| | | | |
|---|---|---|---|
| **Meeting Date** | **28 July 2022** | **Agenda Item** | **2.1** |
| **Report Title** | **Progress against national nosocomial COVID-19 action plan** | | |
| **Report Author** | Andrea Folland, Nosocomial Review Team Manager | | |
| **Report Sponsor** | Richard Evans, Executive Medical Director / Gareth Howells, Executive Director of Nursing / Hazel Lloyd, Acting Director of Corporate Governance | | |
| **Presented by** | Gareth Howells, Executive Director of Nursing / Hazel Lloyd, Acting Director of Corporate Governance | | |
| **Freedom of Information** | Open | | |
| **Purpose of the Report** | To provide the Board with:<br>• an update on work carried out to review cases of COVID-19 which were contracted in healthcare settings (nosocomial);<br>• an update on work carried out to notify families of deceased patients who contracted COVID-19 in healthcare settings of the review process;<br>• assurance in terms of the process followed to date and for the next phase; and<br>• an outline of next steps and timescales. | | |
| **Key Issues** | In line with national requirements on NHS organisations in Wales, reviews into nosocomial transmission of COVID-19 continue to be undertaken at SBUHB.<br><br>In 2022, the Board was notified of the commencement of the phase of activity which includes communicating with the families of patients which started in June 2022.<br><br>Meetings with Service Groups are being established, as well as a recommencement of Scrutiny Panels, to determine whether case reviews have identified any care/service delivery issue relating to the contraction of Covid-19. Lessons learnt in relation to the improvement of systems and processes will also be discussed at these meetings.<br><br>The outcome of the meetings will enable further communication with patient relatives to inform them of the | | |

<table>
<tr><td></td><td colspan="4">conclusion of the review and subsequent action, where necessary.<br><br>A further report will be submitted to the Management Board in September to consider the position at that time and how we increase the rate of contact with the families.</td></tr>
<tr><td rowspan="2">Specific Action Required<br>(please choose one only)</td><td>Information</td><td>Discussion</td><td>Assurance</td><td>Approval</td></tr>
<tr><td>☐</td><td>☐</td><td>☒</td><td>☐</td></tr>
<tr><td>Recommendations</td><td colspan="4">Members are asked to:<ul><li>NOTE the progress made in reviewing nosocomial COVID-19 cases within the health board;</li><li>NOTE the work undertaken to align the activity of the Health Board with the requirements of the National Nosocomial COVID-19 Programme; and</li><li>NOTE the position in relation to communicating this work to patient families; and</li><li>AGREE for a further report updating the Board on progress to be received in November 2022.</li></ul></td></tr>
</table>

## Progress against national nosocomial COVID-19 action plan

## 1. INTRODUCTION

Health Boards in Wales have been carrying out reviews of patients who contracted COVID-19 to determine the cases which are deemed to be nosocomial (acquired in a healthcare setting). To date within SBUHB, this work has focussed on patients who contracted COVID-19 and then died.

In order that this work is consistent across Wales, a National Nosocomial COVID-19 Programme (NNCP) has been established, led by NHS Delivery Unit. The Nosocomial Review Teams (NRTs) of all Health Boards report into the programme monthly which enables sharing of practice and collaboration on cross-cutting aspects. The NNCP also acts as a mechanism for providing update reports on this work to Welsh Government on behalf of Health Boards.

In line with national requirements, communication with families of patients who have died having contracted COVID-19 in healthcare settings has commenced within SBUHB.

Progress on both the reviewing and communication work streams of the programme is outlined below.

## 2. BACKGROUND

### 2.1 Progress with reviews:

A summary of the present position of the reviews is provided in Table 1 which depicts the following data:

- Row 1 – The total number of incidents of nosocomial COVID-19 which have occurred within health board healthcare settings (regardless of outcome to the patient);

- Row 2 - The cohort of 609 cases noted as being under investigation comprises deaths in which COVID-19 was actually and probably acquired in healthcare settings. This is the first set of investigations which will be completed by the SBUHB Nosocomial Review Team.

**Table 1 (data as at 03.07.2022):**

| | Wave 1 (27.02.2020 – 26.07.2020) | Wave 2 (27.07.2020 – 16.05.2021) | Wave 3 (17.05.2021 – 19.12.2021) | Wave 4 (20.12.2021 – 30.04.2022) | Live Reporting (01.05.2022 ---) | Total: |
|---|---|---|---|---|---|---|
| **Total COVID-19 nosocomial incidents** | **300** | **1358** | **298** | **901** | **168** | **3,025** |
| **Incidents under review** | **120** | **334** | **33** | **112** | **13** | **609** |

Of the 609 actual and probable healthcare acquired infections reported, 467 reviews have been undertaken using parts 1 and 2 of the HOPE Network Toolkit for these cases, to date. Of these, 128 cases have been reviewed using a full Toolkit (parts 1 – 5.) These relate, in the main, to wave 1 cases which are being prioritised for full review as they form the cohort which is being targeted for the first round of family communication.

All cases depicted in Table 1 will be considered for review during the full course of the programme. Communication will occur direct with patients where they survived contraction of COVID-19, rather than with relatives.

### 2.2 Communication with families

On 15th June, 2022, the SBUHB Nosocomial Review Team commenced the communication process with calls to ten families of deceased patients who had contracted COVID-19 in SBUHB hospitals. In line with plans previously outlined, the ten cases were actual and probable healthcare acquired infections from among those of the first wave and included COVID-19 on patient death certificates. Ten calls per week have been made to families each week following this.

The chronological approach, working by wave, is intended to ensure that those who have already been waiting the longest for action receive communication first.

