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

Block 5, Carlton Court
St Asaph Business Park
St Asaph
Denbighshire
LL17 0JG

Mr John Gittins
HM Senior Coroner for North Wales (East & Central)
County Hall
Wynnstay Road
Ruthin
LL15 1YN

Ein cyf / Our ref: GD/
Eich cyf / Your ref:
☎: 01745 448788 ext 6364
Gofynnwch am / Ask for: [redacted]
E-bost / Email: [redacted]
Dyddiad / Date: 31st July 2017

Dear Mr Gittins

Re: Report for the prevention of future deaths
Inquest of Lilly Baxandall

This is a joint response to the Report pursuant to Regulation 28 of the Coroners (Investigations) Regulations 2013, dated 17th May 2017 for Lilly Baxandall, which was issued to Betsi Cadwaladr University Health Board (BCUHB), Denbighshire County Council, Conwy County Council, Wrexham County Council, Flintshire County Council, Welsh Ambulance Services NHS Trust (WAST) and the National Assembly for Wales. This response has been prepared collaboratively between the multi-agencies aforementioned.

The letter outlines the actions being taken by BCUHB, WAST and the four Local Authorities in response to the matters of concern you outlined in the recent Regulation 28 notification for Lilly Baxandall, namely; ambulance delays, ambulance handover delays, admission to ED, bed blocking, availability of resources, delayed transfers of care and patient flow. All agencies are also aware of two additional Regulation 28 notifications that have been issued relating to patient flow issues to BCUHB and WAST for Daphne Edith Williams (25th May 2017) and to BCUHB for Catherine Haf Roberts (7th July 2017) to which the actions outlined within this letter also apply, but for which separate formal responses will be submitted from the relevant organisation(s).

The local authorities have not been party to any involvement regarding the previous reports issued and are therefore unable to comment on the content of the responses previously sent or indeed the actions referred to.

(Please note, the local authorities will comment later in this response on those areas that may be of assistance to support cases such as these.)

In reviewing the action plans already submitted in response to the 7 previous Regulation 28 reports that are referenced in the Regulation 28 for Lilly Baxandall, BCUHB notes that all previous actions have been implemented or are work in progress, with the exception of the establishment of a North Wales Bed Bureau. After consideration of this, it was not deemed a feasible way of improving access for acute hospital admissions across North Wales due to geography and enabling the admission of emergency patients to as local a hospital as possible, as often as possible.

In response to the matters of concern raised in the Regulation 28s for Lilly Baxandall, BCUHB and WAST have structured their response along key elements of the patient pathway, these being:

- Avoidance of Ambulance Conveyance / Emergency Department (ED) attendance / Hospital Admission
- Improvement in Handover Times of patients conveyed to EDs by Ambulance
- Improvement in ED patient flow and timely assessment of patients
- Improvement in internal hospital flow to ensure more rapid admission of patients from ED who require this
- Improvement in the discharge/transfer of care of patients at the end of their acute hospital stay.

Our response reflects and compliments the actions outlined in the BCUHB 2017/18 Unscheduled Care plan. BCUHB also recently held 3 Unscheduled Care Summits with clinicians and colleagues from partner agencies to discuss and agree specific focussed actions to improve the provision of unscheduled care services. In December 2016 the cross sector chief executives issued a directive for a detailed analysis of the care sector pressures resulting in an intensive 5 day work programme led by Director's in both health and the local authorities. This work resulted in a comprehensive action plan which is in place to address some of the blockages in the system that contribute to delayed discharge.

In addition through the spring and summer 2017, BCUHB, WAST and key partners have held a number of events with frontline staff to examine, explore and find solutions to the current service pressures, these were called Innovation Unblocked. Through these engagement events staff have identified very practical solutions of how systems can be improved to support flow. These events have also identified key pathways that need to be developed to avoid hospital admission or to improve patient access to the right services avoiding unnecessary attendance to the Emergency Department.

To compliment this work, the Delivery Unit (DU), is also supporting BCUHB to implement improved risk escalation systems in managing unscheduled care demand. This is initially focussed on acute hospital sites to increase patient safety. The DU is initially focusing on providing this support at Ysbyty Glan Clwyd.

