload into any available in ED.

The above are just examples, but are offered to illustrate the level of daily and weekly scrutiny of demand and Unscheduled Care pressures.

The Health Board fully accepts that its current unscheduled care performance, though demonstrating an improvement on this period last year, must improve both in terms of giving our patients and our staff the experience they should be receiving. I expect the move to a position of improvement rather than deterioration to be an important turning point which acts as a springboard to build on. I hope this letter offers the required level of assurance that we are focused on taking action to address the performance issues raised in your letter. Please let me know if you would like further detail on any of the areas within my response.

Yours sincerely

Gary Doherty
Prif Weithredwr
Chief Executive

Enc

Appendix 1

8.3. Urgent and Emergency Care (Unscheduled Care)

The unscheduled care plan describes the services that will be available to residents of North Wales when they have an unplanned or urgent health need. These patients and/or their Carer's are often in urgent need or distress and it essential that the services provided are of a high quality and available in a timely manner.

The waiting time at hospital, measured by the 4 hour wait and 12 hour wait as well as ambulance handover delays, are indicators of the level of pressure on services and the ability of the system to cope with demand. For individual patients, delays at hospital can cause distress, impact upon quality of care and may in some cases affect the outcome from treatment or length of admission to hospital. Delays at hospital particularly drive the urgency for improvement in the unscheduled care system and improvement and will be measured by the 4 hour and 12 hour target performance.

The Health Board, along with other parts of the NHS, has faced significant challenges in providing a timely response to unscheduled care needs. This has resulted in delays in providing treatment and an inability to routinely provide the quality of care that residents of North Wales should rightly expect. The Welsh Government targets for the % of patients waiting less 4 hours and 12 hours have not been met on a regular basis.

The solutions to the above problems are based on changing the Unscheduled Care Model to ensure that more health service needs can be met outside the hospitals. Through providing treatment alternatives to hospital admission and ensuring that patients who do require admission for specialist treatment can be safely discharged from hospital as soon as possible, we can ensure that hospital capacity is available for those in most need.

Therefore, whilst pressures upon unscheduled care often become visible in Emergency Departments, the solutions lie in all areas of the health and social care system.

Our Changing Model of Unscheduled care

Our model of care and planned improvements have been derived from a combination of national guidance, Health Board Strategy (Care Closer to Home) and in response to locally identified issues being addressed with partners across North Wales. BCU is also working closely with other Health Boards across Wales as part of the all Wales Unscheduled Care Board and Emergency Ambulance

Services Collaborative Commissioning programme. The key features of our plan to deliver this model of Care are:

- Development of Community Resource Teams to provide alternatives to hospital care
- Development of alternative pathways and treatments in the community, Single Point of Contact
- Effective processes for redirecting appropriate patients to community services and pathway
- Daily review of patients within Hospital
- Early discharge planning within hospitals (co-ordinated with Community, social services and Independent sector) and Expected Date of Discharge for all patients
- Evenings and weekend services to support patients within their own homes
- Further develop skills of HCSW to enhance support to inpatient wards

Our model and local plan aligns with the all Wales framework which utilises a patient-centred unscheduled health and care patient pathway. The following 10 step model is being utilised to clearly describe the Programme's expectations for delivery of these services to citizens who access them in Wales.

Step 0 - Help to keep me independent
Step 1 – Help me choose
Step 2 – Answer my call
Step 3 – Come to see me
Step 4 – Give me treatment
Step 5 – Take me to hospital
Step 6 – Assess me
Step 7 – Provide me with my diagnosis
Step 8 – Give me treatment
Step 9 – Discharge me from hospital
Step 10 – Ensure my continuing care is effective

The ambulance service plays an important role in all stages of the patient pathway, and will be included in our programmes of work to address unscheduled care pressures.

Key Deliverables in 2017/18

Maintaining Patient Independence and Avoiding Hospital Admissions
We aim to achieve an overall reduction in admissions of 5% across the health board in 2017/18 through the following targeted actions.

