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Dyddiad/Date: 21 July 2023

Mr G Hughes
Senior Coroner
South Wales Central
Coroner's Office
The Old Courthouse
Courthouse Street
Pontypridd
CF37 1JW

Dear Mr Hughes

Regulation 28 Report to Prevent Future Deaths

I am writing in response to the Regulation 28 Report issued to Cwm Taf Morgannwg University Health Board (CTMUHB) on 26 May 2023 following conclusion of the inquest into the death of Ms Paige Allen, whilst under the care of Merthyr and Cynon Community Mental Health Services.

The Regulation 28 report outlines the Coronial concern that patients who contact mental health services in CTMUHB, especially at the time of crisis, may be assessed without the assessing practitioner having immediate and comprehensive access to relevant and proximate medical records, notes and plans. More particularly, that should a patient present to mental health services in the Bridgend locality, but have their secondary mental health care managed in either the Merthyr and Cynon (M&C) locality or the Rhondda, and Taff Ely (RTE) locality or vice versa, the assessing practitioner will not immediately have access to that patient's records.

Cadeirydd/Chair: Jonathan Morgan **Prif Weithredwr/Chief Executive:** Paul Mears

Croeso i chi gyfathrebu â'r bwrdd iechyd yn y Gymraeg neu'r Saesneg. Byddwn yn ymateb yn yr un iaith a ni fydd hyn yn arwain at oedi. You are welcome to correspond with the Health Board in Welsh or English. We will respond accordingly and this will not delay the response.

<https://ctmuhb.nhs.wales>

At the time of Paige's death the multiplicity of patient records across the localities was a known risk, and mitigation as it was at the time, was managed under the scrutiny of the locality Quality Risk Safety and Patient Experience (QSRE) meetings that were in place to provide assurance around clinical and patient risk matters. Patient records were variously recorded and stored in a mix of paper and electronic systems that were not necessarily known to all staff, and service specific information systems were not able to support contemporaneous entries in health records that would be accessible to all multi-disciplinary team staff across the mental health service.

Subsequent to the tragic death of Paige, the Health Board has commenced on a programme of significant structural reorganisation which has resulted in the reformation of a pan organisational Mental Health Care Group. This has given clinicians and operational managers the opportunity to begin to address the conditions that lead to inconsistency of approaches of record keeping and information sharing. A key development of the Care group has been the establishment of a Quality Improvement Programme with a number of workstreams, most pertinently a High Quality Clinical Record (HQCR) group which has core goals of putting in place the actions to ameliorate the risks that come from multiple health records and systems and, in time, eliminating those risks through the instigation of a Single Clinical Record.

Chaired by the Clinical Service Group manager for Merthyr and Cynon Locality, with a multidisciplinary group from across CTM, the HQCR has aligned this work with the recommendations and learning from recent external reviews most particularly the May 2022 Health Inspectorate of Wales (HIW) Review of Discharge Arrangements for Adults from Inpatient Mental Health Services within CTMUHB. A programme of work is underway to:

- Standardise approaches to the management of paper records if these are required
- Maximise risk mitigations for existing processes
- Undertake a scoping exercise to phase out paper notes ensuring that the Care Group maximises the use of existing digital systems prior to the implementation of the Single Electronic Record.
- Learn from the clinical record improvement at Ty Llidiard, regional Child and Adolescent Mental Health (CAMHS) in-patient service, whilst recognising that the wider care group has additional challenge in terms of scale and complexity.

The immediate mitigating actions of the HQCR included the review of all paper and electronic archives and systems to ensure that there was a congruence of all care planning documentation for inpatients and outpatients. This ensures, through the use of only approved Inpatient Management Plan and Care and Treatment Plan (CTP), that all staff are clear on what documents should be available to them when seeking them out. In addition, governance measures were introduced to limit access to any patient information held on the W and T electronic drives, with senior level authorisation required in order to gain access,

the purpose of this measure being to limit variation and potential for confusion when accessing information

The HQCR group has undertaken process mapping regarding passing patient information between Community Mental Health Team (CMHT) and Inpatient for admission and discharge developing flow diagrams that have been shared across the Care Group. They have also developed a number of user guides on how to access and use FACE/w-drive when accessing RTE and M&C records. At present the Mental Health teams will continue to use email to share information between RGH and Bridgend but now a secure email inbox is used at all times to ensure confidentiality but also simplifying access and gathering of information.

