# WRITTEN STATEMENT

# BY

# THE WELSH GOVERNMENT

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| **TITLE**  | **Investigating and learning from cases of hospital-acquired Covid-19**  |
| **DATE**  | **14 August 2024** |
| **BY**  | **Mark Drakeford MS, Cabinet Secretary for Health and Social Care** |

Throughout the Covid-19 pandemic, the NHS in Wales worked incredibly hard to keep the virus out of our hospitals and protect people who were being cared for in difficult conditions. However, despite strict infection control procedures, due to the high transmissibility of the virus, nosocomial (hospital-acquired) Covid-19 infections occurred and, sadly, in some cases people suffered harm or died.

When such incidents occur, it is important NHS Wales is open with those affected and their families and that clinical teams carry out investigations to find out what happened, what lessons can be learned and what needs to happen next to reduce the likelihood of it happening again. It is important the NHS shares the results and findings from these investigations so care can be improved.

In January 2021, the former Cabinet Secretary for Health and Social Care agreed to provide £4.54m pa year, over two years, to support health boards, NHS trusts and the NHS Wales Executive to carry out a major and complex programme of investigation work into cases of hospital-acquired Covid-19. I would like to acknowledge the part played by the Bereaved Families for Justice Cymru in the setting up of this programme.

I am pleased to report that this work has been completed and the NHS Wales Executive has today published its [National Nosocomial Covid-19 Programme End of Programme Learning](https://www.nhs.wales/national-nosocomial-covid-19-programme).

More than 18,360 cases have been investigated, providing reports to individuals, loved ones and families, as well as capturing valuable learning for the NHS. By acknowledging and recognising the impact of Covid-19 on individuals, families, carers and NHS Wales staff, the programme has taken a learning approach that aims not to place blame but maximise the opportunity for learning and improvement.

Expanding on the themes identified in the *Interim Learning Report*, which was published in March 2023, the *End of Programme Learning Report* highlights further national learning in relation to communication with families and carers, clinical record keeping, staffing and resource, discharge planning and the impact of hospital environments.

In addition to the learning that has been captured through investigation processes, the report also acknowledges areas of good practice from across NHS Wales. Recognising and sharing good practice is essential to drive improvements in quality, safety, and experience. Examples of good practice have been identified in a number of areas such as the compassion demonstrated by staff, the way organisations rapidly responded to the pandemic, collaborative working, and the implementation of a number of patient safety initiatives.

Learning and good practice from the programme has been shared at a range of local and national forums and will continue to be used to inform improvements in quality, safety, and experience.

Learning from the investigations is of paramount importance and I welcome this final report. I am committed to ensuring these findings will lead to meaningful change and improvements in the quality and safety of patient care.

I would like to thank all the individuals and organisations across the NHS in Wales for their commitment and dedication to this challenging work. I also pay tribute to, and thank, all the families who lost loved ones for their patience as we have worked to find answers for them.

This statement is being issued during recess in order to keep members informed. Should members wish me to make a further statement or to answer questions on this when the Senedd returns I would be happy to do so.