Eluned Morgan AS/MS
Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol
Minister for Health and Social Services

Llywodraeth Cymru
Welsh Government

Our ref: WQ84844

Russell George MS
Senedd Constituency Member for Montgomeryshire

Russell.George@senedd.wales

22 April 2022

Dear Russell

I write further to your written question of 31 March in which you asked if I would publish copies of the letters sent by the Chief Medical Officer and Chief Nursing Officer to health boards regarding the inclusion within their investigations of families who have raised complaints about NHS services received, and the Putting Things Right process. Please accept my apologies for the delay in responding.

I have no plans to publish the letters but they are attached for your records. Following this, a further letter issued from the Deputy Chief Medical Officer confirming the funding I had agreed to take forward at pace the work arising from the Investigating and learning from cases of Nosocomial Covid-19. There are no plans to publish the individual letters that issued to the health boards. I have, however, provided below the work programme for all the health boards/trusts as provided in the individual letters.

Health Boards/Trust will be expected to:

- Put in place the necessary resource and infrastructure to deliver the programme of investigation work in relation to patient safety incidents of nosocomial COVID-19. Investigation work must be completed in line with the NHS Wales national framework – Management of patient safety incidents following nosocomial transmission of COVID-19 (national framework). This includes investigating cases where a person has acquired nosocomial COVID-19 in a care setting while receiving NHS funded care and when individuals were transferred from hospital into a care home and subsequently contracted COVID-19, within 14 days of transfer. The national framework is currently being updated to provide further clarity of these requirements for NHS funded care.

- Establish relevant internal assurance mechanisms such as scrutiny panels.

- Proactively engage with patients and families who have been affected by incidents of nosocomial COVID-19, including advocacy through the CHC

- Put in place the necessary infrastructure to provide a dedicated point of contact for supporting families for five days a week.

- Develop robust governance structures, including:

    - internal mechanisms to ensure your Board is fully appraised of progress with investigations; and
    - reporting mechanism to update NHS Wales Delivery Unit (DU) on progress. Monthly reporting against an agreed reporting framework will be required. Further details on this will be provided by the DU.

- Engage with colleagues in the DU who will have overall responsibility for national leadership and oversight in relation to implementation and application of the national framework.

- Work with the DU to develop the national learning plan which will incorporate the lessons learned throughout the pandemic.

The investigation work covers all NHS funded cases of Nosocomial COVID 19 infection including those who have raised a concern under the PTR process.

In addition pleased find enclosed the following letters which have issued in relation to engagement and keeping patients and families up to date with the review process and outcomes:

- 18 March and 13 August 2020 at the beginning of the Coronavirus pandemic, which stated the importance of engaging with families who have raised concerns

- 6 December 2021 about the investigation of patient safety incidents following nosocomial transmission of COVID-19

Yours sincerely

Eluned Morgan AS/MS
Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol
Minister for Health and Social Services

Bae Caerdydd • Cardiff Bay
Caerdydd • Cardiff
CF99 1SN

Canolfan Cyswllt Cyntaf / First Point of Contact Centre:
0300 0604400
Gohebiaeth.Eluned.Morgan@llyw.cymru
Correspondence.Eluned.Morgan@gov.wales

Professor Chris Jones
Dirprwy Brif Swyddog Meddygol
Deputy Chief Medical Officer

Sue Tranka
Prif Swyddog Nyrsio – Cyfarwyddwr Nyrs GIG Cymru
Chief Nursing Officer – Nurse Director NHS Wales

Llywodraeth Cymru
Welsh Government

TO:
Chief Executives Health Boards/Trusts
Chief Nursing Officers Health Boards/Trusts
Medical Directors Health Boards/Trusts
Leads Putting Things Right Teams
Finance Officers Health Boards/Trusts

cc: NHS Delivery Unit, NHS Wales

26 January 2022

Dear Colleague

Investigating and learning from cases of hospital-acquired Covid-19

Today Eluned Morgan, Minister for Health and Social Services announced funding to support delivery of the programme of investigation work into cases of hospital-acquired Covid-19 you are undertaking.

Many of you have started work on this important area and the All Wales funding announced today, £4.5m over two years, will enable you to progress this work at pace and extend into other areas including care homes. Please find a link to the Minster's statement which provides further details.

Written Statement: Investigating and learning from cases of hospital-acquired Covid-19 (26 January 2022) | GOV.WALES
Datganiad Ysgrifenedig: Ymchwilio i heintiadau COVID-19 a gafwyd yn yr ysbyty a dysgu ohonynt (26 Ionawr 2022) | LLYW.CYMRU

The NHS Delivery Unit (DU) will continue to provide a national oversight function in relation to implementation of the national framework. The DU will continue to support health boards/trusts with the ongoing challenges of operational implementation and promote as much all Wales consistency as practically possible.

Further letters will issue to each of you to provide details about your funding allocation.

We would again like to take this opportunity to thank you and your staff for all of your hard work during this challenging time.

Yours sincerely

PROFESSOR CHRIS JONES **SUE TRANKA**

Professor Chris Jones
Dirprwy Brif Swyddog Meddygol
Deputy Chief Medical Officer

Llywodraeth Cymru
Welsh Government

To: Directors of Nursing NHS Wales
Medical Directors NHS Wales

18 March 2020

Dear Colleagues

Implementation of Putting Things Right during the time of coronavirus (COVID-19)

I understand the pressures health boards and trusts are under at the moment as a result of coronavirus (COVID-19). You may be considering the deployment of corporate staff into direct patient care in order to cope with the additional demand on services.

