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Cardiff and Vale University Health Board

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Eich cyf/Your ref:
Ein cyf/Our ref:
Welsh Health Telephone Network:
Direct Line/Llinell uniongychol:

28th March 2017

Private and Confidential

Mr Philip Spinney
Area Coroner for South Wales Central area
Coroner's Court
Central Police station
Cathays Park
Cardiff
CF10 3NN

Dear Mr Spinney,

Re: Regulation 28 report – David Robert Griffiths

Thank you for your letter dated 3rd February 2017.

I have reviewed the concerns you've raised within the Regulation 28 report following the inquest regarding the death of Mr Griffiths. My response has been informed by senior clinical and managerial staff who are able to advise me on the arising concerns and pursue the improvements required as a result.

I recognise that this has been a particularly difficult time for Mr Griffiths' family and I would wish to offer them my sincere condolences on behalf of the University Health Board.

You will be aware that the Health Board undertook an internal investigation following the incident involving Mr Griffiths, which was reported to Welsh Government via the Serious Incident reporting procedures in September 2016. Your concerns arising from the inquest align to the findings and recommendations made by the Consultant in Intensive Care Medicine who investigated the incident.

For ease of reference, I have set out below the Health Board's response to the issues you have raised.

- **Consideration should be given to reviewing your procedures related to chest drain insertion and consider introducing an induction programme for all new medical and nursing staff.**

  The UHB has considered the findings of the investigation and has taken the decision to discontinue the practice of inserting chest drains at a 'marked

spot' and is introducing a revised procedure whereby chest drains are inserted under direct vision ultrasound guidance. This was confirmed by the Clinical Director of Radiology and communicated to key senior medical staff across the UHB in early January 2017.

In addition to this, additional support from the Respiratory on-call team has been made available in the in-hours scenario for doctors who require support and are not appropriately accredited. On the rare occasion that an out of hours pleural aspiration or drain insertion is required (e.g. for suspected pleural infection, significant symptomatic or haemodynamic compromise) it has been agreed that the on call medical team should be contacted

A working group has been established with a specific remit to improve the safety of patients undergoing intercostal chest drain insertion and to ensure the Health Board's compliance with the related British Thoracic Society guidance (Reference: Havelock T, Teoh R, Laws D, Gleeson F. Pleural procedures and Thoracic Ultrasound: British Thoracic Society Pleural Disease Guideline 2010. Thorax; 65(suppl 2):ii61-ii76).

There is representation from the Clinical Boards and radiology to consider several issues and it is being chaired by [redacted], respiratory Physician.

- The use of Ultra sound guidance
- The training of staff to use these in and out of hours
- Training in chest drain insertion

This group will also consider the requirement for specific induction in relation to chest drain insertion, on the basis, that registrars and specialist registrars across specific specialities are employed on the basis, that they are already competent in a number of core and essential skills, which would include chest drain insertion. The UHB is currently liaising with the Welsh Deanery on this issue

In relation to general induction programmes for all new medical and nursing staff, the Workforce and Organisational Development Department has procedures in place to assist managers to ensure the appropriate induction of new staff members to an individual department and wider organisation.

Staff members are allocated a day to attend a corporate induction programme for organisational induction. They receive a letter of invitation and managers are required to release staff to attend.

Senior medical staff are offered an opportunity to attend a Senior Medical Staff Induction programme which is coordinated by the Learning, Education and Development Department in conjunction with the Medical Workforce Department.

The Health Board recognises the importance of local induction to individual departments in order to support new employees. A local induction checklist is available to support managers and new staff in the induction process.

Information about induction procedures is available on the Health Board's web site which can be accessed via the link below:
http://www.cardiffandvaleuhb.wales.nhs.uk/induction

It is recognised that requirements for the content of local induction will vary significantly across the many departments within the Health Board. For medical staff, local induction processes are overseen by the relevant Directorate's Clinical Director; by senior Directorate nursing staff for new nurse employees and so forth, depending on the staff discipline.

My response to the concerns that you have raised will be shared with all Clinical Boards with a request that they seek assurance from their Directorates that appropriate induction processes are in place across the Health Board.

- **Consideration should be given to the acquisition of appropriate ultrasound equipment to allow real time guidance of chest drain insertion, pleural procedures and diagnostics.**

I am pleased to be able to advise you that [redacted] Consultant Physician and Respiratory Lead has also coordinated the purchase of two additional ultrasound machines suitable for use in these clinical circumstances. The purchase has been supported by the Health Board's Medical Equipment Group and Procurement Department.

- **Consideration should be given to an ultrasound training programme and governance structure for all practitioners who are responsible for the insertion of intercostal drains.**

It is of paramount importance that staff are appropriately trained to insert intercostal drains using the ultrasound equipment that has been purchased.

A bespoke thoracic ultrasound training course was provided to the Cardiothoracic Directorate on 16th March 2017 with support from [redacted] Davies and the manufacturer of the purchased equipment.

It is recognised that arrangements for ongoing training and competence assessment must be in place across the Health Board and this will be implemented and overseen by the task and finish group.

. The group will report to the Quality, Safety and Experience Committee which receives information regarding Regulation 28 - Prevention of Future Deaths Reports in order to ensure the necessary progress is being made.

Additionally, the Welsh Government issued a Patient Safety Notice PSN034 'Supporting the introduction of the National Safety Standards for Invasive Procedures' in September 2016. Welsh NHS organisations are required to complete the necessary actions on this safety notice by September 2017.

The notice can be accessed via the website link which is provided here for your reference:
http://www.patientsafety.wales.nhs.uk/sitesplus/documents/1104/PSN034%20Supporting%20introduction%20of%20NSSIPs.pdf

A similar safety notice was published in NHS England in September 2015. Resources are therefore developed for use in NHS England that can be adapted and adopted for use in NHS Wales. The task and finish group intends to explore the implementation of a safety checklist for chest drain insertion. An example of such a tool, developed by the Intensive Care Society, is attached in Appendix 1.

I hope that the information set out in this letter provides you with the assurance that the Health Board has fully considered the issues raised as a consequence of the investigation, inquest and your letter of 3rd February 2017, and has taken appropriate action in response.

Yours sincerely

[redacted]

Interim Chief Executive