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

Bwrdd Iechyd Prifysgol Bae Abertawe
Swansea Bay University Health Board

Un Porthfa Talbot | One Talbot Gateway
Parc Ynni, Baglan | Baglan Energy Park
Port Talbot SA12 7BR

Ffôn Phone: [redacted]

[redacted]

Dyddiad/Date: 11th December 2024
Ein Cyf/Our Ref: [redacted]

Mr Aled Gruffydd
HM Senior Coroner for Swansea and Neath Port Talbot
The Guildhall
Swansea
SA1 4PE

Dear Mr Gruffydd,

Re: Inquest Hearing in respect of Mr Peter Parker (Ref: 13893868)

Thank you for providing Swansea Bay University Health Board with an opportunity to address concerns raised at the conclusion of the Inquest of Mr Peter Parker, on 16th October 2024.

As you are aware the Health Board was not directly involved in clinical decision-making or care delivery immediately prior to Mr Parker's death in September 2021 and as such were not a party to your Inquest hearing. The Health Board's last known contact with Mr Parker was in April 2021 in relation to Type II Diabetes Self-Management Clinic, which was a telephone contact.

It is noted that in evidence submission made to your Inquest by the Welsh Ambulance Service NHS Trust (WAST), it was put forward that delay in releasing emergency response vehicles from the Emergency Department at Morriston Hospital was a factor in WAST being unable to respond to Mr Parker within an appropriate clinical timescale.

The Health Board accepts that routinely there are substantive delays within acute unscheduled care pathways, as a local, national and UK wide level. These pathways can include extended waiting times for emergency vehicle response and clinical handover delays on arrival within acute secondary care.

At any point in time (24/7), the Health Board and specifically the Hospital Management Team at Morriston Hospital is aware of the number of open calls being managed by WAST, the clinical priority assigned to each of these calls, by WAST, and a very general comment on clinical presentation; universally referred to as the "stack". The extent of information available, at this point is very limited and the Health Board has no role in determining clinical priority and resource allocation.

Sadly, as described in your Inquest papers, WAST emergency vehicle attendance at the home address of Mr Parker was too late and he was declared deceased and therefore was not conveyed to Morriston Hospital, for emergency care.

At this point I would like to take an opportunity to offer my heartfelt condolences to the family of Mr Parker.

On occasions when such events have occurred, WAST have notified the Health Board of a potential Serious Incident and afforded the Health Board time to reflect on the case and look for learning opportunities, this process has been in place since circa 2019 and continues to date with outcomes shared at joint meetings between the Health Board and WAST. We have not been able to identify such a notification from WAST in relation to Mr. Parker.

The agenda for the Health Board and WAST meetings is driven by exceptional cases, where severe/catastrophic harm has been identified. The meetings are held monthly and are chaired by a Health Board Associate Nurse Director. (Outcomes from these meetings are available).

In lieu of a case review not being undertaken in 2021, the Health Board has taken the opportunity to apply its established review methodology to Mr. Parker's case.

The following key aspects, with regards to the Health Board's response to unscheduled care pressures experienced across the 10th and 11th September 2021 are as follows:

- At the time Mr. Parker contacted WAST (21:21, 10/09/2021), there were 3 emergency response vehicles outside the Emergency Department at Morriston Hospital, awaiting clinical handover.

- During the period between the initial 999 call and the arrival of a WAST response vehicle at Mr. Parker's address, a further 10 emergency vehicles arrived at the Emergency Department at Morriston Hospital and 10 emergency vehicles were clinically handed-over; with an average handover time of 192minutes (range 784 minutes to 13minutes). This includes the 3 vehicles outside Morriston Emergency Department at the time of the initial contact.

- This case occurred when enhanced infection prevention protocols related to COVID-19 were still in place, within the Emergency Department and across the hospital site, which could have impacted on the speed of clinical handover for some patients in order that appropriate risk assessment was undertaken to ensure patient and staff safety. A high-level review of the cases arriving by ambulance on 10th and 11th September 2021, supports this, with a number patients presenting with breathing problems.

- It is apparent from evidence provided by WAST, that there was a significant increase in WAST demand during the period Mr. Parker was awaiting a response, with the number of Amber1 calls increasing from 11 (at 22:28 with a longest waiting time of 7hours 24minutes) to 21 (at 02:19 with a longest waiting time of 9hours 40minutes).

