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

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

David Pojur
HM Assistant Coroner
North Wales (East and Central)
Coroner's Office
County Hall
Wynnstay Road
Ruthin LL15 1YN

[redacted]

Dyddiad / Date: 15th February 2024

Dear Mr Pojur,

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS
Vivienne Greener

I am writing in response to the Regulation 28 Report to Prevent Future Deaths dated 18 December 2023, issued by yourself to Betsi Cadwaladr University Health Board, following the inquest touching upon the death of Vivienne Greener.

I would like to begin with offering my deepest condolences to Mrs Greener's family and loved ones, and to apologise on behalf of the Health Board for the failings you identified in the care provided to Mrs Greener prior to her death in 2018.

In the notice you highlighted a number of concerns which I have responded to below.

Your notice was also issued to the Minister for Health and Social Services. The Minister's officials have liaised with my own officers to ensure a coordinated response. I am aware the Minister has specifically responded to point nine of your concerns, and I will therefore address the first eight points.

Out of hours emergency endoscopy not available at Clan Clwyd Hospital or in this area of North Wales

Ysbyty Glan Clwyd (YGC) does not have the demand to support a 24/7 service in accordance with guidelines from the National Institute for Health and Care Excellence (NICE).

As you identified, Wrexham Maelor Hospital (WMH) would previously take over patients with urgent upper gastrointestinal bleeds, once they were stabilised at YGC. This cross-site cover has stopped due to workforce challenges at WMH. Currently the clinicians will adopt the recommendations set out in the Upper GI Bleeding – Management and Principles of Care at YGC 'pathway. The pathway outlines the following:

Optimal resuscitation measures, excellent major haemorrhage management, close critical care monitoring (and use in extremis of the Sengstaken tube for variceal bleeds) can stabilise *most* Upper GI bleeding until endoscopy can be done at the earliest next opportunity. On very rare occasions when patients cannot be stabilised, and patients display evidence of ongoing life threatening bleeding such as overt large volume bleeding, haemodynamic compromise, shock, NEWS scores >8, or high Glasgow Blatchford scores the following key staff should be contacted - **the on call Consultant Physician, Surgeon, ITU team, and ED consultant** to lead on the management and coordinate care.

Additionally, an instruction to ask switchboard to set up a conference call between the ED consultant, ITU consultant on call, consultant Physician and on call Consultant Surgeon to explore local options in North Wales and reach a joint decision. The detail of this process is outlined in the Upper GI haemorrhage protocol and that is due for review in April 2024.

A new Gastroenterologist has been appointed in YGC and will start in April 2024 and they will be part of an upper GI rota.

The provision of out of hours endoscopy services is recognised as a corporate risk for the Health Board and is recorded on the risk register, which is reviewed monthly by the executive team for any escalating clinical concerns, or progress being made against submitted business cases for future provision of the service. Any incident of failure, or delay, to carry out an endoscopy procedure according to National Guidance (explicit in NICE recommendations) is reported via the Datix system, and is investigated by the Central Integrated Health Community Senior Leadership team. If necessary, the incident will be escalated to the Executive team for consideration of a more senior panel oversight to review all treatment actions and decisions in a Rapid Learning Panel, with recommendations for any learning identified through this process. Provision of out of hours endoscopy remains under review given the historical and on-going concerns and the teams will be working towards the development of a suitable rota.

We acknowledge the department is challenged by acuity and service demand, similar to other Emergency Departments across the UK.

The Emergency Department at YGC is fully staffed with junior doctors, in line with the budgeted provision, and appropriate staffing levels are put in place through rota management each month, with mitigation in place for management of sickness and unplanned absence. In addition, staffing levels have been mitigated with the expansion of Consultant numbers since Mrs Greener's death, and there are now 8.6 whole time equivalent Consultants plus 1 whole time equivalent locum. Our senior consultants, are also available 24/7 to attend to and support cases such as this, and all core clinical consultant shifts are covered.

The Emergency Department are continuously reviewing staffing in relation to increasing the core numbers to meet national recommendations within the funding envelope available, and work is ongoing to map the resource required to meet demands.

Nurse staffing for the Emergency Department is calculated on an annual basis using a triangulated methodology. Within BCUHB the process of calculating nurse staffing levels has three steps:

Step 1: Initial Review

Each department completes the designated proforma available within the 'Nurse Staffing Levels (Wales) Act 2016' Operational Guidance as evidence of the review and application of the triangulated methodology. Once completed the Integrated Health Community Nurse Director / Associate Director of Nursing leads a review to calculate Nurse staffing levels in collaboration with the Heads of Nursing, Matron, Ward Sister/Manager, and senior colleagues from Finance. The review is informed by both qualitative and quantitative information comprising of:

- Acuity data – the overall severity of patient presentations in the department.
- Professional judgement
- Quality Indicators – such as the impact of staffing levels on the risk of falls, pressure ulcers, likelihood of medication errors and complaint
- Department environment, layout and geographical position
- Detail of service and patient pathway changes
- Unit based initiatives including improvement programmes or action plans
- Current nurse staff provision over and above core, (supervisory ward manager, enhanced and advanced practitioners, support workers, ward administrators etc.).

Step 2: Health Board Wide Review

A Health Board wide (multi-site, service specific) review is undertaken, led by the Director of Nursing for Workforce, Staffing and Professional Standards, taking into account national guidance and best practice evidence, to ensure a consistent Health Board wide approach. The review includes sharing good practice and lessons learnt and assurance of compliance with the Nurse Staffing requirements in that all workforce models included have an uplift of 26.9% and a supernumerary Band 7 Nurse in Charge has been calculated within the overall workforce plan for each department.

