[redacted], Cadeirydd | Chair
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[redacted], Prif Weithredwr | Chief Executive
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Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

Our ref: **NP/nr**

Monday 15th July 2024

Caroline Saunders
Senior Coroner (Gwent)
Via email: [redacted]

Dear Ms Saunders

Regulation 28 Report received by Aneurin Bevan University Health Board further to the inquest touching on the death of Sylvia Evans which concluded on 14 May 2024.

Thank you for your Regulation 28 Report dated and received by the Health Board on 20 May 2024.

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 Sylvia Evans.

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.

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 and all Health Boards across Wales 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 5 September 2023 saw very high attendances at the Grange University Hospital (GUH) with activity on 5 September being the second highest during that week which placed significant additional pressure on services, particularly within the Emergency Department (ED).

The management team have 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 the actions

that must be taken to reduce ambulance delays, in particular, and wider system pressures.

Recent initiatives to improve patient flow and subsequent ambulance handover delays saw 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 workstreams:

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

In April 2024, the Health Board was placed under 'Enhanced Monitoring' by the Welsh Government for its Urgent Care services with an inception meeting with our Executive Team on 9 April. There are now three key areas of improvement that are monitored and reported back to the Welsh Government:

1. Three-month continuous reduction of at least 15% each month (from Oct-Dec baseline) for ambulance handovers
2. Continuous improvement towards no more than 5% of patients waiting over 12 hours at each individual site and across the Health Board
3. 100% of patients to be assessed by a senior clinical decision maker within 60 minutes from arrival

To support these key areas of improvement, further support has been provided to the Urgent Care Division to ensure that the managerial capacity to plan and implement required changes is facilitated. This has included:

1. Weekly review meetings with the Urgent Care Division chaired by the Chief Operating Officer and attended by the three Clinical Executive Directors (Medical Director, Director of Nursing & Director of Therapies and Health Science) and key Clinical Divisional colleagues. The purpose being:

    a. To provide a healthy challenge to current processes & procedures
    b. Review of weekly data to support the three key improvement areas
    c. Offer of support to ensure that the Urgent Care Division is working within a collaborative working environment with all other Clinical Divisions

2. A new post supporting the Chief Operating Officer's team to enhance capacity and focus on the urgent care system daily operating and escalation where appropriate.

3. A number of priority developments being tested and considered as part of the improvement programme.:
    a. Substantive and increased provision of the Physician Response Unit (PRU). The PRU delivers community emergency medicine. It brings senior level decision-making to the scene and community, enabling best care to be delivered in a truly patient centred approach. In 2023, 68% of patients seen by the PRU remained at home, 31% streamed directly to a speciality. 97% of the PRU patients avoided the ED, this non-conveyance supports unnecessary attendance at our Emergency Department, subsequently assisting in the reduction of ambulance handover delays
    b. A new business case for additional ED Consultants to reduce clinical assessment times
    c. Further review of the clinical decision-making model within the Flow Centre, ensuring that best clinical advice is provided and that WAST colleagues are directed to the most appropriate receiving site

We initially introduced these meetings as a dual-part format to address both the Urgent Care Emergency Department aspect and the broader operational approach, ensuring comprehensive coverage of all elements.

This was further consolidated in June 2024 into a single session to embrace a holistic system-wide approach that will support this expanded method of working. All three key areas that require development have defined owners of actions and specific outcomes that are expected to support delivery of the required improvements.

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. This 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.

A number of priority workstreams are ongoing that have been instrumental in reducing handover delays within the Health Board. These have been streamed into three distinct workstreams:

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. **Workstream 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

WAST, in conjunction with the Health Boards operate an *'Immediate Release Direction Protocol'* which outlines the principles and processes for the management of immediate release directions that includes a dynamic escalation process to, as far as possible, minimise patient safety risk for patients awaiting a response in our communities when ambulance capacity is reduced when the time for patient handover at emergency departments is extended (the handover standard is 15 minutes and considered extended beyond 30 minutes).

During 5 September, whilst noting that the Health Board did have significant challenges with adhering to the nationally agreed 15-minute ambulance handover time, WAST did not contact the Health Board via approved routes to ask for a vehicle to be released. The 999 call to attend to Mrs Evans had been coded as an amber 1 response and fell within the provision of the Immediate Release Direction Protocol. Had this occurred, the Health Board would have endeavoured, as per the protocol to release a delayed vehicle to respond as requested.

Finally, I would wish to reassure you that the Health Board is rigorously focused on the reduction of ambulance handovers and the associated risk for patients that these delays create. In addition to the focused work referenced above the Chief Operating Office 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