It is noted that the Serious Incident Review undertaken by WAST concluded that due to the number of Amber1 calls polling ahead of Mr Parker, they could not have responded to his call any sooner.

A multi-faceted risk to delivery of unscheduled care is recognised on the Health Board's Risk Register and is scored at 25.

Since Mr Parker's death the All-Wales National Immediate Release Protocol (July 2022) has been introduced (a copy is attached for reference). The objective of this protocol is to provide an escalation process, across NHS Wales, that ensures WAST resources are released when required to mitigate, in real-time, serious cases of potential harm from occurring because of an avoidable delayed response in the community.

The protocol is designed to work alongside, and not replace, organisational management/ clinical safety plans. It is designed to complement joint working to reduce harm and improve patient safety.

The protocol sets out a clear process for request/escalation and requires Health Board's to investigate all occasions when an immediate release is declined.

In summary the steps (S.5) are set out below: -

Step 1 – WAST will contact ED staff via the "red phone" and direct an immediate release of an ambulance delayed outside the ED when no other appropriate resource is available to respond to a Red or Amber1 patient and/or when the resource has an extended travel time and nearer appropriate resources could attend that patient. The direction made by WAST will share the incident priority, patient age and chief complaint, identify the number of resources that are required to be released and the callsigns of the resources to be released (those that are immediately able to respond to the incident).

Step 2 – Health Board colleagues on receipt of an immediate release direction will ensure compliance and facilitate the release of the resources identified without delay.

Step 3 – Should an immediate release direction be declined by the ED staff, WAST will act in accordance with the WAST Resource Deployment SOP and record and escalate the refusal to the Operational Delivery Unit. If a Health Board does decline an immediate release direction, they will be required to provide the reasons for this and the name or identifying detail (e.g., employee number) of the declining staff member.

The reason for handover delays is solely related to a lack of capacity to bring the conveyed patient into the hospital; both in terms of safe physical space including access to essential clinical support and staffing to take care of the patient. All patient's waiting on the back of ambulances will have been clinically assessed and all opportunities explored as to how best to deliver a safe, timely, clinical management plan. The Emergency Department at Morriston Hospital routinely functions with additional patients across its template including within the acute resuscitation area, with "Major" patients overflowing into the "Minors" area and "Minors" patients sitting in the "Waiting Room".

It is important to note that patients can and do self-present at the Emergency Department with significant clinical presentations that require immediate clinical intervention and this is a feature when WAST waiting times for an emergency vehicle are long. This represents a secondary route for very unwell patients to present at hospital that needs to be considered in assessing safety within the Emergency Department. These patients can be more clinically urgent than patients arriving by emergency response vehicle.

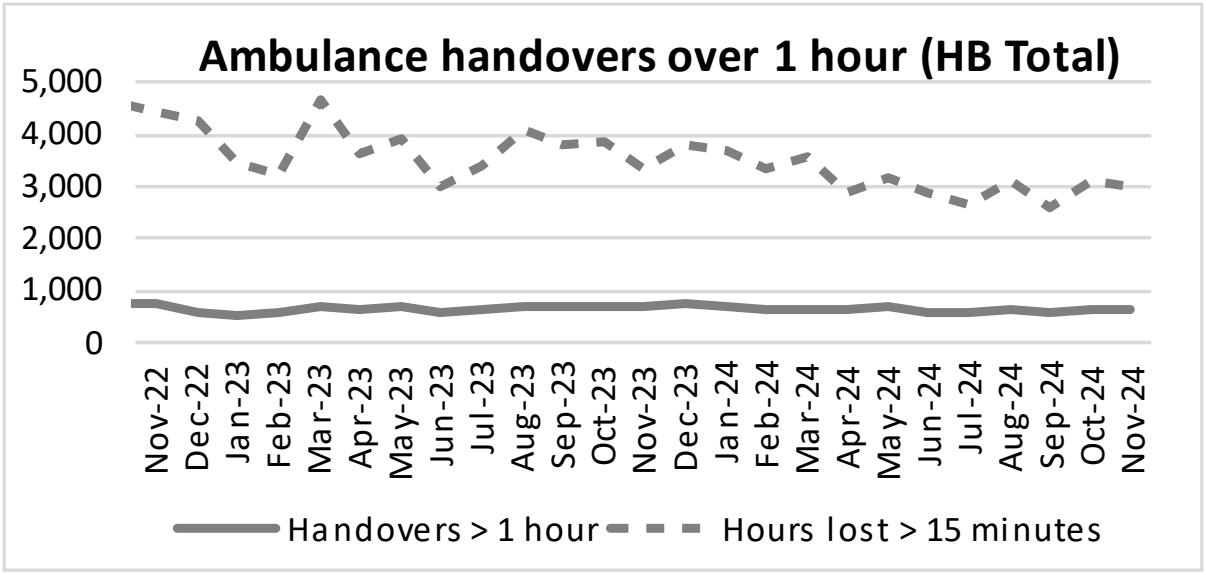
I can confirm that all Red release requests are actioned by the Health Board. Amber1 release requests are managed on a case-by-case basis and the Health Board may have to decline requests when there is a significant/severe clinical safety risk to the Emergency