We will ensure that robust systems are in place to coordinate admission avoidance activities between hospitals, community services and partner organisations including WAST Local Authorities and voluntary organisations. Our actions will include the following –

We will increase the operating hours of our Community Resource Teams in partnership with Local Authorities. We aim to increase hours by at least 2 hours per day in the evenings when this service is often most in demand
Working with WAST we will:

- Ensure effective use of Minor Injury Units to support care closer to home and reduce transfers to Acute sites. The protocol for transfer to MIU will be revised in Q1 and metrics for improvements will be developed based on the revised protocol.
- Fully establish a clinical desk with WAST to assess and direct patients to alternative services and increase calls handled by the clinical desk.
- Fully implement the Frequent Caller Initiative with WAST to reduce transfer to acute sites by re-directing people to alternative services. This project is being revised, with new leadership arrangements and performance metrics will be developed in Q1
- Establish a collaborative hospital/community/WAST system to review patients referred for admission and identify appropriate alternatives.

Taken together the above actions are expected to reduce admissions by 2 patients per day per Area

We will ensure our pathways for IV, falls and catheter management work effectively to build on progress made in 2016/17 and expect to reduce admissions by 1 per day per Area through these actions.

We will implement pre-crises frailty assessment to enable more patients to be treated without admission to acute hospital. Specifically we will :-

- Establish clear pathways to support Care Homes to avoid admission/expedite discharge to reduce admission from Care Homes.
- Develop and Implement frailty assessment services to maintain independence and avoid admission.
- Recruit staff and roll out our falls pathway to support access for GPs, Social Services and the Emergency Department

Through the combined impact of the admission avoidance work we aim to both prevent an increase in admissions (as indicated by the population demographics) and achieve a further reduction in admissions of 5% by the end of the year.

Improving Acute Hospital Processes

We aim to increase the percentage of patients who spend less than 4 hours in A&E from 81% to 86% by March 2018 and reduce the number of patients who spend longer than 12hours in A&E from 600 to 350

We will implement consistent pathways and criteria for streaming through Emergency Departments. There will be increased separation of minor injuries from major injuries/Illness to ensure that, wherever possible, patients can be treated without delay. Through this we will improve the number of minor cases treated within 4 hours to 95 by Q4%

We will place a specific focus on Ambulatory Emergency Care and an increase in the number of patients supported in this way. This will contribute to the overall 5% admissions reductions target.

We will embed the elements of the SAFER bundle across the 3 sites and will improve discharge planning to deliver an Increase in estimated date of discharge (EDD) planning. We will achieve 70% of patients having an EDD across all sites. We will develop baseline metrics and targets for SAFER measures in Q1.

Reducing Hospital Average length of Stay (AVLOS) and Delayed Transfers of Care (DToC)

In 2017/18, we will reduce DToC by 10%

We will undertake a number of actions to reduce average length of stay and specifically to reduce number of Delayed Transfer of Care (DToC) patients, specifically:-

We will improve admission/assessment processes through implementation service improvements including discharge to assess and rehab/re-enablement models of care. Through these improvements in partnership working and discharge planning we will aim to :

- reduce the level of our delayed transfers of care rate per 10,000 population for mental health from 2.5 to 2.3 and for non mental health from 180 to 176.
- Deliver reduction in community hospital length of stay of 10% through improvements such as implementation of "discharge passports" and escalation processes to support early discharge
- Review of admission criteria for "Step up, step down" beds, linked with discharge to assess project which will commence in Q1.
- Deliver strengthened Community Resilience through the full implementation of "proof of concept" projects from 2016/17 in collaboration with the third sector.

These actions will be enhanced by the outcomes from the 5 Day workshops on DTOC developed in 2016/17. Further actions, aimed at reducing risk aversion and maintaining independence will be established into 2017/18.

By avoiding unnecessary admissions, improving our performance in A&E and reducing length of stay and delayed transfers we will assist WAST to maintain delivery of the ambulance response times.

We will also reduce delays to handover of patients between the ambulance and hospital, delivering 65% of emergency ambulance response calls arriving within 8 minutes by March 2018 and reducing the number of ambulance handovers over one hour from 600 to 250 by March 2018.

Improving quality of care for unscheduled care patients

We will deliver improvements in the following clinical areas –

We will continue to improve performance on Acute Stroke care taking note of the learning from the Peer review when this is produced. We will work towards delivery of the revised SSNAP standards, tracking improvement through the year, including the 1 hour time to CT scanning for all patients.

We will implement changes to improve outcomes for patients suffering from a fractured neck of femur. We will use the 30day mortality indicator as an outcome indicator to assess this.

We will ensure patients suffering from sepsis are recognised and treated within one hour in accordance with the Sepsis 6 bundle, improving compliance across all sites to over 75% by year end.