1. Avoidance of Ambulance Conveyance / ED Attendance/Hospital Admission

In October 2015 WAST introduced a new clinical response model to implement new ways in which callers to 999 are assessed. This sought to ensure that patients and users of the service received the most appropriate care and a response to suit their individual needs. The changes made clearly identify those patients who require an immediate life-saving response and these patients receive the highest priority response in the fastest possible time.

All other patients receive a bespoke clinical response based on their condition, rather than a response based solely on a time standard. These changes sought to improve the patient's care, outcome and experience, as well as improve patient flow into hospitals. WAST has been working with BCUHB to develop new services and alternative care pathways. Latterly, this has included holding a series of joint, clinically focused workshops across North Wales to review, identify and implement new emergency care pathways that WAST can access, some of which have been agreed in other parts of Wales. The final workshop took place on 7th July following which a number of key innovations, work streams and care pathways have been prioritised. A clear priority identified will include having a focus on improving the management and care of patients who fall at home (referred to separately in more detail later in this section of the response). The detail of the Unblocking Innovation events is attached as Appendix 1.

In addition, and in line with the BCUHB Unscheduled Care Plan 2017/18, WAST has been focusing on:

- Increasing Conveyances to Minor Injury Units to reduce demand on EDs
- Increasing the effectiveness of the WAST Clinical Support Desk
- Improving support for frequent callers to WAST to reduce ambulance conveyances to hospital.
- Developing the provision of alternative care pathways
- Enhancing WAST Clinical Leadership

1.1 Minor Injury Units (MIU)

The Head of Operations for WAST has been leading work with BCUHB to increase the access to and use of MIUs by WAST, supported by a joint steering group which aims to:

- Ensure a nurse led MIU service is available across all of North Wales
- Improve patient access
- Review and extend the admission criteria
- Extend opening times, particularly over the busy periods
- Launch an "App" to ensure that the opening times of the MIU are publicised for WAST responders and the public.

The next steering group meeting is planned for September 2017 when work to date will be reviewed to ensure progress in all areas.

1.2. Increased effectiveness of the Clinical Support Desk

As the result of a service improvement initiative, WAST has invested in a Clinical Support Desk within the Clinical Contact Centre (CCC). This means that a clinician (nurse / paramedic) is available to clinically assess, through telephone triage, the needs of patients and advise on appropriate alternative care pathways or conveyance. This initiative has proved highly successful, resulting in an average of 2,500 calls per month having a non-ambulance outcome, thereby substantially reducing ambulance conveyances to hospital. Following the success of this initiative, WAST has successfully presented a business case to the Ambulance Services Commissioner and Welsh

Government and has received funding from Welsh Government to increase the clinicians employed in the clinical support desk for up to 30 whole time equivalents. Some clinicians are now located on the North Wales Clinical Support Desk in the CCC.

1.3. Frequent Caller Initiative
A number of patients repeatedly access the 999 emergency ambulance service where alternative care may be more appropriate for them. These individuals often have complex health and / or social needs and may have disengaged from appropriate care services.

Across Wales, WAST has already worked successfully with other Health Boards to provide appropriate alternative care for frequent callers within communities without the need for a conveyance to ED. A joint work stream between WAST and BCUHB has now been established to introduce a similar service in North Wales.

1.4. Provision of Alternative Care Pathways

WAST and BCUHB are working together to proactively manage more patients within the community setting, reducing unnecessary conveyance of patients to hospital. During quarter (April, May, June 2017) the Ambulance Quality Indicators confirm that a conveyance rate of 64-65% of patients to hospital across BCU. This is the lowest conveyance rate across all Health Boards in Wales. Examples of improvement work to achieve include the management of patients who fall at home, patients with a mental health need and the implementation of the Paramedic Pathfinder:

- **Falls:** The Clinical Support Desk is working collaboratively with Wrexham Fire Service and North Wales Police to provide care and assistance to non-injury fallers within the community setting. The fire service will respond and assist the patient and while doing so, undertake preventative work including surveying the house for any immediate fall hazard risks, security and fire prevention.

  As a result of the joint clinical workshops referred to earlier in this response, WAST and BCUHB will implement a North Wales wide falls pathway by the end of October 2017.

  WAST has established a falls strategic improvement group to focus on improving the assessment and response to patients who have fallen across the 5 step model to inform a 'once for wales' approach to falls.

