GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Bae Abertawe
Swansea Bay University Health Board

[redacted]

gofalu am ein gilydd, cydweithio, gwella bob amser
caring for each other, working together, always improving

Rydym yn croesawu gohebiaeth yn y Gymraeg ac yn y Saesneg.
We welcome correspondence in Welsh or English.

Dyddiad / Date: 29th April 2024

[redacted]

ALED GRUFFYDD
Assistant Coroner,
Swansea, Neath & Port Talbot

Dear Mr Gruffydd,

Re: Regulation 28 Response: Mrs. Jean Thomas

Thank you for providing the Health Board with an opportunity to respond to your concerns raised at the conclusion of the inquest of Mrs. Jean Thomas, on 29th February 2024.

At the outset I would wish to send my condolences to Mrs. Thomas' family. Mrs. Thomas' experience following her fall at home on 13th December 2022, is not one that we want for any patient, and I am sorry that delays in her transfer from home to hospital resulted in harm.

As referenced in your inquest conclusion, the challenges in accessing emergency care experienced by Mrs. Thomas are not unique to Swansea Bay University Health Board or the wider health system within both NHS Wales and NHS England. The Health Board fully recognises this, and it is reflected in our Health Board Risk Register, with Access to Unscheduled Care Services being scored at a risk score of 25 (the highest possible). The Health Board Risk Register is reviewed at a Board level on a monthly basis.

It is fully accepted by the Health Board that if we fail to provide timely access to unscheduled care then this will have an impact on the safety of patients and the quality of care we provide, as well as patient and family experience. However, opportunities to change the way services are delivered and the introduction of community-based prevention initiatives are being implemented with an aim to reduce harm, such as that experienced by Mrs. Thomas.

Since receipt of your Regulation 28 outcome letter the Health Board has commenced a programme of targeted intervention, supported by Welsh Government, to address risks associated with urgent and emergency patient pathways at Morriston Hospital. The aim of this programme of work, which is at an early stage, is to critically review and redesign across community access, service delivery, staffing models and infrastructure in order to reduce risk.

All patients arriving at the Morriston Hospital Emergency Department by ambulance, with the exception of pre-alert patients who need immediate clinical intervention, go through a REACT process. The Rapid Emergency Assessment Care Team assess the patient in order to identify their needs and this review includes identification of pre-existing pressure injuries, assessing risk of deterioration of any existing injuries and the risk of acquiring a new pressure injury. The aim of the assessment is to enable treatment/prevention to be started immediately. Sadly, during periods of significant unscheduled demand there may be occasions where following REACT assessment, patients have to be returned to the ambulance due to a lack of space in the Emergency Department. This was the case for Mrs. Thomas when she arrived at Morriston Hospital in December 2022. Whilst on the ambulance, patients continue to be monitored by the Emergency Department.

There is ongoing work in conjunction with the Welsh Ambulance Service to address how pressure relieving equipment can be used on ambulances, both in transit and in situations where patients are unable to be handed over from the ambulance crew to the Emergency Department Team. The Health Board has proactively shared with the Welsh Ambulance Service comprehensive risk assessment documentation relating to the use of pressure relieving mattresses which are able to be used on ambulance trolleys since 2021 (and subsequently in 2023 and 2024). Independent audit outcomes from two Ambulance Trusts in NHS England, who have adopted the use of pressure relieving equipment in ambulance vehicles (using Swansea Bay's risk assessment) have shown a significant reduction in healthcare acquired pressure injuries of up to 30%.

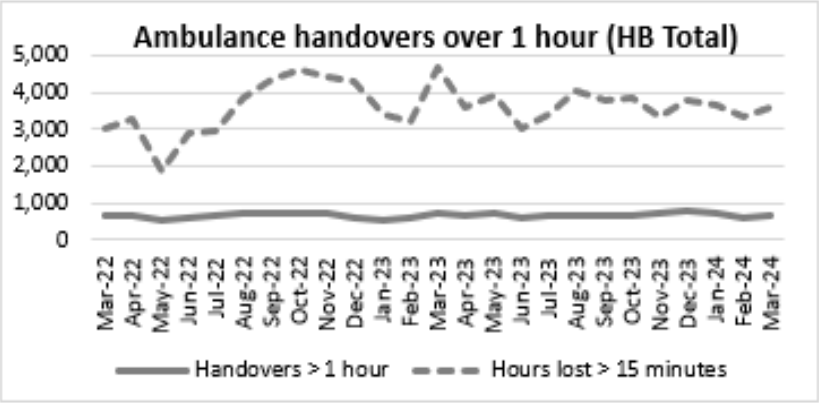
The Emergency Department at Morriston Hospital maintains the ongoing offer of providing pressure relieving equipment to the Ambulance Service (25 mattresses available), to date this offer has not been accepted.

