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GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

Our ref: **NP/GJ/kh**

Thursday 11th January 2024

Mr Graeme Hughes
Senior Coroner South Wales Central
Coroner's Office
The Old Courthouse
Courthouse Street
Pontypridd
CF37 1JW

[redacted]

Dear Mr Hughes

Regulation 28 Report received by Aneurin Bevan University Health Board further to the inquest touching on the death of Lynda Blackmore which concluded on 1 November 2023

Thank you for your letter of 15 November 2023 and accompanying report, which the Health Board received on 17 November 2023.

I am writing to provide you with the Health Board's response to the Regulation 28 Report to Prevent Future Deaths, which was issued following the inquest into the death of Lynda Blackmore.

You have advised, via your letter, that your concern is that handover delays are impacting upon response times in respect of patients requiring emergency treatment and/or conveyance to hospital and that in your opinion, action should be taken by the Health Board to prevent future deaths in regard to Mr Andrew Garner's witness statement, in particular paragraphs 43 – 49.

As requested, the information presented below is intended to describe the actions which have been taken/are being taken by Aneurin Bevan University Health Board to mitigate the risk of future deaths:

1. Paragraph 43 – 45 The Trust (WAST) was experiencing hospital handover delays in the Aneurin Bevan University Health Board area.
2. Paragraph 46 – The response to Mrs Blackmore was 13 hours.

With regard to the first point, it is acknowledged that the Health Board was experiencing handover delays at all of its sites on this day. During the previous days all hospitals within the Health Board and indeed, neighbouring Health Boards experienced delays that were in excess of the 15 minutes standard as stipulated in the Welsh Health Circular (May 2016).

The days leading up to the incident on 1 February 2023 saw very high attendances at the Grange University Hospital (GUH) with activity on 31 January 2023 one of the highest during January (270 attendances) which placed significant additional pressure on services, particularly within the Emergency Department (ED). As can be seen from the table below, there was significant pressure seen from 29 January to 1 February, with average handover being in excess of the 15 minute standard; this was also reflected in the cumulative daily lost hours (the time recorded from 15 minutes onwards for each ambulance patient handover).

Grange University Hospital

Date	Daily Activity	Ambulance Arrivals	Average Handover Time	Lost Hours	Red & Amber Release Requests
29.01.2023	268	80	119 mins	109	2
30.01.2023	252	63	105 mins	91	3
31.01.2023	270	68	80 mins	64	2
01.02.2023	248	69	121 mins	116	0

The Division of Urgent Care had managerial and operational responsibility for the ED at the GUH at the time of this incident. The management team have had a number of processes in place to improve flow. Therefore, the pressures at the front door and leadership on a day-to-day basis for GUH was managed by the Corporate Site Operations Team who ensured that where delays were being experienced that the Health Board's *'Emergency Pressures Escalation Policy'* is actioned. This document provides clarity on the responsibilities of a wide range of Health Board colleagues including the Emergency Department, Operational Site Managers, Senior Divisional Leadership Teams and Executive Directors and that actions that must be taken to reduce ambulance delays, in particular, and system pressures.

Since this incident, a review of the Health Board's Divisional structures have been strengthened, with the Division of Urgent Care now assuming full responsibility for the Corporate Site management team to ensure a full and co-ordinated focus is maintained on safe patient flow and ambulance handover delays.

Other initiatives have seen the introduction of weekly Patient Safety Flow meetings during May 2023, chaired by the Deputy Director of Operations with input from the Executive team including the Chief Executive, Chief Operating Officer, Director of Nursing, Director of Therapies and Medical Director. These meetings focus on the delivery and performance of the Health Board's ED and MIUs with very clear action plans to mitigate the risk and seek improvements in patient flow and ambulance handover delays. The focus has been on the following areas:

1. Pre-Hospital / Flow Centre. Due to the unique nature of the Clinical Futures model that the Health Board manages, a Flow Centre is operated to ensure that all ambulance admissions (excepting life threatening emergencies) and admissions received from General Practitioners are screened to ensure that the patient is referred and streamed to the correct hospital and department. Further actions within this workstream include:
    a. Consultant presence in the Flow Centre to aid senior clinical decision making
    b. Redirection for specific conditions to eLGH sites rather than the GUH for more appropriate and rapid assessment and treatment
    c. Falls response in the community
2. Emergency Department/Assessment Area Focus
    a. Revision of the escalation framework to ensure that the points of escalation during any ambulance handover delays are appropriate
    b. Creation of inter-speciality standards
    c. Prioritisation and assessment of the balance of risk

3. Discharge Logistics
    a. Focussing on how the Health Board can better utilise its discharge lounges to provide an immediate and early pull from wards across all sites to create capacity to support ambulance handover times
    b. Improving how the internal process for the handover of patients who are transferred from the GUH to the eLGH sites

The Health Board is also fully engaged with the NHS Wales Six Goals for Urgent and Emergency Care programme which has been co-designed on a national basis by clinical and professional leads. Spans the urgent and emergency care pathway and reflects the priorities in the Programme for Government 2021 – 2026 to provide effective, high quality and sustainable healthcare as close to home as possible, and to improve service access and integration. The expectation is that adoption of nationwide best practice, including a local input into specifics will improve handover delays and reduce clinical risk.