- **Mental Health:** As a result of both service user and staff feedback, WAST has developed a Mental Health Improvement Plan outlining 6 priority areas for those with mental health needs. This includes supporting WAST staff through the use of an assessment of the patient's mental health illness or mental distress. This will be based on using up to date evidence based education and training and developing risk assessment tools for frontline clinicians to support their decision making.

In addition, a key priority is to develop alternative care pathways for patients experiencing mental health distress to ensure that wherever appropriate conveyance to an ED is avoided. In other parts of NHS Wales, WAST has successfully developed joint pathways with mental health crisis teams. This learning has been shared with BCUHB and informs joint work underway to develop and implement this care pathway within North Wales. This approach will need to be discussed further with the local authorities.

- **Paramedic Pathfinder**
  The demand for emergency ambulance attendance is increasing year on year. Many patients can be treated through safe alternatives to transportation to an ED. Paramedic Pathfinder has been designed to support ambulance clinicians in assessing patients in the pre-hospital environment. It does this by enabling the exclusion of serious discriminators before any consideration is given to an alternative pathway of care other than conveyance to an ED. WAST is currently undertaking a trial of the Manchester Triage System (decision support tool) in the Abertawe Bro Morgannwg University Health Board area. This will be evaluated for potential future roll out across Wales to inform alternative pathway development.

1.5. Enhancement of WAST Clinical Leadership

A key priority area for WAST, identified in the service's Integrated Medium Term Plan, is the development of its paramedic workforce. Following the changes to the WAST clinical response model outlined earlier, the service is becoming a more clinically focussed service, requiring the complimentary development of a clinical leadership structure to support paramedics to work their full scope of practice. This will in turn enable them to identify more patients suitable for alternative care pathways to conveyance to ED. This work has already commenced with the appointment of a new Assistant Director of Paramedicine.

Complimenting this work by WAST are a range of BUCHB initiatives to reduce ambulance conveyance//ED attendance. These include:

- Introducing Treatment Escalation Plans (TEPS) to reduce the number of people brought to EDs by ambulance from nursing/residential homes. These plans outline alternative care pathways and treatment options for individuals to manage them safely in their residences.
- Developing enhanced multi-disciplinary community resource teams (CRT) to provide more care for individuals in their own homes. The CRTs are in varying degrees of development across North Wales and whilst have the potential to better manage care closer at home need to build on the range of successful intermediate care provision already delivered in the 6 local authorities.
- Developing a range of alternative care pathways including for catheter management, palliative/end of life care at home or in a nursing/residential home and work with WAST to develop a number of alternative care pathways including one for falls (see below). One authority already provides a successful palliative care service on behalf

of the health service and the local authorities are keen to enhance services they could be commissioned to provide.

2. **Improvement in Handover Times of patients conveyed to EDs by Ambulance**

BCUHB has developed an escalation protocol to ensure a consistent approach to the safe management of patients whose handover is delayed. This is to support the procedure to enable the immediate release of delayed ambulances to enable WAST to respond to life threatening or clinically urgent 999 calls in the community (the immediate release system).

With WAST, BCUHB has also developed a Local Escalation Action Plan (LEAP) which clearly outlines the escalation processes for WAST and BCUHB staff to apply to enable ambulance crews to hand over patients to ED with minimum delay. As part of the 'LEAP' protocol, WAST provides a Hospital Ambulance Liaison Officer (HALO) or a Duty Operational Manager (DOM) at hospitals when ambulances are delayed. These are usually WAST Clinical Team Leaders whose role is to supervise crews experiencing handover delays and liaise directly with ED.

The WAST Clinical Contact Centre (CCC) uses a demand management plan to ensure good communications with hospital sites about WAST community activity and demand, particularly during times of handover delays. Delays are escalated to a WAST senior manager who liaises with senior BCUHB officers to agree how resources can be safely released to respond to WAST community activity.
WAST and BCUHB have together developed guidance for paramedics to identify patients well enough to be placed in the ED waiting room, rather than wait on an emergency ambulance.

