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

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Kate Robertson
Assistant Coroner
North Wales (East and Central)
Coroner's Office
County Hall
Wynnstay Road
Ruthin LL15 1YN

[redacted]

Dyddiad / Date: 21 June 2023

Dear Ms Robertson,

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS
Nancy Carolyn Price

I write in response to the Regulation 28 Report to Prevent Future Deaths dated 26 April 2023, issued by yourself to Betsi Cadwaladr University Health Board, following the inquest touching the death of Nancy Price.

I would like to begin by offering my deepest condolences to the family and friends of Mrs Price for their loss, and to apologise to them and to yourself for the failures that were identified during the inquest which led to your Notice.

In the Notice, you highlighted concerns regarding the Health Board's strategic management of investigations and improvement actions.

I am aware that we have responded to a Notice form you on 09 May 2023 on the matter of investigations and actions, and we also have a further Notice to respond to along the same subject. I am also aware you met with our deputy director of nursing responsible for patient safety and the head of patient safety on 09 June 2023 to discuss investigations and actions.

For this response I would therefore wish to focus on reiterating the plans we have in place, as advised to you in other correspondence:

- We are re-evaluating the incident process to identify how it can be streamlined and a new procedure document will be developed setting out roles and responsibilities. This will be complete by the end of August 2023.
- We are working to address those investigations currently overdue. A weekly improvement and scrutiny meeting, chaired by the Deputy Directors of Nursing, is held with clinical directors from our services to monitor, track and support the completion of serious incidents.
- We will be strengthening the performance and accountability process with our services to include overdue investigations.

- In April 2022 we migrated to the new national “Once for Wales” Datix system for managing incidents. We are now utilising this system for the recording of actions following an investigation. All actions arising from a completed serious incident investigation will be added to this system on final approval of the investigation report by the Patient Safety Team, in addition to any that have already been identified from the rapid review or Rapid Learning Panel.
- Our divisionally-based Quality Governance Teams will support our services locally with understanding their open and overdue investigations and actions, and will support services to collate evidence of action completion. The Patient Safety Team have the role of monitoring performance and assuring the completion of actions.
- A new Organisational Learning Forum has recently been established. It is chaired by the Deputy Director of Nursing who leads on the patient safety agenda. This monthly meeting considers learning from across the organisation that arises from incidents, complaints, mortality reviews and other processes and is attended by clinical directors from all services with an aim of sharing learning.
- We have moved resources to strengthen our approach to learning, and a new Organisational Learning Manager has been appointed. We have also appointed a Director of Nursing for Quality Assurance and Learning who is supporting the Organisational Learning Forum mentioned above.
- We are strengthening the sharing of learning by developing a digital learning portal, a new lessons learned on a page template and a new learning bulletin.
- We will be strengthening the assurance of learning by developing a new Quality Assurance Framework and a strengthened quality assurance team.
- Over the next few months, our Organisational Learning Manager is engaging with staff across the organisation to understand how we can better support learning. This will develop into a new approach to learning with a framework and toolkit, which will include the actions already mentioned.
- We are looking at best practice both within NHS Wales, across the border and in the private sector. We are hopeful to be getting national support from the NHS Wales Executive to co-pilot an innovative new learning model for the NHS in Wales.
- We are reviewing our training for those undertaking investigations and writing action plans and will launch new training programmes following approval of the new procedure outlined above.
- To support the delivery of safety and quality improvements across the organisation, we have commissioned a Patient Safety Improvement Programme. This patient safety initiative aims to support a culture of safety, continuous learning and sustainable improvement across the healthcare system. The programme will focus on the reduction of avoidable harm through safe and reliable care processes.

As we wrote in our response to your earlier Notice, you will be aware the Health Board has been placed into Special Measures and one domain of this is clinical governance, patient safety and experience and a second domain is learning from incidents.

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The actions we have detailed above form part of our plans for Special Measures, particularly the review of our incident process and ensuring the timely completion of investigations and the timely completion of action plans with evidence. This work is one of our immediate priorities for the first six months of Special Measures.

As part of this Special Measures process we are awaiting an expert independent review into Patient Safety, and a further expert independent review into Clinical Governance will be commencing shortly. We will using the findings of these reviews to help identify and make further improvements to our processes.

We would be happy to meet with you further and discuss our plans in more detail, or provide further information and assurance should that be helpful.

Once again, I offer my deepest condolences to the family and friends of Mrs Price for their loss and I reiterate my sincere apologies to them and to you for the concerns rightly identified at the inquest.

Yours sincerely

[redacted]

[redacted]
Cyfarwyddwr Meddygol Gweithredol / Dirprwy Prif Weithredwr Dros Dro
Executive Medical Director / Acting Deputy Chief Executive

cc [redacted], Executive Director of Nursing and Midwifery
[redacted], Deputy Director of Quality