AGENDA ITEM
6.5

QUALITY & SAFETY COMMITTEE

MANAGEMENT OF HEALTH CARE AQUIRED INFECTIONS – COVID-19

Date of meeting	18 May 2021
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
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Presented by	Greg Dix, Executive Director of Nursing, Midwifery and Patient Care
Approving Executive Sponsor	Executive Director of Nursing
Report purpose	FOR DISCUSSION / REVIEW

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	**Date**	**Outcome**
Executive Medical Director Corporate Governance Team	Various dates	NOTED

ACRONYMS	
	Explained in the report.

1. SITUATION/BACKGROUND

On 16 March 2021 the National Framework for Management of Patient Safety Incidents following Nosocomial Transmission of Covid-19 was published in Wales. The Framework, produced in conjunction with representatives from Health Board's across

Wales, is in response to the demand for a standardised and timely approach. There is now a need to develop a Health Board Strategy to undertake this work ensuring a safe, consistent approach is taken at pace.

During the pandemic, CTMUHB saw several Covid-19 outbreaks across sites. These were managed in line with local Infection Prevention and Control guidance and later, in line with Welsh Government (WG) guidance and support. Clarity around the reporting process was not immediate and there was noted disparity in reporting across Wales.

In late summer 2020, WG guidance required Health Boards to report outbreak data daily to WG and for site specific data to be reported to Public Health Wales on a twice weekly basis. Health Boards were advised to report deaths related to Covid-19 Healthcare Acquired Infections (HCAI) through Datix. Each Integrated Locality Group (ILG) undertook a reporting process which included retrospective reporting. Where an outbreak occurred, the outbreak itself was reported as an incident via the Datix system.

Outbreak data and deaths have been reported through the Outbreak Control Team (OCT) meetings. Data has been collected by ILG, by Infection, Prevention & Control (IPC) and by Public Health Wales (PHW). PHW data is also informed by laboratory testing. This data is currently being triangulated and cross referenced to confirm its accuracy and is maintained in a live database.

2. SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

Health Board Responsibilities

Within the National Framework there are several steps outlined which includes the pathway for both those who have survived Covid-19 and those who have died. For the ease and success of this work, it is important to consider these as

- *Phase 1* – those who have died and
- *Phase 2* – those who have survived.

This consideration focusses on *Phase 1* only.

Initial requirements in the process and current status for all known Covid-19 deaths across the Health Board (HB) is outlined below. It is important to note that the HB has not progressed these cases further whilst awaiting the release of the National Framework.

Process	Status	Action required
Patient contracts Covid-19 – HB undertake review to determine HCAI category	**Complete**	Continue reporting when new cases arise.

Determine level of harm and report via Datix	**Complete**	Continue reporting when new cases arise.
Refer deaths to Medical Examiner	**Incomplete**	Medical Examiner service not available HB wide. **This will be mitigated within recommendations.**
Undertake Stage 1 Mortality Review	**In progress**	Continue with stage 1 mortality reviews.
Undertake Stage 2 Mortality Review	**Incomplete**	**Consider recommendations below.**

The HB currently has access to a database of all known Covid-19 HCAI cases, including both deaths and those who have survived. Given the HB responsibilities outlined, it will be necessary to cross reference **ALL** known cases with the Datix system to be certain of accuracy.

The Database

The database held by PHW can be considered accurate. The information within the database is sufficient to facilitate CTMUHB in actioning the National Framework. The database can be broken down to suit the needs of Phase 1 (those who died) and Phase 2 (those who survived), although there is no nationally agreed timescale for Phase 2 as yet.

Of the patients who have died, the database has already categorised them into one of the 4 categories identified within the Framework:

HCAI category	Criteria
Community onset	Positive specimen date ≤2 days after admission
Indeterminate healthcare-associated	Positive specimen date 3-7 days after admission
Probable healthcare-associated	Positive specimen date 8-14 days after admission
Definite healthcare-associated	Positive specimen date 15 or more days after admission

**This has been achieved by applying the criteria set out above.*

The data collected between March and September 2020, considered as the *first wave*, differs to the data from September onwards, referred to as the *second wave*. In the first wave the national testing strategy did not support testing symptomatic patients if a Covid-19 positive contact was not identified. This strategy changed in the second wave when all symptomatic cases were tested. This will invariably result in the appearance that the first wave saw less outbreaks and less cases of HCAI than the second wave. Additionally, whilst it can be considered the later data is most reliable,

there is a risk of unidentified cases from the early part of the pandemic and as such the thoroughness of this work can only be as successful as the data collected at the time. However, it should be considered that as the testing strategies and advice at the time were based upon a national approach, CTMUHB should not be an outlier when compared to other Health Boards across Wales.