For Ysbyty Glan Clwyd, patients who cannot be immediately accommodated into a clinically appropriate ED space will undergo a triage assessment by an ED nurse and a clinical medical review. Patients held in an ambulance for an hour or more will have a full 'harm' review to commence assessment/treatment and ensure their care outcome is not compromised. The recording of patients' vital signs including the National Early Warning Score (NEWS) is routinely recorded as part of these assessments and is integrated into the paramedics' patient record.

At Ysbyty Maelor Wrecsam, a holding area in ED is created whenever possible during the day to enable patients of low risk to be handed over without delay by WAST and brought into ED. At Ysbyty Glan Clwyd, options are being explored to establish a physical 'RATS' (Rapid Assessment & Treatment Service) area in ED to enable the rapid handover and assessment of patients.

3. **Work to Improve Assessment Times / Flow in ED**

BCUHB constantly reviews its clinical and operational processes to improve waiting and assessment times for patients and to admit patients in a timely manner to an inpatient

bed where this is required. BCUHB acknowledges there remains much work to do but examples of more recent improvements are outlined below.

3.1. Ysbyty Glan Clwyd

- A review of the use of the physical space within ED has created an open ambulatory chair centric area with 4 additional assessment/treatment spaces; the commissioning of 2 additional beds in the observation bedded area of the ED; the use of the co-located GP Out of Hours area during the day (Monday to Friday, 9am - 5pm) to provide 4 rooms for assessment / treatment; and the adoption of a flexible approach, in extenuating circumstances, to the use of all space within the ED during times of peak pressure.
- A further review of the physical layout of the ED is underway to identify space to create firstly an area to rapidly assess patients handed over by WAST (RATS) and secondly to better manage the 'minors' flow in ED to improve the waiting times and assessment of these patients.
- On-going recruitment of nursing and medical staff is a key focus. This has resulted in an increase in the funded nursing establishment in ED from 56 WTE to 94 WTE, and an increase in funded medical staff posts to double the posts from 4 to 8 full time Consultants and from 5 to 8 middle grade senior doctors. It will take time to attract and recruit substantive staff to all posts although recent recruitment campaigns for senior medical staff have met with success. It is anticipated that the Consultant and senior middle grade doctor posts will all be filled with substantive appointments by the end of 2017. Until this time, the service is employing locum medical staff to provide as much service cover and continuity of care as possible.
- The service is also working towards better matching senior medical staff working hours with times of peak patient demand. The aim is to have the Consultant late day shift extended from 18.00hrs to 22.00hrs and have a second Consultant working until 9pm Monday to Friday
- Work is also underway with the co-located GP Out of Hours service in the ED department to identify more suitable patients through the triage of self-presenting patients to ED for 'pull' into the GP Out of Hours service.
- A day time GP, Monday to Friday, is also in place in ED to treat primary care self-presenters to ED.
- Work is also on-going to increase specialty 'in reach' into ED by medical and surgical specialties who attend ED to review patients rather than wait for them to be admitted to an inpatient ward. This does result in some patients being discharged home from ED.

3.2. Ysbyty Maelor Wrecsam

- The recruitment of medical staff is ongoing to improve cover of the medical rota from August 2017 at middle grade and SHO level. There are 2 wte Consultant vacancies currently covered with locum Consultants. There is a focused campaign of work ongoing to recruit to these key posts on a permanent basis.

- The recruitment of nursing staff has been successful. However, retention of staff remains a challenge with the senior nursing team focussed on maintaining patient safety in ED.
- Medical and nursing staffing rotas have been reviewed and amended to better reflect the peaks of patient demand in ED and changes have also been made to increase the senior level cover in the department.
- The ENP service has protected staffing and clinical space to ensure patients with minor injuries are treated in a timely manner.
- 3 additional rooms in ED have been opened for Minors patients, the ENP service and GP Out of Hours Services.
- Work is also underway with the co-located GP Out of Hours service in the ED department to identify more suitable patients through the triage of self-presenting patients to ED for 'pull' into the GP Out of Hours service.
- There is specialty 'in reach' into ED by medical and surgical specialties who attend ED to review patients rather than wait for them to be admitted to an inpatient ward. This does result in some patients being discharged home from ED.
- A Night Sister post has been put in place to assist the Clinical Site Manager with patient flow and associated quality and safety issues

4. Work to Improve Site Flow across Ysbyty Glan Clwyd / Ysbyty Wrexham Maelor

Much work is also on-going to admit patients in a timelier manner into inpatient beds from ED. As with service improvements in the EDs, BCUHB acknowledges there remains work to do but examples of recent improvements are outlined below.