Step 3: Formal Presentation of Nurse Staffing Levels to Executive Director of Nursing & Midwifery

Integrated Health Community Nurse Director / Associate Director of Nursing formally present their proposed nurse staffing levels to the Executive Director of Nursing and Midwifery and on approval; this is formally presented to the Board.

The current nurse roster template is held in the rostering system and details the number of registered nurses and health care support workers on designated shifts. The fill rates for these shifts are as below:

	Day RN Fill Rate	Day HCA Fill Rate	Night RN Fill Rate	Night HCA Fill Rate
Jul-23	118%	100%	130%	90%
Aug-23	114%	92%	129%	91%
Sep-23	110%	94%	130%	88%
Oct-23	117%	103%	131%	83%
Nov-23	120%	89%	137%	87%
Dec-23	115%	96%	132%	85%
Average	116%	96%	131%	87%

Fill rates denote the staffing levels that should be in place, with 100% being the desired staffing. The Registered Nurse fill rate for days and nights during 2023 has been above this level.

The YGC ED department along with the other two sites are in the process of being reviewed as part of the 2023/2024 annual nurse staffing review cycle and have they have proposed that the current staffing roster template is increased.

To support sufficient nurse staffing, a twice-daily report is completed electronically on the Safe Care electronic system. This records available nurses on shift. A red flag on the system marks any deficit, which is visible by the Matron and Head of Nursing who will attend the department to support a review of nurse staffing.

The YGC Matron of the Day will have information on all nurse staffing across YGC and can reallocate staff across departments and/or approve additional nurse staffing to mitigate any risks identified during the daily site system calls which occur three times a day.

The electronic rostering system enables easy identification of any staffing deficits which assists workforce planning for the nurse in charge, matron and head of nursing. All temporary staffing requests and bookings are made via the rostering system. The electronic system will also generate a response that temporary staffing cover has been successfully arranged, which is visible to the nurse in charge, Matron and Head of Nursing on the system. From this, all staffing deficits with a red flag identified and leading to potential patient harm are reported via the Health Board incident reporting system and are reviewed at a weekly meeting led by the Executive Deputy Directors of Nursing, to understand any ongoing risks and harms that may have occurred as a direct consequence, where IHC Nurse Directors present evidence of mitigation and quality of care actions taken against each incident reported.

Space is an issue due to the increase in demand on the Emergency Department. On average daily attendances range between 130 and 150, however we are experiencing an increase in volume to 150 – 180 attendances per day. Furthermore, due to challenged bed capacity across YGC, we are experiencing a greater length of stay within the department and on occasions seeing patients with a length of stay between 12-48hrs; this creates further congestion within the department.

Processes are taking place in respect of patient flow to release capacity, however, we are reviewing the opportunity to create additional capacity in terms of infrastructure changes and a review of our current START clinical area. This would create a dedicated speciality waiting area with cubicles for review. This scoping is work in progress, and will be formalised.

Ineffective triage and record of triage of patients arriving at Glan Clwyd Emergency Department by ambulance

Within the ED at YGC, the Manchester Triage Tool is in place (which staff have been trained in) which highlights prioritisation of patients. A waiting room member of the nursing team is in place 24 hours a day, 7 days a week and the triage registered nurse and nurse in charge will address stroke, chest pain and silver trauma – this is for walk in patients prior to formalised triage assessment. All ambulance handovers are triaged by a senior nurse. Triage outcomes and decisions are recorded electronically on Symphony system, which is a relatively new system that was introduced on 30th March 2022.

A clear understanding of when the Emergency Treatment Team should be called

With regards to understanding when to call the Medical Emergency Team (MET), evidence of the MET call process is included on the National Early Warning Score (NEWS) chart and is clearly visible to all clinicians assessing and reviewing patient recorded observations. For clarity, the Emergency Treatment Team is now known as the Medical Emergency Team.

Use of the National Early Warning Score (NEWS) is a standard approach to assessing the acute illness and severity of the individual's clinical presentation.

No clear understanding of when the Major Haemorrhage Pathway should be engaged

Any member of staff can trigger the Major Haemorrhage Pathway and it is printed on the wall in all clinical areas, including the resuscitation area in ED, and is clearly visible to all. Senior staff who are all very familiar with the pathway are always available and support all resuscitation cases, and can advise if agency staff are unsure or unfamiliar with the pathway.

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Upper GI Bleeding Management and Principles of Care 2022 is no longer fit for purpose

I can confirm this was updated in July 2023 and will be reviewed again in April 2024. This guideline follows the appropriate NICE guidelines and the acute upper GI bleed care bundle from the British Society of Gastroenterology.

Learning from the Health Board's Investigation Report is not adequately shared with its practitioners

In relation to your concern that incident investigation reports are not shared with clinicians, I can confirm that following concerns from other coroners, a new incident process is being developed and will be implemented in April 2024.

Part of the Investigation Report changed in different versions and obscured the reason why the provision of blood products was delayed meaning issues are not sufficiently identified and actioned

Finally, regarding your concern that the investigation report changed in different versions and obscured the reason why the provision of blood products was delayed, I understand [redacted], IHC Medical Director provided a statement regarding this. Our new incident process mentioned above will introduce a new report template making it clear which version is the final, approved version of the report avoiding any confusion between the final approved version and any draft versions.

I hope this letter offers you assurance on the action we will now take to ensure the concerns you raised are addressed and that changes are made to our clinical services.

Once again, I offer my deepest condolences to the family and friends of Mrs Greener for their loss.

Yours sincerely

[redacted]

[redacted]

Cyfarwyddwr Meddygol Gweithredol / Dirprwy Prif Weithredwr Dros Dro
Executive Medical Director / Acting Deputy Chief Executive

cc [redacted], Deputy Director for Quality Governance