Department, in accepting additional patients into the Department. This risk is assessed at a point in time, by the senior clinical staff in-charge of the Emergency Department (medical & nursing) and would be consistent with the nationally reported emergency care status or SAPhTE score (Staffing, Acuity, Physical Capacity, Transfer, Environment). The decision is documented and notified to the Hospital Site Management Team who record it as part of the situation reporting throughout any 24hour period.

The Health Board actively monitors ambulance handover performance against the following two performance measures, on a daily basis:

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

Diagram1: Ambulance Handover Performance covering the period 1st November 2022 to 30th November 2024:



(Source: Health Board Performance Scorecard – weekly update 03/12/2024)

The above graphical representation demonstrates the number of delayed WAST handovers (>1hour) has reduced by 15% (744 in November 2022, to 632 in November 2024) and the number of lost hours (>15mins) as a result of handover delays has significantly reduced by 32% (4456 hours in November 2022 to 3028 hours in November 2024).

The Health Board has commenced a programme of targeted intervention in conjunction with the National Strategy for Right Care, Right Place, First Time: Six Goals for Urgent & Emergency Care, supported by Welsh Government, to address risks associated with urgent and emergency patient pathways, including the ability to release emergency response vehicles, following arrival at Morriston Hospital. The aim of this programme of work is to critically review and redesign across community access, service delivery, staffing models and infrastructure in order to reduce risk of patient harm and service failure.

Right Care, Right Place, First Time: Six Goals for Urgent & Emergency Care
The above strategy focuses on strengthening signposting to clinically safe alternatives to admission, rapid emergency care response, good discharge practice and preventing readmission.

I have attached a copy of the Policy Document, for your information.

In support of delivery of this programme of work the Health Board has an Urgent and Emergency Care Project in place, which is led by the Morriston Service Group.

With reference to Goal 2&3: Signposting people with urgent care needs to the right place, at the right time and providing clinically safe alternatives to admission to hospital

It is anticipated that in ensuring that there are robust alternatives to presenting at an Emergency Department, there will be a reduction in demand. This in turn will enable Emergency Departments to better manage patient flow and capacity.

In developing this model, a Same Day Emergency Care (SDEC) service is available on the Morriston Hospital site. Providing an alternative to presentation at the Emergency Department. This service can sign-post and facilitate urgent review into specialist “hot” clinics and represents a tangible link between primary and secondary care services.

In addition, the Health Board have developed an Acute Medical Unit and recently opened an Older Person’s Assessment and Short Stay Unit (June 2024) on the Morriston Hospital site, which again provides alternative pathways for patient’s presenting to the Emergency Department and funnels into appropriate care delivery settings, including being supported at home by services such as the “Virtual” Ward and Acute Care Team.

With reference to Goal 4: Rapid response to physical or mental health crisis.

This goal focuses specifically on safe alternatives to ambulance conveyance into secondary care, thus enabling a more responsive service to patients who are in danger of losing their life or require access to time-sensitive treatment; such as that for Stroke or life-threatening injury.

There is an inherent expectation that the number of people waiting over 60minutes between arriving by ambulance and being handed over to a clinician, reduces year on year (as per Diagram1).

I would like to offer my sincere condolences to Mr Parker’s family on behalf of the Health Board. Whilst it is fully appreciated that these developments will not change the outcome for Mr. Parker and his family, I hope that you are assured that the Health Board has a clear focus on improvement in access times for unscheduled care with an aim of preventing events, such as those identified in Mr. Parker’s case, from occurring today and in the future.

Yours sincerely,

[redacted]

Chief Executive