4.1. Ysbyty Glan Clwyd

- A modified form of unified assessment documentation for patients awaiting admission from ED has been under development. This supports the provision of inpatient level type care to ED patients, ensuring their clinical outcomes and treatment is not compromised. It is intended to fully introduce this process in early August, following a period of trial to ensure all documentation and processes are fully fit for purpose.
- In early autumn, a Frailty Assessment Unit will be trialled, providing a more comprehensive assessment of frail patients at the 'front door' with the aim of avoiding admission for some of these by providing additional community support to enable patients to be safely managed in their own homes. This needs further discussion with the local authorities.
- During times of peak demand, additional 'surge' inpatient bed capacity is opened in line with available staffing. This includes the use of medical and surgical assessment spaces as overnight inpatient beds and the escalation of additional beds on some wards where staffing levels enable this to be done safely.
- A 'Step Down' Manager post has been created who works collaboratively with community health and social care colleagues to ensure that patients with complex care needs are moved to the next stage of their care pathway without undue delay

(this may be: placement in a nursing/residential home, transfer to a community hospital or back to their own homes with packages of support). However local authorities already provide swift discharge to social care packages and often the choice of the patient in relation to their preferred care settings can contribute to delay.

4.2. Ysbyty Maelor Wrecsam

- From the 1st August 2017, a rapid assessment unit will be operational to assess and admit patients from ED (and GPs) without undue delay. From the autumn, this will be complimented with a Frailty Assessment Unit with a focus on admission avoidance to return individuals to their own homes with the support of community staff, including therapists. The unit will provide rapid assessment and treatment of patients who have the potential to return home the same day or within a maximum of 72 hours. Patients will be treated as ambulatory until proven otherwise and within the unit, individuals will receive rapid diagnosis and stabilisation before they are supported home. The ethos of the unit is to proactively diagnose and treat patients; to prevent deterioration that could lead to an emergency admission; and, to refer to the appropriate community services to support patients in their own home during their need for support.
- During times of peak demand, additional 'surge' inpatient bed capacity is opened in line with available staffing. This includes the escalation of additional beds on some wards where staffing levels enable this to be done safely. The District Nursing Service in Wrexham is now available overnight, enabling more patients to be safely cared for at home rather than remain in hospital.
- The provision of an IV suite continues to develop as an important service to enable individuals to receive IV therapy as a day attender (both emergency and elective) without the need for an overnight hospital stay.
- In times of extreme pressure, additional holding areas are staffed away from ED to assist with the pull through of patients from ED to sustain flow of emergency patients.
- A proposal has also been drafted to provide a Clinical Manager of the Day, 7 day a week, in addition to the Clinical Site Manager model already in place.

4.3. SAFER

BCUHB has committed to implement the SAFER bundle in all 3 acute hospital sites over the next 6 months. This is an evidence based bundle of actions shown to reduce length of stay and support safe patient discharge. The key elements of this are:

- A daily senior review of all inpatients (S)
- All patients to have an expected date of discharge (A)
- Patients are moved out of assessment areas earlier in the day into inpatient specialty wards (F)
- A third of patients being discharged leave their ward before midday (E)
- Regular review of patients who have been in hospital for 14 days or more to identity actions required to facilitate safe discharge.(R)

This was endorsed by the National Unscheduled Care Board and implemented locally. A number of elements are already set up (such as reporting key measures i.e. 'Expected Date of Discharge'), with work ongoing to fully implement the patient flow bundle, with senior clinical leadership at the helm, and supporting communications. The objective is to align actions of ward teams (Nursing, medical, therapy and partners) more closely and deliver actions earlier; this should result in improvements to length of stay (LOS) and therefore flow. Medical leadership is vital, and job plans will be reviewed in some cases. Key measures will be:

- Numbers of discharges before 12:00 midday
- Compliance with Expected date of discharge (with expectations that this should be > 80% on wards, allowing for new arrivals)
- Length of stay

A guide for the SAFER patient flow bundle produced by Welsh Government is attached at Appendix 2 for information.

