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

Our ref: INQ/ABHB70455/DM Direct line 01633 431673 Date 19 April 2018

Ms W James
H M Coroner
Coroner's Office
Victoria Chambers
11, Clytha Park Road
Newport
South Wales
NP20 4PB

23 APR 2018

Dear Mrs. James

I am writing further to your correspondence issued on 6th March 2018, regarding the outcome of the inquest held on 26th February 2018 into the death of Ellie-May Clark on 26th January 2015. In accordance with paragraph 7, Schedule 5 of the Coroner's and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013, you request a response from the Health Board outlining its position and the actions taken to prevent similar occurrences through shared learning and its monitoring and assurance arrangements.

I can confirm that the Health Board has duly noted your recommendations and ensured a formal review of the action plan which was developed and implemented in 2015 immediately following the Health Board's own investigation undertaken by the former Clinical Director, Primary Care Division was completed. This has been conducted in liaison with the Grange Clinic practice.

It may be helpful to clarify that the Health Board does not directly manage the delivery of services or the oversight of staff employed within independent primary care contractors. Independent contractors are directly responsible for ensuring that the delivery of services is safe and also for ensuring that services conform to the expected professional standards and regulations and are appropriately accessible to patients. Nonetheless, there is a requirement for practices to provide assurance to the Health Board in respect of the adequacy of services provided. The Health Board has established processes to monitor the compliance of practices with contractual requirements and to intervene where it has concerns, contractually or professionally.

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The recommended actions arising from this tragic event have now been formally reviewed with the Clinical Director for Quality and Patient Safety and the Quality and Patient Safety Manager for our Primary Care Division. The action plan has been updated to ensure it is reflective of its current state, acknowledges the improvements made and those further developments required to provide ongoing assurances.

During the meeting held with Health Board representatives and the practice on 29th March 2018, there was representation from senior GP and partners, Practice manager, Practice Safeguarding lead, Receptionist and the Practice Nurse with specialist interest in asthma. The practice were able to confirm and provide evidence of completion of actions as outlined following completion of Health Board serious incident investigation and discussion was held regarding any further actions and developments that have arisen from this learning.

I understand that the Practice will be writing to you separately to confirm their specific actions and evidence of implementation of the actions they have taken.

The practice provided confirmation that the duty doctor responsible for triaging deals with this solely and does not take routine appointments. There was evidence of extensive work undertaken to ensure that all existing and new staff members are instructed in a standardised best practice approach and that the standard operating procedure is used by all. A red flag/alert system is now in place to ensure that any patient specific condition concerns will appear on screen to alert the GP during review/consultation.

There has been a significant amount of work undertaken within the practice to address workplace culture issues to promote an open and transparent healthy workplace which is advocated and supported by all partners and practice staff

The Health Board can confirm that those actions and request for assurances outlined in your correspondence have been implemented and continue to be the focus of cross divisional work with primary care and lead consultant paediatricians. I am advised by our Lead Consultant Paediatrician that the consultant leads for asthma have met to discuss Ellie May's case and the Regulation 28 report. He confirms that the plan for the next 6 months includes:

1. An audit of documentation (as per the pathway) of asthma education at discharge.
2. An audit of PAAP (person's asthma action plans) being given in clinic and at discharge.

3. As part of the paediatric consultant's regular commitment to asthma teaching the team provide teaching for peers and juniors around their responsibilities, where adverse outcomes in Gwent are shared in terms of lessons learned, and the need for PAAPs as part of current standards review.
4. The team acknowledge that the high risk children may not be seeing their GPs nor paediatric services, and the team liaise with our Emergency Department(ED) to identify those children who have attended ED for asthma exacerbation more than twice per year.
5. The team recommit to following up all children who have received more than steroids and nebulisers for at least one year and any child that has been to Intensive Care Unit to follow up until transition or exacerbation-free stepdown in preventer treatment down to step 2 or less.
6. If these two groups of patients don't attend then the team will reappoint with a highlighting of neglect, with a referral to safeguarding if they do not attend (DNA) a second time.

Within Primary Care a programme of work in response to the national audit of asthma-related deaths has taken place led by respiratory pharmacists within the Neighbourhood Care Network clusters. This has led to the development of a community pharmacy Local Enhanced Service to identify those patients with review outstanding or who were overusing reliever medication. Support has been enlisted from the respiratory specialist nursing team to support promulgation of learning.

Since the inquest was held further correspondence has been issued by the ABUHB Medical Director to all GP practices and paediatric consultants to ensure that those lessons learned following this sad case are acknowledged and shared by the GP community.

I hope this response has addressed the recommendations outlined and provided reassurance that lessons have been and continue to be learned across the Health Board and the wider GP community. However, if you have any further questions or concerns, please do not hesitate to contact my office on 01633 431673

Yours sincerely

Judith Paget
Prif Weithredwr/Chief Executive