Witness Name: Judith Paget
Statement No.: WITN5712002
Exhibits: WITN5712003 – WITN 5712009
Dated: 13 September 2023

INFECTED BLOOD INQUIRY

WRITTEN STATEMENT OF JUDITH PAGET

I provide this statement in response to a request under Rule 9(1) and (2) of the Inquiry Rules 2006 dated 14 August 2023.

I, Judith Paget, will say as follows: -

Section 1: Introduction

1. My name is Judith Paget, Director General of Health and Social Services/Chief Executive of NHS Wales. My work address is Welsh Government, Cathays Park, Cardiff, CF10 3NQ .

2. I was appointed as the interim Director General in November 2021 and have held the post permanently since June 2023. Prior to this I was Chief Executive of the Aneurin Bevan University Health Board.

3. Catherine Cody and Teresa Bridge, Senior Policy Officials within the Welsh Government's Department of Health and Social Services (DHSS) have been involved in providing advice and information to me in respect of the issues set out below.

Section 2: Evidence

1. You will see that Mr Bragg proposes that there should be a statutory responsibility for all employees in the NHS to make a report when serious injury or death has occurred which might have been preventable, and that there should be a new, single organisation with responsibility to collect such information, to investigate incidents and to make sure that effective action has been taken. Please set out your response, from the perspective of the Welsh Government, to this proposal. Please provide any further comments regarding Mr Bragg's proposals that you wish to provide.

2. You will see from the statement of Ms Braithwaite that the Professional Standards Authority for Health and Social Care supports the establishment of a single body responsible for overseeing the safety system for health and social care. To the extent not already addressed above, please set out your response, from the perspective of the Welsh Government, to this suggestion.

3. You will see from the statement of Dr Benneyworth that the Healthcare Safety Investigation Branch in England supports the operation of safety management systems and towards this the aggregation of data regarding patient safety collected by local, regional and national organisations to inform the identification of patient safety priorities. To the extent not already addressed above, please set out your response, from the perspective of the Welsh Government, to this suggestion. As part of this, please set out your views as to the appropriate body or bodies who should be responsible for identifying patient safety priorities from aggregated data about patient safety.

4. In Wales, we have taken steps to address these issues and have clearly set out the actions we expect those working in NHS bodies in Wales to undertake when a serious injury or death has occurred. It is important that we learn from such incidents and our newly established NHS Executive will use the data collected to inform assurance activities across our NHS bodies.

5. The following response addresses the above questions and details the organisations and process we have in place in Wales.

6. The written statement of Professor Chris Jones [WITN4065010] dated 25 November 2022 provides information at Section 7 on the statutory Duty of Candour which came into force on 1 April 2023 [WITN5712003]. At paragraph 10 it provides our response on the role of the Commissioner.

Statutory Duty of Candour

7. The organisational duty of candour applies to all NHS bodies in Wales and requires them to be open and transparent with service users when they experience harm whilst receiving health care. Regulation 9(1) of the Duty of Candour states 'The responsible body must keep a written record for each notifiable adverse outcome in respect of which the candour procedure is followed.'

8. The duty of candour builds on the National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) (Amendments) Regulations 2011 [WITN5712004] and [WITN5712005] which established the Putting Things Right process, introduced redress on NHS bodies in Wales, and requires NHS bodies to be open and transparent when things go wrong for patients in their care. Regulation 23 states that all concerns (complaint, claim or reported patient safety incident) must be managed and investigated in the most appropriate, efficient, and effective way. The intention is 'to investigate once, investigate well'.

Reporting of patient safety incidents

9. NHS bodies in Wales report all patient safety incidents, including near misses, through Datix Cymru, the incident reporting module of the Once for Wales Concerns Management System [WITN5712006]. The system has been developed to ensure a consistent national approach to data collection and analysis across Wales. NHS bodies have systems and processes in place to investigate incidents, analyse data, identify risks, themes, and trends to extract learning and disseminate throughout their organisation. It is important that incidents are

investigated locally so NHS bodies can learn from what may have gone wrong and make improvements to prevent reoccurrence.