Specific actions to support the delivery of these improvements are set out in Appendix 4. Performance indicators are set out within supporting technical appendices.

Appendix 2

Emergency Department 1 hour ambulance wait review

Patient Identification

Unit Number or ED Number_____ Age (years) ___ Gender: Male__ Female__

Arrival and Triage

Time ambulance arrived at ED __/__/_____ Time of Triage by ED Nurse __:__

Did the patient triage take place on board the ambulance Yes__ No__Triage Category(colour): _____

Was there regular clinician/Nurse Review whilst on Ambulance?

Clinical Management by ED staff whilst delayed in ambulance (ED)

NEWS Score:

15 minutes___ 30 minutes___45 minutes___60 minutes___90 minutes___

120 minutes___150 minutes___180 minutes___210 minutes___240 minutes___

270 minutes___300 minutes___ Other_____

Do you think the patient deteriorated whilst awaiting transfer into ED? Yes__ No__

If Yes please give reasons for this opinion.

If the patient deteriorated which of the following took place whilst in the ambulance:

The triage nurse was informed Yes__ No__ Not Recorded__

A Doctor assessed the patient on the ambulance Yes__ No__ Not Recorded__

The situation was escalated and the patient was transferred into the department Yes__ No__

No action was taken (please comment below)

Evidence of Risk Assessment in the ambulance

NEWS__ MAELOR__ PAIN SCORE__ FRAILTY__ MUST__

During the delay did any of the following take place?

Was patient kept informed of delay?- Yes__ No__ Not recorded__

Were relatives/carers/Homes kept informed of delay?- Yes__ No__ Not Recorded__

Was patient kept comfortable?- Diet&fluids: Yes__ No__ NBM__ Not Recorded__

-Toilet needs: Yes__ No__ N/A-independent__ Not Recorded__

-Pressure area care: Yes__ No__ N/A-independent__ Not Recorded__

The patient received their regular medication? Yes__ No__ Not Recorded__

The patient required additional analgaesia Yes__ No__ Not Recorded__

The patient had investigations carried out (blood tests, ECG, Xray) Yes__ No__ Not Recorded__

The patient was administered emergency Treatment that would normally be given in hospital (e.g.IV antiniotics) Yes__ No__ Not Recorded__

Where was the eventual destination within ED? (place a cross in one box only)

Resuscitation room☐ Majors☐ Minors ☐ Waiting Room ☐ Other ☐

NEWS Score at Triage _____ Length of Stay in ED _ _hr : _ _mins

<u>Overall Outcomes</u>

<u>Grade</u>

0__ No suboptimal care

1__ Suboptimal care, but different management would have made no difference to outcome

2__ Suboptimal care – and different care **MIGHT** have made a difference (possible avoidable harm)

Additional comments/Improvement actions

Signature of Reviewer(s): _____ Date: __ /__ / ____

Appendix 3

Patient Identifier	Cas Card Number	Incident ID	Outcome Of Att.	Vehicle At Hosp	Hand Over Time	Wait in Minutes
		N1960		25/04/2017 02:07	25/04/2017 03:19	72
	CA1-000100		Admitted	24/04/2017 21:24	24/04/2017 23:01	97
				24/04/2017 21:14	24/04/2017 22:42	88
				24/04/2017 21:11	24/04/2017 22:49	98
				24/04/2017 13:38	24/04/2017 15:10	92
	CA1-000100		Not-Admitted	24/04/2017 08:58	24/04/2017 10:07	69
				24/04/2017 08:44	24/04/2017 09:52	68
	CA1-000100		Admitted	24/04/2017 07:53	24/04/2017 09:19	86
	CA1-000100		Not-Admitted	24/04/2017 07:29	24/04/2017 09:12	103
	CA1-000100		Not-Admitted	24/04/2017 04:08	24/04/2017 05:25	77
	CA1-000100		Admitted	24/04/2017 03:59	24/04/2017 05:15	76
	CA1-000100		Not-Admitted	23/04/2017 23:32	24/04/2017 01:15	103
	CA1-000100		Not-Admitted	23/04/2017 23:32	24/04/2017 01:25	113
	CA1-000100		Admitted	23/04/2017 21:53	24/04/2017 00:30	157
	CA1-000100		Admitted	23/04/2017 21:24	23/04/2017 23:44	140
	CA1-000100		Admitted	23/04/2017 21:19	23/04/2017 22:35	76
	CA1-000100		Not-Admitted	23/04/2017 21:13	23/04/2017 22:55	102
	CA1-000100		Not-Admitted	23/04/2017 20:42	23/04/2017 22:43	121