5. Improvement in the discharge/transfer of care of patients at the end of their acute hospital stay.

As well as the actions outlined above, BCUHB works collaboratively with WAST and Local Authorities to support the safe discharge/transfer of care of patients following their acute hospital stay to ensure patients don't remain in hospital longer than they require.

At both Ysbyty Maelor Wrecsam and Ysbyty Glan Clwyd, there is a strong focus on early identification of patients who are medically fit for discharge to ensure timely discharge. Daily 'board rounds' are held across acute adult wards to ensure daily discussion of each patient and their care needs, including discharge planning as appropriate with local authority colleagues. There is a weekly review at both hospital sites of patients experiencing a 'Delayed Transfers of Care' (DTOC).

Healthcare Inspectorate Wales is soon due to commence a patient discharge thematic review within BCUHB which may identify new actions for the Health Board and possibly its partners to complete to realise improvements to the discharge planning process.

WAST is currently developing 'Patient Transfer, Discharge, Routine and Repatriation Guidance' to ensure that WAST and the wider NHS community fully understand the process of requesting an ambulance resource for particular groups of patients who need transport to enable their discharge/transfer to another facility. This will help ensure timely discharge using the most appropriate resource whilst also maintaining the availability of WAST resources to respond to 999 calls.

6. The view of the four local authorities referred to in the Regulation 28 notification

It is important to note that Lilly Baxandall was not known to any of the local authorities and was indeed self-managing in her own home, the system issues described by the health board may have resulted in her speedier admission on to a ward, however the role of the local authorities in supporting discharges from hospital was not an issue in this

case. Having stated this, the local authorities have a clear role in supporting the general discharge of individuals from hospital if there are clearly identified social care needs and we do this very well. The figures in table 1 below demonstrate this, the four local authorities are amongst the highest performing in Wales.

Table 1

New measure	The number of delayed transfers of care for social care reasons for adults aged 75 or over (by month)	Apr '16	May '16	Jun '16	Jul '16	Aug '16	Sep '16	Oct '16	Nov '16	Dec '16	Jan '17	Feb '17	Mar '17	Total 2016-2017
	Flintshire	4	4	1	2	0	1	2	1	1	3	3	1	23
	Wrexham	1	4	2	2	2	0	0	4	4	0	0	0	19
	Conwy	1	1	1	2	1	0	2	0	2	2	0	1	13
	Denbighshire	2	2	4	2	0	5	5	2	1	0	0	2	25
														80

The local authorities are committed to reducing inappropriate hospital admissions and delays in transfer of care where appropriate, some of the initiatives are described further

6.1. <u>Flintshire</u>

Flintshire has community based, responsive Community Care services which work effectively to prevent people being admitted to hospital when it is feasible and safe for these people to be supported at home. We have a leading Reablement Service which intervenes effectively, often on the same day and certainly with due urgency to ensure people maintain their independence, do not deteriorate and are supported at home. We also have a fully functioning Single Point of Access with involvement of the Voluntary Sector and co-located with Health. Finally, Flintshire leads on behalf of Wrexham, BCUHB and our County with a Community Equipment Service which provides rapid and responsive equipment again if needed, on the same day.
There are 10 dedicated hospital social workers to facilitate discharge as soon as an individual is medically fit to leave the acute hospital. This social worker maintains a close working relationship with the discharge liaison team based at each acute hospital. Flintshire County Council provides this service to 3 acute hospitals, Chester, Wrexham in addition to YGC and to community hospitals.

Once a referral has been received from the ward with an estimated discharge date, the patients' progress is monitored to ensure that the correct assessment process is followed and that all involved understand the discharge plan.

Flintshire uses a broker to source and negotiate care packages and all hospital discharges are given priority. This enables hospital discharges to be appropriately prioritised and Flintshire has maintained a strong record of arranging care packages quickly to support timely discharge.

Flintshire has a designated Reablement team who are able to start work with a patient whilst still in hospital to ensure that the person is at their optimum prior to discharge, providing consistency of support when back in the community. Weekly meetings are held with managers to ensure that there is a flow of people through the Reablement process and this allows an opportunity to discuss and prioritise discharges from hospital.