A timeline of National advice to manage the pandemic and localised UHB practices in response is crucial to decision making in respect of contextualising individual cases and consideration of Putting Things Right (PTR).

Post-Discharge Cohort

From the commencement of the pandemic up until the time of this report, the national guidance supports HCAIs being attributed to those who are inpatients at the time of testing. In the first wave, routine hospital discharge testing was not advised or carried out. This guidance changed during the second wave and negative swab results are now required for all hospital discharges. There is a cohort of people who will have been discharged from hospital and later tested positive for Covid-19.

Whilst there is not a national definition for a 'post-discharge cohort', locally this information has been collected with accuracy. The same principles have been applied in collecting this data – if a patient has tested positive within 14 days of discharge they can be defined within the 4 listed categories above. As with inpatient cases, this data also considers discharge to positive test days and also considers contacts and index cases. In the absence of national guidance for this cohort, it is anticipated that these will be considered as Community Acquired within other Health Boards. This element is considered within the recommendation section of this report.

3. KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

As of the 16 April 2021, the data has been cross checked and triangulated by PHW, it can be summarised as:

Table: Episodes of Nosocomial infections in CTM patients (90 day episode period), by site and type of infection – both those who survived and died.

Site	Indeterminate	Probable	Definite	Post-Discharge	Total
Glanrhyd	1	3	21	0	**25**
Maesteg	2	0	20	0	**22**
Other	0	18	6	0	**24**
PCH	102	126	138	105	**471**
Pontypridd	0	0	1	0	**1**
POW	125	147	234	75	**581**
RGH	207	211	289	125	**832**
YCC	4	19	76	5	**104**
YCR	24	17	82	4	**127**

YGT	0	0	3	0	**3**
Total	**465**	**541**	**870**	**314**	**2190**

The number of deaths within the above **2190** instances of nosocomial transmission in CTM, will be reported as **689** patients.

It is recommended that sufficient resources can be identified to ensure that this significant undertaking is well planned, led and executed. Recent meetings with Welsh Government and the Delivery Unit have recommended halting any further progression of this work until there is a firm steer and a full understanding of the challenges.

However, in ensuring the National Framework is successfully integrated within CTMUHB, it is pertinent to consider key principles. These include:

- Ensuring a consistent approach is taken to identify, review and report patient safety incidents following nosocomial transmission of Covid-19 in compliance with Putting Things Right (PTR).
- Undertaking investigations into cases of nosocomial transmission to determine instances of actual or potential patient harm, and to learn lessons to improve communicable disease control for the future. Upon completion of investigation the cases will be determined as to whether they require referral to formal PTR. The framework advises that the HB; *'must seek Legal and Risk advice prior to communicating any decision on Qualifying Liability and Breach of Duty as per the framework.'*
- The framework outlines that upon identification of a nosocomial case, considered as indeterminate, probable or definite – the HB should initiate contact with the next of kin (or identified representative). There is a nationally agreed contact with families' letter, however this has not yet been rolled out until key support resources have been identified and PTR consideration clarified. A Single Point of Contact (SPOC) service will be required to ensure consistency of support for families through to outcome. There has already been significant delay in providing contact to affected families and individuals.
- It will not be appropriate to conduct in-depth investigations for all cases and so it is important to determine as accurately as possible from the outset what will be proportionate in the circumstances.
- To ensure CTMUHB investigate once and investigate well.

Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
	This report outlines key areas of quality across the Health Board.
Related Health and Care standard(s)	Governance, Leadership and Accountability
Equality impact assessment completed	Not required
Legal implications / impact	Yes (Include further detail below)
	PTR/BoD/QL implications
Resource (Capital/Revenue £/Workforce) implications / Impact	Yes (Include further detail below)
	This will be a significant undertaking by the CTMUHB. There are resource requirements over and above what can be provided by refiguring of current arrangements to enable a well-planned, well-led and sustained programme of work.
Link to Strategic Well-being Objectives	Provide high quality, evidence based, and accessible care

5. RECOMMENDATION

Members of the Quality & Safety Committee are asked to:

5.1 **NOTE** the content of the report

5.2 **DISCUSS** the content of the report and flag areas (if not already identified) where further assurance is required

5.3 **NOTE** the risks identified

5.4 **SUPPORT** the direction of travel in developing a wider reach of quality reporting and locality based assurance reports