NHS Wales Executive

10. The NHS Wales Executive provides an oversight and assurance function to ensure information shared about investigations is of good quality, utilises a suitable approach and is undertaken in a timely manner. Where necessary, the NHS Wales Executive seeks further assurance from the reporting health body.

11. Learning from data and intelligence from nationally reportable incidents are used by the NHS Wales Executive to inform local and national assurance activities, for example the development of patient safety alerts, notices, policies and improvement programmes. Before the NHS Wales Executive came into being in April 2023, these reports were made to the NHS Wales Delivery Unit.

12. Nationally Reportable Incidents (NRIs) are also reported to the NHS Wales Executive as set out in the National Policy on Patient Safety Incident Reporting and Management [WITN5712007]. NRIs are defined as 'patient safety incidents which cause or contribute to *unexpected* or *avoidable death,* or *severe harm*, of one or more patients, staff or members of the public, experienced during NHS funded healthcare'. All NRIs are subject to investigation by health bodies in accordance with the principles set out in the Putting Things Right process. Investigation outcomes, actions and learning must be submitted to the NHS Wales Executive.

13. Reporting nationally to the NHS Wales Executive provides oversight and assurance of incidents that cause most harm and/or high levels of service impact and inform national learning and action e.g. development of patient safety solutions, policies and improvement programmes. National patient safety alerts issued by NHS Improvement, England are adapted for Wales by the NHS Wales Executive and disseminated across NHS Wales.

14. The NHS Wales Executive has developed a National Quality Management System (NQMS) to support the management of quality and safety intelligence across NHS Wales. Intelligence from the system is integrated with that of the Welsh Government performance assurance framework [WITN5712008]. Integration of quality and safety intelligence with performance provides a rounded picture of organisations which can be used as an early warning to identify where support for an organisation can be provided or if escalation is required.

15. The NHS Wales Executive undertakes a regular review of quality intelligence including NHS Wales organisations' board papers, NQMS data dashboards, NRIs, Never Events, Healthcare Associated Infections (HCAIs), mortality rates and compliance with Patient Safety Solutions (Alerts and Notices). The team identifies any emerging risks which may need escalating at Integrated Quality, Planning and Delivery (IQPD) and look for local and national themes for learning. IQPD meetings are held monthly between Welsh Government and NHS Wales organisations to discuss, challenge and assess their ability to deliver quality services.

Healthcare Inspectorate Wales (HIW)

16. HIW is the independent inspectorate and regulator of healthcare in Wales. It is responsible for inspecting, reviewing and investigating NHS services and regulating independent healthcare services throughout Wales. It undertakes reviews of NHS bodies in Wales in response to concerns arising from a particular incident or incidents as well as undertaking national reviews. The NHS Escalation and Intervention Arrangements [WITN5712009] sets out when the Welsh Government, Auditor General for Wales and HIW will work together to share information and respond when issues of concern become apparent in NHS bodies in Wales.

Care Inspectorate Wales (CIW)

17. CIW is the independent regulator of social care and childcare in Wales. It inspects and drives improvement of regulated services and local authority social services. It undertakes national reviews of social services.

Statement of Truth

I believe that the facts stated in this witness statement are true.

Signed GRO-C

Dated 13 September 2023

Exhibit Table

Date	Title	URN
25 November 2022	Prof Chris Jones Witness Statement	WITN4065010
April 2023	Duty of Candour	WITN5712003
8 March 2011	National Health Service (Concerns, Complaints and Redress)	WITN5712004
Amendment Regs 7 March 2023	Arrangements) (Wales) (Amendments) Regulations 2011	WITN5712005
	Once for Wales Concerns Management System	WITN5712006
12 May 2023	National Policy on Patient Safety Incident Reporting and Management	WITN5712007
June 2023	Welsh Government performance assurance framework	WITN5712008
March 2014	The NHS Escalation and Intervention Arrangements	WITN5712009