Assurance Framework for the delivery of the Royal College of Physicians' recommendations relating to the casenote review (Cohort 2)

Recommendation 1. The Health Board should consider sharing the outcome of this report with the relevant bodies in Wales, to include Health Inspectorate Wales, the Welsh Health Specialist Service Commissioning and chief medical officer for Wales.

Recommended timescale for completion: 6 months | Lead Officer: Executive Medical Director

	Key actions taken to meet the requirements of the recommendation	Evidence to support action completion	Completion timescale	Additional Actions	Assurance Group	Updated timescales for completion
a	Outcome of report to be shared with HIW, WHSSC and Welsh Government.	Outcomes shared with key stakeholders	Completed	None		

Recommendation 2. The Health Board should consider whether the management of patients, seen in the context of the service provision of TAVI at the time, would amount to a breach of duty of care for the following cases: [14 cases listed]

Recommended timescale for completion: 6 months | Lead Officer: Head of Patient Experience

	Key actions taken to meet the requirements of the recommendation	Evidence to support action completion	Completion timescale	Additional Actions	Assurance Group	Updated timescales for completion
a	Assessment of breach of duty of care	Advice from Legal & Risk team	September 2021	Outcome of legal advice reported to Quality & Safety Committee	Quality & Safety Committee	October 2021
b	Communication with families/next of kin if breach deemed to have occurred	Communication with families	September 2021			

Recommendation 3. The Health Board should ensure that learning takes place within the organisation from the concerns raised about individual cases. In particular, the TAVI team should discuss case RCP38 at a morbidity and mortality (M&M) meeting, as there were important lessons to be learned from this case. Other cases that should be discussed at a M&M meeting are those highlighted under recommendation 2.

Recommended timescale for completion: 6 months | Lead Officer: Unit Medical Director, Morriston Hospital

	Key actions taken to meet the requirements of the recommendation	Evidence to support action completion	Completion timescale	Additional Actions	Assurance Group	Updated timescales for completion
a	Dedicated Morbidity and Mortality meeting to discuss highlighted cases.	Minutes from Morbidity & Mortality meeting	Completed	Lessons learned and any action plan to be shared with Quality and Safety Committee		October 2021
b	Lessons learned to be collated and developed into action plan by Directorate team	Action plan arising from review of cases	Completed			
c	Any action plan arising from R3b to be reported to TAVI Gold meeting	Action plan arising from review of cases	September 2021			

Recommendation 4. **The Health Board should take steps to learn from several cases that were outside the scope of the review as the patients were never actually on the TAVI pathway. The fact that patients did not reach the TAVI pathway was itself a cause for concern in the following cases: [6 cases listed]**

Recommended timescale for completion: 6 months | Lead Officer: Unit Medical Director, Morriston Hospital

	Key actions taken to meet the requirements of the recommendation	Evidence to support action completion	Completion timescale	Additional Actions	Assurance Group	Updated timescales for completion
a	Cardiology Directorate team to review the cases highlighted and provide assurance to TAVI Gold that the improved pathway oversight mean this could not happen again	Report to TAVI Gold on review of cases and assurance regarding governance and oversight of current waiting list arrangements	Completed	None		

Recommendation 5. **In considering the findings of this report, and particularly recommendations 2, 3 and 4, the Health Board should give thought to offering the families of patients concerned an opportunity for discussion about the learning derived from this review.**

Recommended timescale for completion: 6 months | Lead Officer: Head of Patient Experience

	Key actions taken to meet the requirements of the recommendation	Evidence to support action completion	Completion timescale	Additional Actions	Assurance Group	Updated timescales for completion
a	Communication with all families of patients to offer the opportunity for discussion about learning derived from the	Communication with families and notes from meetings	September 2021	None		