The national target for ambulance handover is 15minutes. Currently the Health Board actively monitors ambulance handover performance against the following two performance measures:

- Number of ambulance handovers greater than 1hour
- Number of lost hours as a result of delayed ambulance handovers greater than 15minutes

Performance against these two targets for the 12months, 01/04/2023 to 31/03/2024 is:

- 8,161 ambulance handovers greater than 1hour (average 680 per month)
- 43,453 lost hours in delayed handovers greater than 15minutes



In November 2023, a "zero" tolerance to ambulance off-load delays, in excess of 10 hours, was introduced, at Morriston Hospital. The introduction of this tolerance is part of a reduction trajectory to improving handover times and achieving the 15-minute target. However, despite improvements in this area, continued pressures on the unscheduled care system has resulted in delays over 10 hours still being experienced by patients.

The majority of delayed ambulance handover events do not result in a significant harm to a patient. This is largely due to the REACT risk assessment described above. In the rare case when a patient does incur a significant harm, a Duty of Candour process is triggered; notified to the patient and/or family and a full investigation undertaken with the outcome provided in line with "Putting Things Right" (2011) Regulations.

The Health Board recognises that older patients presenting at the Emergency Department, with an acute injury will often have additional needs related to frailty. In September 2024, a dedicated Frailty Unit is due to open at Morriston Hospital. The Unit will have direct ambulance access and senior clinical decision-makers to ensure that patients are placed on the correct clinical pathway at the time of arrival at hospital. In addition to in-hospital pathways, out of hospital pathways, such as "Virtual wards" are also available to ensure that patients can access acute care but have a clear plan to get them home when they are fit enough to do so.

I am confident that the operational response to these events means that there is a focused effort on finding a resolution to each individual handover delay, which considers individual patient needs and their immediate safety. In some cases, this will include a risk assessed additional patient within the Emergency Department.

I would also like to take this opportunity to focus on prevention of falls as a key factor in reducing the demand on acute services. The Health Board has identified prevention of falls as a key quality priority with a focus on both reducing in-hospital falls and preventing falls, from occurring within the community requiring acute admission.

The following key workstreams have been developed:

1. **"Bay Watch"** is an in-hospital falls prevention initiative to reduce falls through co-production with our patients. Supporting them to make the right decisions about their mobility whilst in hospital.
2. Launch of the **Regional Falls Prevention Taskforce** – this brings 3rd sector, emergency services, health and local authority together to look at falls prevention in the community and feeds directly into the National Falls Prevention Taskforce.

3. **Safe Care Collaboration with Improvement Cymru** have looked at response to non-injurious falls at home and within supported living accommodation, residential homes and nursing homes, utilising the "iStumble" digital application and multi-agency falls prevention training. The initial project has seen a 75% decrease in ambulance call outs for this category of fall event allowing ambulance services to focus on patients who have acute injuries.

4. Use of **"Dance to Health"** which is an evidence-based falls prevention programme available in Swansea Bay Region to encourage older people to maintain strength and mobility. The Health Board are currently sourcing additional funding for expansion this initiative across other sites/regions.

5. Introduction and awareness of **Podcast Series available on YouTube** – discussing everyday fall prevention strategies and highlighting some taboo subjects – these are publicly available.

6. **Intergenerational Falls Prevention Programme** focusing on the fall incident scene – now linked with the National Taskforce. This is an educational support pack available to all schools to educate and support children and families about falls prevention within their wider family.

7. The Health Board Falls Improvement Lead is currently undertaking a scoping exercise commissioned by the **Regional Partnership Board**, looking at providing a fuller offer of community falls prevention services.

In conclusion, I hope that you are assured that the Health Board is taking a holistic, proactive approach to the issues encountered by patients such as Mrs. Thomas, in an effort to reduce the risk of any future deaths, as a result of delayed access to emergency care following an acute fall event.

Yours sincerely

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INTERIM CHIEF EXECUTIVE OFFICER