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

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

[redacted]

Dyddiad / Date: 20 March 2024

Dear Ms Robertson,

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS
Philip David Taylor

I write in response to the Regulation 28 Report to Prevent Future Deaths dated 02 February 2024, issued by yourself to Betsi Cadwaladr University Health Board, following the inquest into the death of Phillip David Taylor.

I would like to begin by offering my deepest condolences to the family and friends of Mr Taylor, and to apologise to them for the failures that were identified during the inquest that led to your notice.

In the notice, you highlighted your concerns about the management of patients placed Out of Area by the Health Board for acute care when there are no available beds within North Wales. You specifically noted a lack of sharing of information, joined up planning meetings, the timely sharing of key documentation and lack of a standard operating procedure defining the standard requirements and expectations between the Health Board and independent providers.

The Health Board recognises that the use of out of area acute beds is a necessity in the current climate and is a nationally recognised issue for all NHS providers. However, the Health Board is committed to ensuring that the safety and experience of those patients is not compromised.

In response to the Notice, I requested our Mental Health and Learning Disabilities Division (MHLD) to consider your concerns and provide details of their plans to make our services as safe as possible, taking into account the learning from the inquest.

After the inquest a memorandum/alert was shared with MHLD staff as an immediate “make safe” notice. This memorandum reinforced the requirements for the monitoring of out of area patients and key responsibilities for roles and wider teams. This memorandum was presented in each area of mental health through the established daily safety huddles, ensuring all staff understood the context of the communication, responsibilities and action. This was disseminated on 08 February 2024 and I can confirm that mental health

services in East, Centre and West are directly overseeing acute out of area patients within their services.

All areas have stood up a formal weekly out of area monitoring meeting. The purpose of this meeting is to promote timely repatriation where possible, assurance that key clinical activity and standards are being met and that discharge plans are being implemented and actioned. These meetings are underpinned by terms of reference, agenda, minutes and a log of actions to be completed. Membership includes the multidisciplinary team, including Health and Social Care, Consultant and Medical staffing, Occupational Therapy, Home Treatment Team and Care Coordinators. Outcomes from the meetings are provided to Divisional Putting Things Right meetings and the weekly Divisional Senior Leadership meeting to ensure appropriate escalation arrangements can be put in place where required.

The learning from the inquest of Mr Taylor has identified that a standard operating procedure is required (SoP) and must include the requirements for sharing information, joined up planning for repatriation and/or discharge and standards for the development and sharing of key documentation.

A multi-disciplinary task and finish group has been established, chaired by the Head of Integrated strategy and development, who is leading on the development of the SoP in collaboration with both operational and clinical teams. Progress will be overseen by the MHLD Policy and Procedure Group. Following ratification, the Task and Finish Group will oversee the launch and implementation of the SoP and compliance with the SoP will be monitored through established local and divisional Putting Things Right Meetings. I am advised that the SoP will be fully ratified by the end of August 2024.

For out of area acute placements, the health board uses providers' identifed as part of the All Wales Commissioning Care Assurance and Performance framework, commissioned by the National Collaborative Commissioning Unit. These providers have qualified to be on the framework by undergoing a robust due diligence process including provision of evidence to demonstrate they are meeting required quality standards with regard to patient safety, quality and experience. The Health board currently uses 3 of the identified providers, including Elysium.

Implementation of the fully ratified SoP, will provide clear direction for health board staff and providers on the framework and will ensure a coordinated approach to the management of out of area placement and optimise communication between all parties.

I share your disappointment that the action plan presented at the inquest of Mr Taylor did not identify the need for stronger governance in relation to the management of acute out of area patients and I would like to advise you that the Health Board is currently reviewing completed proportionate reviews and action plans to identify and address issues such as this. We expect this review to be fully completed towards the latter end of summer 2024.

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I hope this letter sets out for you the actions we have taken to ensure the concerns raised by yourself are being addressed.

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 Mr Taylor for their loss and I reiterate my sincere apologies to them for the concerns identified at inquest.

Yours sincerely

[redacted]

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

cc [redacted], Divisional Director for Mental Health and Learning Disabilities
[redacted], Deputy Director of Quality