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Sarah Riley
HM Assistant Coroner
North Wales (West)
Coroner's Office
Coroner's Office
Shirehall Street
CAERNARFON
Gwynedd, LL55 1SH

Dyddiad / Date: 10 April 2024

Dear Ms Riley,

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS
Teresa Ann Bennett

I write in response to the Regulation 28 Report to Prevent Future Deaths dated 14 February 2024, issued by yourself to Betsi Cadwaladr University Health Board, following the inquest into the death of Teresa Ann Bennett.

I would like to begin by offering my deepest condolences to the family and friends of Ms Bennett.

In the notice, you highlighted your concerns regarding:

- The lack of compliance with the target of 12-15 monthly medication reviews in Health Board managed GP practices;
- The absence of a standard practice for medication reviews leading to a lack assurance that all pertinent matters will be covered and the approach varying between clinicians and practices;
- The risk of inadvertent overdose in individuals like Ms Bennett, where medication that can cause e.g. drowsiness and fatigue, is prescribed alongside strong opiates and other drugs that have the ability to depress the central nervous system when such medicines are prescribed without regular reviews nor specific advice in respect of the associated risks issued to patients.

In response to these concerns, I asked our primary care teams to review and submit improvement actions which are detailed below.

We have commenced benchmarking work on 21 February 2024 for all Health Board managed practices to identify all patients on regular repeat medication who have not got a medication review documented in the notes in the last 12-15 months. This work will be completed by 31 May 2024. These patients will then be risk stratified for medication review. This will occur parallel to implementing new procedures as outlined below.

A pan Health Board policy is now being developed to outline the standards for medication review within our managed practices. This will be completed by 30 June 2024.

In order to ensure we review outstanding patients on repeat medication the policy will risk score patients on a priority level from 1 to 4 and outline exactly who will be included in each level. For example, Level 1 risk patients will be those >75 on polypharmacy, patients on high dose opiates, down to level 4 patients who are under 50 and on less than 4 medications.

Standard Operating Procedures will then be put in place at each practice to add the detail of responsibility and governance of the process; this will differ at each practice due to staffing skill mix.

Practices will report their progress against medication review targets at assurance meetings that will be held regularly (every 2 months). These will be reported at a newly formed managed practice Quality and Governance Group which will cover all North Wales services.

Addressing the concerns regards patient information and their awareness of risks, additional warnings are included on pharmacy labels on the outside of medication boxes, which reference the risks of drowsiness. In addition, patient information leaflets are included in every box which outlines what to do in various scenarios e.g., increased drowsiness, if patches no longer giving pain relief, and if a patch falls off.

Health Board Managed Practices will, from 01 May 2024, add the Faculty of Pain Medicine opioid leaflet onto the clinical system. This will be printed and given to patients on opioids at their medication review, or when opioids are started or doses changed. A copy of this leaflet is attached as an appendix.

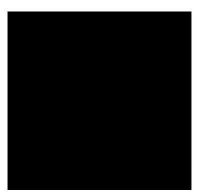
Learning will be shared with independent contractor GP practices via the primary care governance processes.

Our medicines management Local Enhanced Service (LES) running from April 2024 - March 2025 will contain two sections on opioid prescribing. This LES is applicable for all GP practices within the Health Board area and is mandatory.

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

Yours sincerely



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

cc ███, Deputy Executive Medical Director
███, Deputy Director of Quality