GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

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Block 5, Carlton Court, St Asaph Business Park, St Asaph, LL17 0JG

Mr John Gittins
Senior Coroner
North Wales (East and Central)
Coroner's Office
County Hall
Wynnstay Road
Ruthin
LL15 1YN

Ein cyf / Our ref: JW/MJ/DL/3127
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☎: [redacted]
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E-bost / Email: [redacted]
Dyddiad / Date: 1st July 2022

Dear Mr Gittins,

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS
Trevor Reynolds

I write in response to the Regulation 28 Report to Prevent of Future Deaths dated 06 May 2022, issued by yourself to Betsi Cadwaladr University Health Board, following the inquest touching the death of Trevor Reynolds.

I would like to begin by offering my deepest condolences to the family and friends of Mr Reynolds, and I apologise for the concerns identified at the inquest that have given rise to your notice.

Firstly, I would like to address the concerns regarding the length of time taken to make changes and how we ensure new working practices are adopted by staff.

Within the Cancer Division, all clinicians and secretaries in oncology and haematology have been made aware of the Standard Operating Procedure (SOP) for the Escalation of Urgent Radiology Results Containing Unexpected Findings. The SOP has been added to the Induction Checklist for all new starters who commence within the Cancer Division and it has been added as a regular agenda item on all secretarial meetings. The learning from this matter has been shared with other health board services.

The Cancer Division have completed two audits of compliance with the SOP (27 May 2022 and 21 June 2022) since the notice was issued. The first audit did identify areas of non-compliance with the SOP, however following further training and reinforcement, the second audit shows the change in procedure has become embedded as normal working practice and there is evidence within the medical notes that action has been taken in all cases. Ongoing monthly audits of the process will be completed and the findings will be reported formally to the Cancer Services Governance Meeting. The SOP has been updated following the results of the audits so far and will be regularly reviewed along with future audit findings.

In respect of diagnostic results and follow up, I am aware this is an issue that you have raised previously, and despite the introduction of written procedures, this does remain a concern. We accept that a resilient solution is needed.

Last year, the Health Board established a Results Management Project with the aim of eliminating printed or hard copy results and integrating reporting to our digital clinical system known as the Welsh Clinical Portal. This work has been developed in collaboration with Digital Health and Care Wales, the national NHS Wales organisation who manage many of our digital clinical systems. I am pleased to advise this development work has been completed and the new electronic functionality has been tested and is ready for roll-out.

Following your notice, our senior medical and quality teams have discussed rapid rollout of this electronic solution. Our intention is to implement this new digital solution over the summer with our respiratory speciality as an early adopter service, with the learning from that implementation informing full roll-out across the health board by the end of the year. A formal evaluation covering the implementation will then take place in January/February 2023.

We have reviewed the case of Mr Reynolds in detail following the inquest and note that the investigation report was completed within the required time and the action plan stated reasonable deadlines; however, these deadlines where not achieved and as you have identified the delivery of actions was unacceptably delayed.

To improve internal oversight, our bi-monthly Patient Safety Report (from June 2022 onwards) will provide a breakdown of all overdue actions by division and service. This report is presented to our Executive-led quality group and ultimately our Board quality committee. This will ensure the visibility of action delivery performance and enable divisions to be held to account for their performance through these governance forums and through their Accountability Review Meetings.

Additionally, we will shortly be undertaking an organisational change process for our quality function and this will provide greater clarity and expectation for quality staff based locally within divisions. They will operate in a business partner model, providing local support at directorate and divisional level with a key part of their role supporting, challenging and reporting on action delivery. We are currently finalising the proposal for this function with a view to the changes taking place over the coming months. A workshop for staff has been arranged for 14 July 2022. This work links to our wider organisational development strategy called Stronger Together, which is also implementing a new operating structure for divisions and new leadership roles with clearly defined responsibilities (this includes delivery of improvement work). This new divisional model is planned for implementation during late summer 2022. I have provided broad delivery dates - the exact dates for this work will be finalised shortly following conclusion of certain workforce change processes.

Additionally, we are currently in the process of reviewing our approach to clinical audit. We will closer align our audit programme with the risks that we have identified through issues such as serious incident reporting and inquest matters. We have also recently procured a new electronic audit system and we are in the process of rolling this out. This system will improve the digital completion of audits and the reporting of assurances.

Taken together, the improved clarity of new leadership roles, improved local support for quality, improved visibility of performance reporting, and a strengthened approach to clinical audit, will allow us to strengthen the timely delivery of actions and the visibility of performance across the organisation.

I hope my letter offers you assurance that we have worked to address the concerns you identified.

One again, please may I offer my condolences to the loved ones of Mr Reynolds.

Should you require any further information or evidence of the actions outlined above please contact either myself or Matthew Joyes, Associate Director of Quality.

Yours sincerely

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Prif Weithredwr/Chief Executive