



GIG  
CYMRU  
NHS  
WALES

Bwrdd Iechyd Prifysgol  
Aneurin Bevan  
University Health Board

Freedom of Information Request

FOI 22-440

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**Families from wave 1 would be the first group to be contacted, as well as families that had already submitted their own concerns via the putting things right process, I can see Donna has referenced this below. Therefore, some people in this priority group may be contacted if the event that impacted their family was Oct 2020 or Jan 21 as in your examples, due to already having submitted a formal complaint. Largely, the first contacts will be wave 1, with some later cases too due to PTR initiation. At the time of launching this national programme, ABUHB were hopeful that wave 1 (plus PTR cases) would all be contacted by July/August and then moving on to wave 2 and later cases in quick succession.**

***However, this isn't the case hence our questions. Members from Wave 1 that have made a complaint haven't been contacted but others from Wave 1 that didn't have. Some from Wave 2 made a complaint have been contacted some haven't. Can you confirm why?***

The Health Board COVID-19 Investigation Team are systematically working through caseload in line with the National framework. Families that have submitted concerns via the Putting Things Right process are also being prioritised. Attempts have been made to contact families from Wave 1 by telephone, with varying success. At this point in time contact has also been made with some cases from Wave 2 that have submitted concerns through Putting Things Right.

**Consent - I understand that consent can come from a letter or an email to the team. I don't believe there is any formal form, as a letter or email is sufficient for formal written consent. I recall from our meeting that you mentioned your sister had been contacted, as this was sited from the "contact details" in your late father's medical record, but if the health board are now aware that the next of kin is still your mother, then consent from your mother is required. So a letter/email from your mother to the team will be sufficient to secure consent for the team to include you too. I can see Donna provided the mailing address below.**

***But who are they contacting- next of kin or key contact? If they are contacting key contact why aren't they getting approval from next of kin first? My mother has always been next of kin, other members are also next of kin and yet the HB are contacting someone else with no approval from next of kin. This is vitally important where the next of kin would not want someone else to be involved and yet the next of kin isn't even aware that someone else is involved in the investigation.***

***When one of our members contacted your team about next of kin approval they were advised they had to complete a form- is this correct or not as we're being given different info***

The Health Board COVID-19 Investigation Team is taking all reasonable steps to contact the appropriate person. The team are using the information available

within clinical systems to initiate contact, this may be Next of Kin or primary contact. If it's confirmed that this person or an alternative person is nominated to be involved in the investigation, written consent (email/letter) from the Next of Kin is required in order to proceed.

**On "who" will be contacted for your wider group members, this will be very individual depending on the contact details and next of kin cited in records, or dependent on whether someone gave specific instructions on a primary contact if the next kin wasn't preferred. So I'm afraid it isn't possible to be concrete on who will be contacted, as I explain, it will be very individual and I'm hopeful that in most cases, contact will largely be the recorded next of kin/preferred contact.**

***So from a GDPR perspective are you saying the next of kin is not always captured on the patients record?***

Next of Kin information is not always available. Next of Kin/Primary Contact information captured in patients notes and on clinical systems would have been checked with the patient when they were alive at each attendance at hospital whether it is an outpatient appointment or as an inpatient.

**The scope of the programme is all cases of hospital acquired COVID-19 infections.**

***The question isn't just who will be investigated but what does the investigation cover.***

***The definition of nosocomial infection is 14+ after a negative test, probable 8 days + and yet the FAQ says 48 hours. Can you confirm if only those that tested 8+ days will be investigated or it's wider than this?***

***Is the scope finding out how the hospital gave the patient Covid at an individual level? Is it their treatment before and after diagnosis? The lack of infection control? Lack of communication? Does it include DNACPRS? Palliative care? Human Rights? Bereavement support? Is it to aggregate all the individual issues into a hospital and health board level report of what went wrong and recommendations? Plans to implement and ongoing monitoring?***

***Will the Welsh Gov be reporting as national and health board level like Ombudsman outcomes- upheld, party upheld etc?***

The purpose of the review is to conduct a proportionate investigation into the care people who tested positive for COVID-19 received whilst in receipt of our services in line with the parameters of the National framework. The review is based around 4 key themes;

- 1) Symptoms & Testing
- 2) Environmental
- 3) Contact Management
- 4) IPC Precautions

and also takes into account other factors (avoidable or unavoidable) relating to the patient's overall management that could have contributed to the acquisition of COVID-19 whilst in hospital. The collective findings will inform learning and required actions at both Health Board and National level.

**Learning and recommendations – as you know, the Delivery Unit has oversight of the national programme and I understand a national learning and improvement programme will be collating national learning. Having discussed local learning here, Aneurin Bevan UHB monitor local learning from themes or serious/good practice outcomes through their quality and patient safety committee and then their Public Board. On an individual level, each family's investigation will produce a formal investigation report, so individual families will have their own outcome report following each investigation. I know this national programme is looking towards March 2024 as the full programme, but I'm not able to confirm when the Delivery Unit might publish overall learning or recommendations.**

***How can we find out how the national learning will be collated and implemented? Why aren't there regular updates on their findings at a health board level and plans of action? We need them to implement change now not in 2024.***

The NHS Wales Delivery Unit will produce an interim learning report at the end of the financial year (March 2023) and will be submitted to Welsh Government. This coincides with the end of the first year of the programme and the timing will ensure sufficient validation of the learning and actions required, including a handling plan.

**On the matter of families being asked "what they want investigated", I'm of the understanding that during the UHB calls to families, when the first contact is made and the investigation process is being explained, people are being asked (in a sensitive way) if there is anything that the family feel the investigation needs to cover, from the family's point view. To ensure that their current questions/worries/experiences are covered during the investigation. I support this approach as it ensures the family's input and direction setting is welcomed and the family's wishes for specific answers are dealt with in the investigation and report.**

***Members are confused as they want to know what is being investigated. If they ask for something that isn't in scope what happens?***

Inviting family involvement in the investigation is by nature going to be experiential. If a family ask for something that is not related to the scope of the COVID-19 Investigation they would be sign posted to the appropriate service for example the Putting Things Right Team, Community Health Council for independent advice advocacy and support services or Care After Death Team.