As a mitigation for the multiple record system that are still in place across the CTM Mental Health service the HQCR Workstream has developed a Clinical Information Access and Recording matrix (CIARM) for clinical team /staff access ("who accesses what system for what purpose") for all systems across the mental health service. This informs all clinical staff of how to access patient clinical risk and discharge planning information both in and out of hours and is the primary tool by which the care Group will mitigate the potential risks inherent with our present multiple systems.

The CIARM covers all clinical areas and teams and will be accessible through the Health Board SharePoint (CTMUHB intranet) system for ease of access from every CTM desktop. A simple Standard operational procedure accompanies the matrix. Local copies have been copied, laminated and distributed to all inpatient units and unscheduled mental health assessment teams and strict version control will be maintained by the HQCR group.

The ongoing implementation, audit and development of future mitigating processes will be reported/escalated routinely by the HQCR group through the Care Group Governance Framework.

In relation to the longer term work to develop safe systems for sharing information, I would like to provide assurance that the Executive and Board are committed to the implementation of a unified electronic record system for the Mental Health and Learning Disabilities Care Group, which includes Child and Adolescent Mental Health Services.

A business case has been developed and endorsed by the Executive. There are however challenges with the preferred national system. The Health Board is working closely with Digital Health and Care Wales and other Health Boards as part of the review of the national strategic programme for the Welsh Community Care Information System. The outcome of this review will influence timescales for WCCIS implementation for the Health Board.

In November 2021 the Health Board signed off a deployment order enabling the move of 460 existing users accessing Welsh Community Care Information System (WCCIS) within the Local Authority over to a health board platform. However, in

March 2022, the project was paused due to health board infrastructure and resource issues.


In April 2023, key stakeholders met to recommence the project with, an initial Programme Board meeting in May 2023 with the Deputy Chief Operating Officer for Primary Community and Mental Health and the Director for Digital undertaking the joint role of Senior Responsible Officers. The next meeting is planned for 10 July 2023, with initial Operational Group to be held on 26 July 2023, chaired by the MHLD Service Director and co-chaired by the Assistant Director of Digital Systems.

Currently, planning is underway for a pre implementation phase to bring all existing users, mainly within the CMHT's who currently use WCCIS via the local authorities, over to a Health Board WCCIS system. The timescale for this is approx. 6 months, however CTM will be meeting with Aneurin Bevan University Health Board on 27 July 2023 to capture lessons learnt from their implementation

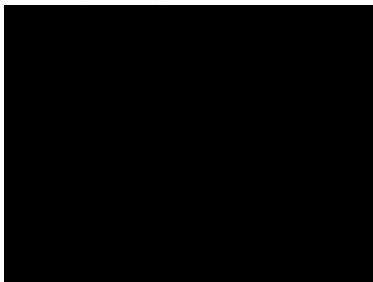
As soon as the above is completed, phase 1 will commence, whereby the rest of CMHT Adults and Older Persons and also Tier 4 inpatients for CAMHS are brought onboard as users. Phase 2 will then see our inpatient and rehab units being brought on board; timescales are dependent on point 2.

The business case is in the process of review, with the lessons from Aneurin Bevan seen as key to fully understanding the resources and approach required to best move forward with minimal delay. In addition the Health Board is working in partnership with Health Education Improvement Wales to develop digital champion roles to influence and lead digital workforce transformation.

I hope that this response provides assurance that CTMUHB are committed to investing in the development and implementation of an integrated single digital health record but also developing robust and sound mitigations that fully address the concerns in the Regulation 28 Report relating to Paige's death.

Please do not hesitate to contact 
Executive Medical Director, if you would like further assurances or if you require a meeting to discuss any arising areas of continuing concern.

Yours sincerely



Prif Weithredwr/Chief Executive