I appreciate that in these challenging times there may be occasions when you will need to curtail corporate business and you may be considering how best to manage your Putting Things Right (PTR) procedures. I urge you to continue to adhere to the National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 for the Putting Things Right process wherever possible.

Concerns

It is important that investigations into concerns are not curtailed, but are proportionate to the concern. If there are likely to be any delays in responding to concerns, you should continue to inform complainants of any delay and the reasons for it. You may wish to explain that there may be delays in responding to their concern due to essential staff redeployment due to coronavirus. As you know, it is essential to keep complainants informed of the progress of their concern and this should be the case for existing as well as new complaints.

Community Health Councils will also be stretched to provide advocacy services to complainants and so we would ask you to exercise your discretion and look favourably on accepting complaints that are submitted after the initial 12 month deadline.

Serious incident (SI) reporting

As with concerns it is important that the investigation of patient harm continues to ensure good quality care provision is maintained and the learning shared. For this reason we still expect organisations to investigate serious incidents locally in line with PTR guidance. We are looking to relax the reporting of some incidents however

to Welsh Government whilst the NHS is experiencing significant pressure as a result of the coronavirus. With immediate effect NHS organisations will therefore only need to report the following serious incidents to Welsh Government:-

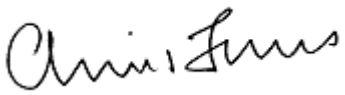
- all never events
- in patient suicides
- maternal deaths
- neonatal deaths
- homicides
- unexpected deaths – adults and children
- Human Tissue Authority incidents
- incidents of high impact and likely to happen again (for local decision)

NHS organisations will not be required to undertake full root cause analysis for each incident. The investigations carried out should be proportionate to the incident being reviewed and should ensure immediate 'make safes' are put in place with all learning shared across the organisation in the usual way. These changes are temporary but they are in line with the suggested revision of the incident reporting policy currently underway.

In terms of the formal 60 day target for SI closure reporting Welsh Government had already decided to remove this from the NHS Wales Delivery Framework from 1 April 2020. Again with immediate effect NHS organisations will still be required to work towards the 60 days as a guide, but will not be formally monitored against it.

Finally to ease pressure on staff, you may wish to request your local coroner wherever possible does not call staff to give evidence unless essential.

Yours faithfully



PROFESSOR CHRIS JONES
DEPUTY CHIEF MEDICAL OFFICER

CC: Professor Jean White, Chief Nursing Office

Professor Chris Jones
Dirprwy Brif Swyddog Meddygol
Deputy Chief Medical Officer

Sue Tranka
Prif Swyddog Nyrsio – Cyfarwyddwr Nyrs GIG Cymru
Chief Nursing Officer – Nurse Director NHS Wales

Llywodraeth Cymru
Welsh Government

Medical Directors NHS Wales
Directors of Nursing

6th December 2021

Dear Colleagues

Investigation of incidents of Nosocomial transmission of Covid-19.

We are aware that questions are being asked about the investigation of patient safety incidents following nosocomial transmission of COVID-19.

In accordance with the '***NHS Wales national framework – Management of patient safety incidents following nosocomial transmission of COVID-19***' that was developed and agreed by the NHS and the Delivery Unit in March of this year1, such investigations should be conducted in compliance with the National Health Service (Concerns, Complaints and Redress Arrangements)(Wales) Regulations 2011.This includes arrangements for contacting patients or their families to advise them of any review and keeping them up to date with the review process and outcomes.

It has also come to our attention that a number of families consider there has been delay in dealing with subject access requests. We would be grateful if subject access requests could continue to be dealt with in line with the requirements of GDPR legislation.

I am sure you will understand the importance of engaging with patients and families and ask that you make every effort to respond to questions and concerns in a timely manner.

Yours faithfully

PROF CHRIS JONES

SUE TRANKA

Professor Chris Jones
Dirprwy Brif Swyddog Meddygol
Deputy Chief Medical Officer
Dirprwy Gyfarwyddwr Gofal Iechyd Poblogaeth
Deputy Director Population Healthcare Division

Llywodraeth Cymru
Welsh Government

13 August 2020

Dear Colleagues

I wrote to you on 18 March 2020 advising of changes to the Putting Things Right (PTR) serious incident reporting requirements and again on 17 April 2020 advising of changes to mortality reviews, during the time of coronavirus (Covid - 19). This allowed for the temporary suspension of some serious incidents to be reported at a national level and the suspension of some mortality reviews to ease the burden on NHS organisations as a result of the pandemic.

As we are now seeing a reduction in the number of coronavirus cases in Wales and the easing of restrictions, it seems an appropriate time to re-instate reporting arrangements and request that all health boards and NHS Trusts report to Welsh Government in line with PTR guidance. This return to full reporting should incorporate serious incidents which are Covid-19 related, including for example indirect harm as a consequence of being unable to provide care in a timely way. More generally, I would like to also remind organisations that any serious harm or death which is associated with a delay in diagnosis and/or treatment, including whilst a patient has remained on a hospital waiting list, constitutes a serious incident and needs to be reported and investigated as such.

This is also an opportune time to reinstate the requirement to undertake mortality reviews for inpatient deaths, particularly as the Medical Examiner Service, which will assume responsibility for conducting the Stage 1 / UMR function, is in the process of being implemented across Wales.

Finally most of you will be aware we are currently reviewing serious incident reporting with a view to developing a quality assurance framework which will incorporate serious incidents. This work is on-going and is focussing on the need for shared learning to improve patient outcomes. We are also considering options on where the reporting of serious incidents best fits going forward, at a national level. We will be working with organisations as this work progresses.

Yours sincerely

PROFESSOR CHRIS JONES