Appendix 5

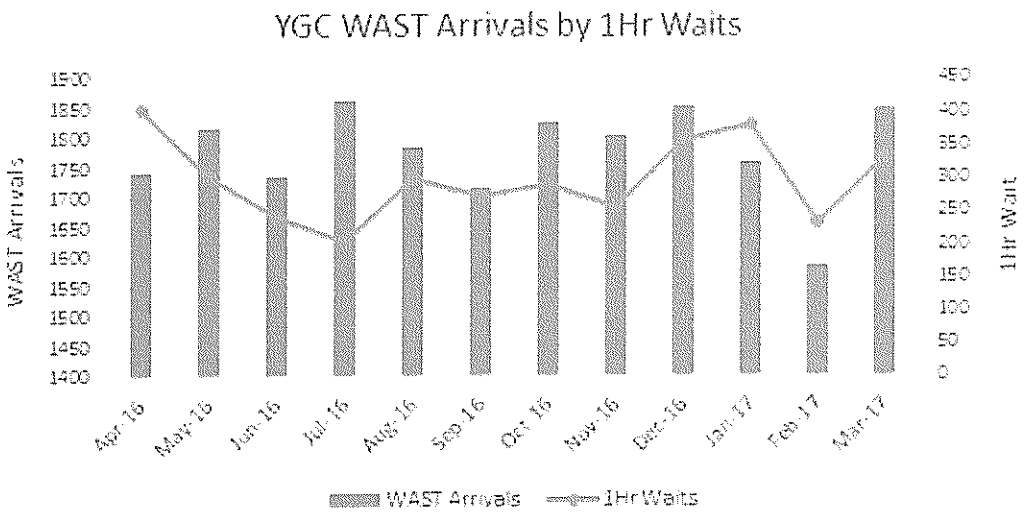
Betsi Cadwaladr University Health Board
Primary Care and Specialist Medicine Clinical Programme Group - Central Area
Safe Management of Patients Awaiting Transfer into the Emergency Department

Date: .... Shift Lead 07.30 to 20.30: .... Shift Lead 20.00 - 08.00: ....

Time of Arrival	Ambulance	Patient Identifier	Observations 1st set	Diagnostics		Discussion with nurse / clinician on ambulance	Time offloaded to ED staff from WAST		Fluids, Food, Pressure area assessment	Any evidence of Harm? Patient outcome / risk after intervention	Next Action	
	Crew	Name	RR	BM			> 60				NFA	
			O2 Sats	ECG			> 120				ED SAGE	
		Complaint	O2 Y / N	ECG Check			> 180				RCA	
	Call Sign		BP	X-Ray			Offload to:				YGC QSG	
			P	NEWS								
			T									
	Crew	Name	RR	BM			> 60				NFA	
			O2 Sats	ECG			> 120				ED SAGE	
		Complaint	O2 Y / N	ECG Check			> 180				RCA	
	Call Sign		BP	X-Ray			Offload to:				YGC QSG	
			P	NEWS								
			T									
	Crew	Name	RR	BM			> 60				NFA	
			O2 Sats	ECG			> 120				ED SAGE	
		Complaint	O2 Y / N	ECG Check			> 180				RCA	
	Call Sign		BP	X-Ray			Offload to:				YGC QSG	
			P	NEWS								
			T									
	Crew	Name	RR	BM			> 60				NFA	

			O2 Sats	ECG			> 120				ED SAGE	
		Complaint	O2 Y / N	ECG Check			> 180				RCA	
	Call Sign		BP	X-Ray			Offload to:				YGC QSG	
			P	NEWS								
			T									
	Crew	Name	RR	BM			> 60				NFA	
			O2 Sats	ECG			> 120				ED SAGE	
		Complaint	O2 Y / N	ECG Check			> 180				RCA	
	Call Sign		BP	X-Ray			Offload to:				YGC QSG	
			P	NEWS								
			T									

Appendix 6


YGC WAST Arrivals by 1Hr Waits
WAST Arrivals
1Hr Wait
1900
1850
1800
1750
1700
1650
1600
1550
1500
1450
1400
450
400
350
300
250
200
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Apr-16
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Dec-16
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WAST Arrivals
1Hr Waits