The varied outcomes from each of the calls made have presented situations for which the team is ensuring workable processes are in place by which to respond.

Follow-up letters have been sent to families with whom contact has been made within 3 working days of the calls having taken place. The letters confirm the discussion held, provide details of sources of support for families and contact details for the NRT. Early feedback from those contacted confirmed that leading by telephone call, as opposed to letter, is a favoured and welcome approach.

The team will continue communication at a rate of ten calls per week until the process is fully established, at which point opportunities to pace-up will be considered. The current pace of contact allows enough time around calls to adapt and quality assure processes and ensures sufficient opportunity to liaise with those who are cited as sources of support for relatives (the CHC and the Care After Death Service) to confirm that the number of people accessing their services remains manageable for their current staffing. Monthly debrief meetings with these organisations have been scheduled to this end. It is intended that any further delays for families are avoided at all stages of communication, once the process has been set in motion.

Weekly debriefs are scheduled between the Nosocomial Review Team and senior management to discuss the progress of the communication process. This enables the agreement of further development / adaptation of administrative processes and documentation, in line with early learnings.

These meetings are also used to ensure the wellbeing of those handling calls. A series of reflective sessions is to be scheduled to assure wellbeing, also.

### 2.3 Next Steps

Meetings to discuss case reviews with the relevant Service Groups are being established. The purpose of these meetings will be to determine the level of harm caused to patients in light of their contracting COVID-19 in healthcare settings, based on the findings of the NRT. Lessons to learn for the improvement of systems and processes will also be discussed at these meetings.

Cases deemed to have caused medium harm or above will require submission to the Nosocomial Death/Harm Scrutiny Panel for further consideration in terms of the NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011.

The outcomes of the meetings with Service Groups and/or the Nosocomial Death/Harm Scrutiny Panel will form the basis of the final communication with families, enabling provision of a summary of patients' case reviews and information on follow-up actions, where relevant. This communication is to take place no later than six months from the point of initial contact.

A report will be submitted to the Management Board in September to consider the position at that time how we increase the rate of contact with the families.

## 3. GOVERNANCE AND RISK ISSUES

The top three risks of the Nosocomial Review Programme have been presented to the NNCP as follows:

- **Distress caused to families resulting in receipt of additional complaints and/or negative media attention following commencement of the communication phase of the programme:** This risk has been mitigated, as far as possible, by ensuring the briefing of key stakeholders, including those who will provide support to families. Further, the paper presented at Public Board during May has been published and the SBUHB Communications Team has been briefed, accordingly. Regular debriefs are scheduled with relevant parties, such as the CHC and the Care After Death Team, to ensure ongoing alignment of priorities and availability of support for families.
- **Failure to provide a final outcome response to families within the designated 6-month timeframe, in line with the NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011:** In mitigation of this risk, the high volume of cases to be reviewed is being monitored and the communications process balanced against progress made in completing the reviews. Regular appraisal of both the reviewing and communication processes will determine whether modification of either is required.

## 4. FINANCIAL IMPLICATIONS

Once the reviews have been completed, there may be financial implications in relation to compliance with the NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 and further updates will be provided in this respect.

## 5. RECOMMENDATION

The Board is requested to:

- **NOTE** the progress made in reviewing nosocomial COVID-19 cases within the health board;
- **NOTE** the work undertaken to align the activity of the Health Board with the requirements of the National Nosocomial COVID-19 Programme; and
- **NOTE** the position in relation to communicating this work to patient families; and
- **AGREE** for a further report updating the Board on progress to be received in November 2022.

| Governance and Assurance | | |
|---|---|---|
| **Link to Enabling Objectives** ***(please choose)*** | **Supporting better health and wellbeing by actively promoting and empowering people to live well in resilient communities** | |
| | Partnerships for Improving Health and Wellbeing | ☐ |
| | Co-Production and Health Literacy | ☐ |
| | Digitally Enabled Health and Wellbeing | ☐ |
| | **Deliver better care through excellent health and care services achieving the outcomes that matter most to people** | |
| | Best Value Outcomes and High Quality Care | ☐ |
| | Partnerships for Care | ☐ |
| | Excellent Staff | ☐ |
| | Digitally Enabled Care | ☐ |
| | Outstanding Research, Innovation, Education and Learning | ☐ |
| **Health and Care Standards** | | |
| ***(please choose)*** | Staying Healthy | ☐ |
| | Safe Care | ☐ |
| | Effective Care | ☐ |
| | Dignified Care | ☐ |
| | Timely Care | ☐ |
| | Individual Care | ☐ |
| | Staff and Resources | ☐ |
| **Quality, Safety and Patient Experience** | | |
| Cases of complaint and concern are being prioritised for full review. Lessons identified documents have been recirculated via Datix Alerts and by email to triumvirates. Suggested methods of cascading and integrating learnings were incorporated. | | |
| **Financial Implications** | | |
| Limited financial implications are anticipated, in terms of the Team, given the allocation of WG funding to cover the next two years' work. Redress / legal action could result in financial implications over the next phases. | | |
| **Legal Implications (including equality and diversity assessment)** | | |
| Following review, cases may translate into redress or clinical negligence cases and further information will be provided to the Board once the reviews have started to be completed in full. | | |
| **Staffing Implications** | | |
| There may be a requirement to recruit a small number of staff to continue with the work of the programme. This will be conducted in line with Health Board process, with consideration given to the redeployment register. | | |
| **Long Term Implications (including the impact of the Well-being of Future Generations (Wales) Act 2015)** | | |
| o To be considered following completion of reviews. | | |
| **Report History** | Public Board Meeting, May 26th 2022 | |
| **Appendices** | NIL | |