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

Bloc 5, Llys Carlton, Parc BusnesLlanelwy, Llanelwy, LL17 0JG

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

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

Ein cyf / Our ref:
Eichcyf / Your ref:
☎: [redacted]
Gofynnwch am / Ask for: [redacted]
E-bost / Email: [redacted]
Dyddiad / Date: 09 September 2024

Dear Ms Robertson,

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS
Philip Martin Evans

I write in response to the Regulation 28 Report to Prevent Future Deaths dated 18 July 2024, issued by yourself to Betsi Cadwaladr University Health Board, following the inquest touching upon the death of Mr Philip Evans.

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

In the notice, you highlighted your concerns over the quality, effectiveness and timeliness of the Health Board's investigations, leading to issues or concerns with care and treatment not being identified, or identified quickly enough, in order to put in place learning and improvements. You also highlighted you had raised these concerns over a long period of time.

As you know, the Health Board had started actions to implement a new incident procedure from April 2024. However, in response to the increasing number of concerns you raised and our own internal concerns, the new Chief Executive commissioned a significant programme of work to review previous investigations in order to gain a deep understanding of the issues. The Learning from Investigations Programme reviewed 262 investigations against a set of good practice standards that we developed. This work commenced in January 2024 and concluded at the end of June 2024 with a dedicated review team established and an oversight panel of senior leaders reporting to an executive steering group. The findings from this programme led to a clear understanding of where the problems were occurring in our processes.

The Chief Executive therefore commissioned a further programme of work to develop this new Integrated Policy covering Incidents, Complaints and Mortality Reviews. This is known as the Integrated Concerns Policy.

As Executive Director of Nursing and Midwifery, I oversaw this work along with the Acting Executive Director of Therapies and Health Sciences. The new policy was approved at

the Board meeting in July 2024, and become operational from 01 September 2024. My Deputy Directors of Nursing are leading implementation of this new policy through a working group consisting of our Patient Safety Team, Patient and Carer Experience Team, Complaints Team, Clinical Effectiveness Team and Legal Team. As with any major new policy, we expect full implementation to occur over the next three months.

There are a number of changes being made through this policy as follows:

- The new policy has five guiding principles as to how we approach incidents, complaints and mortality reviews, which are that our approach will be: 1) Person-centred, 2) Fair, 3) Open and Honest (candour), 4) Timely, effective and proportionate, and 5) Outcome and improvement focused.
- An Integrated Concerns Hub will meet daily to ensure incidents, complaints and medical examiner referrals are triaged and triangulated to ensure the right review or investigation commences (proportionate to the issue) – our approach will be to *investigate once, investigate well*.
- The Duty of Candour has been embedded into the process so it is seen as an integrated part of, and not separate to, the management of an incident or complaint.
- As part of the new policy, there is new guidance, training and templates to be used and a new portal has been created on our staff intranet to access this in one place.
- Clear deadlines are being set for each review and investigation – a new Investigations Tracker has been developed to monitor progress, which itself is part of our new Quality Dashboard providing ward to Board quality data.
- Clear standards on what is expected in terms of investigation quality and engagement with those affected and those involved.
- A weekly executive meeting will have oversight of commissioned investigations and rapid reviews.
- A clearer and consistent approvals process is now established.
- There are clear accountabilities now set on divisions to deliver the improvement and action plans.
- The Patient Safety Team, Complaints Team and Clinical Effectiveness Team will conduct rolling audits of the Datix system to ensure divisions are uploading their Learning and Improvement Plans to Datix, that actions are being managed within date, and that evidence is being uploaded to support closure. This information will be used as part of governance and accountability processes and meetings to ensure the Health Board is delivering on its improvement commitments.

Later this year, we will also be launching a new Digital Learning Portal which is being designed to capture and cascade learning. Once this is launched, divisions will be responsible for ensuring information is entered into this system to enable learning to be recorded and cascaded across the organisation. This development is the first of a kind in Wales and is currently being actively developed by our IT department.

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I want to assure you that the Health Board has understood and shared your concerns regarding our approach to investigations – and this new Integrated Concerns Policy is in response to those concerns and provides a clear framework for us to change how we work.

I understand you have already been provided a copy of the new policy however I would be happy to meet with you and discuss the policy or our work to improve patient safety in more detail, or provide further information and assurance should that be helpful.

I hope this letter sets out for you the actions that we are taking to address the concerns you raised.

Once again, I offer my deepest condolences to the family and friends of Mr Evans for their loss.

Yours sincerely

[redacted]

[redacted]

Cyfarwyddwr Gweithredol Nyrsio a Bydwreigiaeth
Executive Director of Nursing and Midwifery

cc [redacted], Deputy Director of Quality