Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

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Kate Sutherland
Acting Senior Coroner for North West Wales
HM Coroner's Office
Shirehall Street
Caernarfon
Gwynedd LL55 1SH

[redacted]

Dyddiad / Date: 12 December 2022

Dear Ms Sutherland,

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS
Glenys Roberts

I write in response to the Regulation 28 Report to Prevent Future Deaths dated 24 October 2022, issued by yourself to Betsi Cadwaladr University Health Board, following the inquest touching the death of Glenys Roberts. I note that the Welsh Ambulance Service Trust, as joint parities to the Notice, will also respond to you.

I would like to begin by offering my deepest condolences to the family and friends of Mrs Roberts.

In the Notice, you highlighted concerns regarding the progress of improvements following Mrs Roberts' death. I would like to address the concerns you raised below:

Review of and action relating to intra hospital transfers has been too slow

The review and actions for the intra hospital process is ongoing, with support from the National Collaborative Commissioning Unit (NCCU), to assist the review in line with similar national work that has commenced. The actions from the review of the intra hospital transfer process has resulted in significant work to model the service demand and draft an options appraisal for future development, to support additional resources required. As detailed below, we have made changes to the vascular pathway and implemented a change in protocol that in the event a paramedic crew is not able to transfer the patient between hospital sites in a timely manner, then the the Ambulance Critical Care Team (ACCT) will transfer the patient.

Review of the current vascular pathway to ensure vascular emergency transfers have direct admission into hospital is still not operational and has been too slow

Prior to the Inquest, the Health Board had recognised these delays in time critical pathways and work had commenced on mapping out the current Emergency Ischaemic Limb Pathway across all three hospitals in North Wales. This was a multi-disciplinary approach including Emergency Departments (EDs), diagnostic services, pharmacy

teams, operational teams, vascular teams and the Welsh Ambulance Service Trust (WAST). Work has progressed steadily with regular transformational sessions across all three sites led by the vascular network team.

To date the following actions have taken place:

- Process mapping of the patient journey from point of referral to WAST and mode of arrival in to the ED; identifying the bottlenecks and delays in the patient journey and taking steps to reduce the delay.
- A change in protocol that in the event a paramedic crew is not able to transfer the patient between hospital sites in a timely manner the Ambulance Critical Care Team will transfer the patient.
- In order to avoid the need for a paramedic crew to transfer the patient between hospitals, a change in clinical protocol from an Intravenous Anticoagulant Infusion to a bolus dose has been agreed. This means that a non-paramedic crew, which are more readily available, can convey the patient.
- Vascular surgeons and the emergency department clinicians have agreed to support the implementation of the South East Wales WAST Bypass Pathway. WAST crews will contact the Vascular Consultant having confirmed an emergency ischaemic limb and if the patient is stable they will be accepted and go straight to the vascular ward, by-passing ED. This is commencing from 01 December 2022 and will be monitored fortnightly through regular meetings with all key stakeholders to address issues or concerns which arise. This will continue until all parties are confident that the new pathway is fully embedded.

I have enclosed a copy of the Clinical Notice and Vascular Emergency Bypass Pathway confirming these changes.

<u>Development of a pan Health Board ambulance handover plan to support reducing lost hours to improve performance and availability is still not in force and has been too slow</u>

An integrated commissioning action plan (ICAP) has been completed following on from the Health Minister's Summit on Monday 28 November 2022, to support the rapid improvement in performance as part of the national six goals programme for urgent and emergency care.

The Health Board and WAST have a fortnightly review meetings with the NHS Wales Delivery Unit on ambulance performance in line with the initial zero tolerance of delays greater than 2 hours, with a national plan being developed to have a zero tolerance on 1 hour delays during 2023-2024.

The local Ysbyty Gwynedd handover plan has been shared across sites within the Health Board for local adoption, along with ED full protocols and hospital full protocols. These are aligned with the national Operational Pressures Escalation Levels (OPEL) with clear triggers to support de-escalation and reducing delays.

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I have enclosed a copy of the integrated commissioning action plan.

We would be keen to present to you the work being done across North Wales on urgent and emergency care, aligned to the Welsh Government national programme.

I hope my letter offers you assurance that we have worked to address the concerns you identified. Significant change to clinical protocols have been made across North Wales involving multiple specialisms and organisations, and we have sought to implement these in a safe and effective way.

One again, please may I offer my condolences to the loved ones of Mrs Roberts.

Should you require any further information or evidence of the actions outlined above please contact us.

Yours sincerely

[redacted]

[redacted]
Prif Weithredwr Dros Dro
Interim Chief Executive

CC.
[redacted]
[redacted]Executive Medical Director
Matthew Joyes, Associate Director of Quality

Enc.
Clinical notice
Vascular Emergency Bypass Pathway
Integrated Commissioning Action Plan