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

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Kate Robertson
HM Senior Coroner
North Wales (West)
Coroner's Office
Shirehall Street
CAERNARFON
Gwynedd LL55 1SH

[redacted]

Dyddiad / Date: 23 April 2024

Dear Ms Robertson,

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS
Nesta Jones

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

I would like to begin by offering my deepest condolences to the family of Mrs Jones. On behalf of the Health Board, I apologise to them for the failures in the care of Mrs Jones. I will be writing to them directly to offer our apologies and to offer to meet.

In the notice, you highlighted your concerns about the complaint and incident processes and your concerns about the ability for junior medical staff to challenge already established clinical decisions.

On the issue of medical challenge, I can confirm the Health Board encourages full multi-disciplinary working and actively encourages all staff, regardless of grade or seniority, to raise concerns or differing professional views. All doctors have a duty to listen and act on concerns. Our clinical standards, in accordance with national best practice, establish robust multi-disciplinary team meetings in specialties to review cases collectively. This does however need to be balanced against the responsibility of a medical consultant to make decisions as the most senior clinician in charge of a patient's care.

We are issuing a Safety Alert to share the learning from this case and to highlight and support the improvement of listening to differing professional views and concerns including those from more junior clinicians. This will be shared across the organisation by the end of April 2024.

Since Mrs Jones' death in 2017, we implemented a revised approach for staff to raise concerns outside of their team, if necessary. This new approach, called Speak out Safely, was launched in 2021 and allows any member of staff to raise concerns with a Speak out Safely Guardian or through an anonymous online messaging system where they can

reach senior staff. Whilst we aspire to a culture where concerns are raised and resolved locally, this new system provides an important safety net.

In relation to the complaint process, I can confirm that since Mrs Jones' death the process in the Complaints Team has now changed. A new Complaints Procedure was introduced in March 2022. This procedure includes an escalation process. However, I acknowledge that further improvement is still needed and we are currently undertaking a full review of the complaint process alongside the review of the incident process detailed below. We will create a new, integrated framework that covers incidents, complaints and mortality. This work is underway at present with a view to completion in the next two months.

In addition, as mentioned at the inquest, the Health Board has also launched a new service to allow patients or relatives to escalate their clinical concerns, called Call 4 Concern. The Call 4 Concern Service was launched in Ysbyty Gwynedd during 2022 and following a pilot is now being rolled out at our other general hospital sites this year.

The Call 4 Concern Service enables patients at the hospital and their families to call for immediate help and advice if they are worried that the health care team has not recognised their changing condition. The service is run by the Acute Intervention Team, a group of highly skilled and experienced Advanced Nurse Practitioners available 24/7 to support ward teams in the care of acutely ill patients. Upon receiving a Call 4 Concern, a member of the Acute Intervention Team visits and reviews the patient on the ward. After assessing the situation and liaising with the medical team and other healthcare professionals as needed, the team will ensure the necessary intervention is implemented.

Finally, in relation to the incident process, you will be aware of the Chief Executive's and my own personal intervention in this area as discussed at our most recent meeting and as outlined in previous letters.

The Chief Executive is now personally driving this work which will include a new, integrated framework that covers incidents, complaints and mortality as I have detailed above. The Chief Executive is also personally overseeing performance in relation to overdue incidents and complaints with that area being escalated for close executive scrutiny. As a result, we expect to see significant improvement in the process, and the quality and timeliness of investigations, over the coming months as changes are implemented. We are also engaging the support of the NHS Wales National Executive quality team to support us in this improvement work.

The new framework will include an explicit reference to the national joint memorandum of understanding between the NHS and police, which covers situations where there are concurrent investigations. This will ensure that we operate in accordance with these national standards.

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 to discuss any issue in further detail, or provide further information and assurance should that be helpful.

Once again, I offer my deepest condolences to the family of Mrs Jones and I reiterate my sincere apologies to them for the failures in the standard of care.

Yours sincerely

[redacted]

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

cc [redacted], Deputy Director of Quality