The individual goals and workstreams that have also been instrumental in the reduction in handover delays within the Health Board since February 2023 the Six Goals priorities have been streamed in to three distinct workstreams and includes:

1. Workstream 1 – Redesigning Services for Frail and Older People
    a. Development of a permanent acute frailty team to focus on this cohort of patients
    b. Redesign of the model for community hospitals including Direct Access beds
    c. Extending the Community Resource Team offer to support people with complex needs within the home
    d. Work with WAST on a Virtual Ward Model
    e. Greater support to Care Homes
2. Workstream 2 Urgent & Emergency Care Redesign
    a. Improvements to the Same Day Emergency Care (SDEC) services established within GUH and YYF Hospitals, increasing patient selection which will release capacity for ED and Assessment Units. These services have seen a continued upward trajectory in medical patients since March 2023.
    b. Continuing of WAST's 'waiting stack' reviews and continuing redirection of patients where deemed clinically safe and appropriate Improvements in WAST access to the Health Board's Flow Centre
    c. Single phone number for health care professionals to enable a smoother contact process with alternative services including community frailty and Urgent primary Care
    d. WAST referral line for agreed alternative to ED pathways within the Health Board to prevent direct ED attendances Initial scoping and commitment from the Health Board and WAST to create a collaborative working workstream, specifically looking at alternatives to hospital conveyance:
    e. Review of Ambulatory Care pathways including respiratory and chest pain pathways
    f. Improvements in community falls including head injury and fractured neck of femur pathways
    g. Pilot of an Electronic Triage system within the ED and MIU department waiting rooms to improve efficiency and risk management.
3. Discharge Improvement to support more timely discharge and supporting people back to their own homes thereby reducing urgent and emergency care delays
    a. Introduction of focussed patient safety events across all the key Health Board sites to improve discharge processes and number of patients waiting in hospitals for discharge to either home or another facility
    b. Creation of a discharge hub at the Royal Gwent Hospital jointly with social care
    c. Creation of a Ready to Go Ward and a discharge floor at the Royal Gwent to bring together a discharge lounge, the Ready to Go Ward and in integrated hub to manage patients transition more effectively to their own home
    d. Creation of a Hospital to Home service to provide additional support within the community

e. A focused project at Nevill Hall Hospital working with Monmouthshire Local Authority focused on proactive discharge arrangements to people's own homes

Regarding the second point, whilst the response to Mrs Blackmore was 13 hours, it was acknowledged by WAST that an ACA2 crewed ambulance could have attended to her and conveyed should one have been available to do so. An ACA2 staff member has a skill set that is below that of a Paramedic or Emergency Medical Technician but does have the ability to monitor, treat and convey patients that are within their scope of practice. The Health Board operates an Inter Site Transfer Service (ISTS) comprising a maximum of 10 ACA2 crewed ambulances at peak times. This service was commissioned from WAST specifically to support the Clinical Futures model's required transfers in and out of the Grange University Hospital.

WAST do have the ability to utilise these vehicles for a community-based response B and do so on a regular basis, this would have been an appropriate resource to meet Mrs Blackmore's needs. However, on this occasion, this was not requested or actioned. The Health Board understands that there were twenty occasions between 14:56 on 1 February 2023 and 01:39 on 2 February 2023 where one of the Health Board's ISTS ACA2 ambulances could have been allocated to Mrs Blackmore's amber two category 999 call and this did not happen.

Finally, I would wish to reassure you that the Health Board is rigorously focused on the reduction of patient handovers and the associated risk for patients that these delays create. In addition to the focused work referenced above the Chief Operating Officer and the Clinical Executives are providing leadership and challenge to addressing this important issue and it is a personal ambition as Chief Executive that we eradicate these delays as soon as we practically can. I trust that this information reassures you about the Health Board's plans to improve ambulance handover delays. However, if you require any further information or assurance, please do not hesitate to contact me.

Yours sincerely

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Prif Weithredwr / Chief Executive