6.2. Wrexham

The importance of preventing people being admitted into hospital or being delayed from leaving hospital is recognised by both officers and Elected Members. Partnership working between Wrexham staff and Betsi Cadwaladr University Health Board Area Director and his senior team is strong, with officers and managers from across health and social care dedicating a significant proportion of their time to working on individual cases and on broader system change. In common with other areas of the U.K. the challenges however remain considerable for all agencies concerned. There are a number of key ways that Wrexham County Council is working to reduce hospital admissions and delays in transfer of care, including:

Provision of dedicated hospital social workers and Assistant Team Manager to facilitate discharge as soon as an individual is medically fit to leave the acute hospital. The social workers are based at the Maelor Hospital and Chirk community hospital and are integrated with the Discharge Liaison team.

Once a referral has been received from the ward with an estimated discharge date, the patients' progress is monitored to ensure that the correct assessment process is followed and that all involved understand the discharge plan.

Wrexham uses a broker to source and negotiate care packages and all hospital discharges are given priority. This enables hospital discharges to be appropriately prioritised and despite capacity issues in the care market, Wrexham has maintained a strong record of arranging care packages quickly to support timely discharge. Where discharge home is either not possible or not appropriate full use is made of commissioned step down beds linked to intermediate care services to support timely discharge and a focus on supporting people to return home.

Wrexham has a designated Reablement team who prioritise hospital discharge patients and work in an integrated way with the intermediate care service. Together with BCUHB Wrexham has also invested in a team of generic health and social care support staff who support people from hospital.

6.3 Conwy

Preventing hospital admission and facilitating the timely discharge of citizens out of hospital is given priority in Conwy. There is good partnership working between the Local Authority's Social Care staff and Betsi Cadwaladr University Health Board staff across all areas, with officers and managers from across health and social care working hard on individual cases as well as on much wider system change. Regular face to face communication take place with the Discharge Liaison Team and the Step Down Matron at YGC. Weekly focused meetings are taking place with key health and social care staff to ensure all potential DTOC cases are progressed.

There are a number of key ways that Conwy Council is working to reduce hospital admissions and delays in transfer of care, including:

The provision of a responsive social work support service to facilitate discharge as soon as an individual is medically fit to leave the acute hospital. Conwy County Council provides this service to 2 acute hospitals, Ysbyty Glan Clwyd and Ysbyty Gwynedd in addition to Llandudno General Hospital and also to Colwyn Bay community hospital.

Once a referral has been received from the ward with an estimated discharge date, the patients' progress is monitored to ensure that the correct assessment process is followed and that all involved understand the discharge plan.

Conwy has a designated Reablement team and also has a broker to source care packages. Hospital discharges are always given priority. We aim to use the "Discharge to Assess" way of working wherever possible and have two Social Workers based within the emergency quadrant to prevent inappropriate admission.

Conwy County Borough Council have a Monitoring Team who in partnership with Safeguarding and Section Managers are supporting Residential Homes and Nursing Homes to raise standards. This has reduced the number of Homes being taken through the Escalating Concerns Process – therefore reducing the risk of Home closures which would in turn affect hospital discharges.

Conwy have established 5 successful short term apartments at our Extra Care Housing Schemes. These apartments provide individuals with their own flat and an on-site support teams focused on Reablement and retaining independence. This supports individuals to either avoid a hospital admission or facilitate discharge to an intermediate facility before (primarily) returning home. These beds have further strengthened our ability to offer appropriate and timely discharge for people who are medically fit to leave inpatient beds but are not yet ready to go home.

6.4. Denbighshire

Denbighshire is committed to supporting BCU to ensure that the flow of patients through hospital is effective. We take seriously our responsibility to ensure that individuals with social care needs are able to access the right care, at the right time, in the right environment to either prevent the need for hospital admission or to support their timely discharge. Operationally, managers from adult social services, community health services and Ysbyty Glan Clwyd, meet regularly to discuss individual situations and develop solutions to any delays. In addition, senior managers from both organisations meet regularly to ensure that there are effective services and systems in place to support this agenda.

This has resulted in a number of changes to how services have been provided in the past and include a joint Single Point of Access with agreed pathways for discharge from hospital and a co-located Community Team of health and social care professionals able to work together more effectively. The latter will be rolled out across the County when its effectiveness has been reviewed.

Denbighshire provides a responsive social work support service to facilitate discharge as soon as an individual is medically fit to leave hospital to Ysbyty Glan Clwyd in addition to Denbigh and Ruthin community hospitals

To support this we also have a dedicated Reablement service which works with individuals in their own homes to regain a good level of functioning following a health issue (such as a fall) and also to support individuals to develop better resilience to avoid such issues recurring. We also have a brokerage service to source care packages as quickly as possible to both prevent admission and also to ensure timely discharge.

Denbighshire have developed a 'step down cluster', working closely with the hospital's Discharge Liaison Team to facilitate smooth transition from hospital to an appropriate discharge destination for each individual with the appropriate level of support and follow on intervention.

7. Identified challenges for care commissioned by the local authorities and the health board

Across North Wales the size and capacity of the nursing, residential and domiciliary provider market differs considerably in each Local Authority. There is over-provision of some services but a severe under-provision of services in others such specialist provision for those older people with complex needs including dementia.

The health board and local authorities regularly commission care from the independent sector and there is a significant reliance on the ability to provide a good range of choice and quality care. The providers themselves continually raise with commissioners that the fees they receive for this service are insufficient and this is an issue that has been subject to much scrutiny and wider debate. The Welsh Government have sought to support local authorities during 17-18 with additional grant monies to aid the care sector however owing to increasing demands and pressures, there continues to be a shortfall.

There have been a number of legislative and regulatory requirements which have come into force recently which has contributed to strain on the care sector. In addition increased costs relating to the living wage, sleeping in, pension changes, travel costs for domiciliary care, moving away from 15 minute calls, and impact of HMRC and avoidance of zero contract hours have taken their toll. There are further pressures that the sector will need to face when the Regulation and Inspection Act comes into force; this will require all providers of services to re-register their services with the CSSIW as well as registration of the workforce. The local authorities can apply a charge on individuals to contribute to the cost of their care however the raising of capital limits for care home charging and the charging cap on domiciliary care packages can limit this charge.

The care sector is also facing considerable challenges in being able to attract and retain a skilled and competent workforce particularly in relation to registered managers and more significantly nurses and this is impacting on the ability to deliver a quality service in the community. The concern about the care sector is national and the sustainability and reliance of such provision to sustain itself through significant legislative, demographic and financial strains poses considerable risks to commissioners of both social care and health services.

8. Concluding Remarks

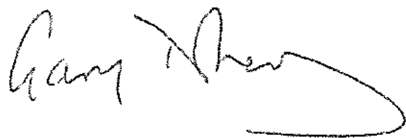
We trust this multi-agency response from BCUHB, WAST and the four Local Authorities, outlining actions being taken across the patient pathway provides you with the assurances you require in response to the matters of concerns raised within the Regulation 28 notice issued for Lilly Baxandall. All organisations are committed to working together, sharing learning and making service improvements to improve patients experience and outcome of care.

Clearly as partners working together we prioritise effective hospital discharge services and just as importantly preventative services. However we need to acknowledge that there are some frailties in the provision of care due to national pressures impacting on care home and home care providers. These do pose some risk to the service which have been acknowledged on a regional and national basis. Moreover the frailties in provision are not down to national pressures alone. A further point is that in supporting people at home and avoiding admissions there has to be a degree of calculated risk taking between quality of life and health episodes. This issue was fully reflected in the discussion that took place between the Chief Executives and the Coroner recently.

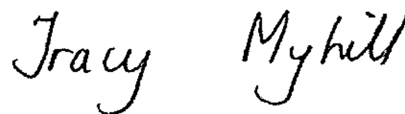
We collectively acknowledge the multi-faceted system changes required by all organisations in North Wales and will continue to work together collaboratively to improve the services we provide to our patients and the wider local populations.

Please do not hesitate to contact us if you require any further details or have any additional areas of concern.

Yours sincerely



Chief Executive
Betsi Cadwaladr University Health Board



Chief Executive
Welsh Ambulance Services NHS Trust

Chief Executive
Flintshire County Council

Chief Executive
Denbighshire County Council

Chief Executive
Wrexham County Council

Chief Executive
Conwy County Council

Enc Appendix 1 – Innovation Unblocked event programmes
Appendix 2 – SAFER patient flow bundle guide