GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

AGENDA ITEM
6.6

QUALITY & SAFETY COMMITTEE

NATIONAL NOSOCOMIAL COVID-19 PROGRAMME – CTM UPDATE

Date of meeting	(24/05/2022)
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Carole Tookey, ILG Nurse Director, Rhondda & Taf Ely
Presented by	Carole Tookey, ILG Nurse Director, Rhondda & Taf Ely
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**
Integrated Locality Leadership Team	Week commencing 02/05/2022	NOTED

ACRONYMS	
CHC	Community Health Council
COVID-19	COVID-19 is an illness caused by a strain of coronavirus called SARS-CoV-2. This virus is responsible for the global pandemic since 2020.
CTMUHB	Cwm Taf Morgannwg University Health Board
DU	NHS Wales Delivery Unit

NNCP	National Nosocomial COVID-19 Programme
PHW	Public Health Wales
PTR	Putting Things Right

1. SITUATION/BACKGROUND

1.0 The purpose of this report is to provide the Quality and Safety Committee of Cwm Taf Morgannwg University Health Board with information regarding the establishment of the National Nosocomial COVID-19 Programme (NNCP) and in future, will provide assurance regarding the progress and delivery within CTM of the programme.

1.1 On 25 January 2021, the Quality & Safety Team at the NHS Wales DU were commissioned by Welsh Government to develop a national Framework to support a consistent national approach towards investigations following patient safety incidents of nosocomial COVID-19. In March 2021, the Framework into the 'Management of patient safety incidents following nosocomial transmission of COVID-19' was published and updated in October 2021.

1.2 In January 2022, the Minister for Health and Social Care announced £9m additional funding over 2 years to increase the pace of the implementation. The key outcome of the programme will be to provide a high level of assurance that all patient safety incidents of nosocomial COVID-19 are investigated in line with the requirements of the National Health Service (Concerns, Complaint and Redress Arrangements) Regulations 2011 – Putting Things Right.

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

Objectives and requirements

2.0 The National Wales Framework Guidance has been implemented to provide a consistent approach for NHS Wales organisations to identify, review and report patient safety incidents following nosocomial transmission of COVID-19 in compliance with PTR regulations.

2.1 Proportionate reviews will be undertaken for all patients who experienced Moderate or Severe harm as a result of nosocomial COVID-19 and those who sadly died following a positive COVID-19 test. Individual patient reviews will consider whether the care that was provided was reasonable in relation to the prevention of the spread of COVID-19 in as far as we are able to establish. It will involve appraising clinical records and seeking expert professional opinions where needed. The investigations will triangulate individual patient-level information with ward and site-level infection, prevention control and epidemiological data.

2.2 Each patient or next of kin of those identified as having experienced moderate and above harm will be contacted and provided with a named contact throughout the review process. On completion of the review, we will share our findings, an explanation as to why we have come to that conclusion and a comprehensive PTR-compliant response.

2.3 Themes and learning from the reviews will be shared and collated for both Health Board and national improvement of communicable disease control in the future, in the interest of public safety.

Scope and investigation

2.4 The investigatory work will be completed in line with the NHS Wales National Framework – *Management of patient safety incidents following nosocomial transmission of COVID-19*. This includes investigating cases where a person has acquired nosocomial COVID-19 in a care setting while receiving NHS funded care, with the exact details of this programme in development.

2.5 The programme includes nosocomial acquisition of COVID-19 from 27/02/2020 until 30/04/2022 with any new cases after that time being investigated in line with current investigation timelines.

2.6 The CTMUHB Nosocomial COVID-19 Incident Management Programme will work to the DU road map of milestones expected by the NNCP **(Appendix 1 – available on request).**

2.7 The CTMUHB Nosocomial COVID-19 Incident Management Team will approach the work programme by focusing on cases of hospital-acquired COVID-19 within CTMUHB hospitals. Cases will be reviewed chronologically, acknowledging the long time that patients who contracted the infection in Wave 1 have already waited.

2.8 The numbers of affected patients identified within services directly provided by CTMUHB is as follows:

	Wave 1 (27/2/2020 - 26/7/2020)	Wave 2 (27/07/2020 - 16/05/2021)	Wave 3 (17/05/2021 - 19/12/2021)	Wave 4 (20/12/2021 30/04/2022)
Total Number of Cases *	400	1488	314	950
Deaths within 28 days of COVID-19 positive **	133	457	81	112

* Please note these numbers are subject to change as the investigations progress

** The investigation will determine the extent to which Covid was involved, or not involved, in the patient death

2.9 Investigations will be commenced using the NNCP Nosocomial COVID-19 Patient Safety Incident Investigation Proportionality Decision Tool **(Appendix 2 – available on request)**.

Finance

2.10 The Health Board will have access up to a maximum of £596,155 per annum for 2 years. The resource to allocate the first year of funding has been provided.

Recruitment

2.11 The intended establishment, funding details and role responsibilities are provided below:

	WTE	Responsibilities
Programme Lead	1	Programme delivery, reporting, governance, shared learning, external stakeholder engagement and representation
Clinical Lead	0.5	Meeting with families when required, designing investigation tools and provision of clinical and contextual expertise.
Clinical Investigators	2	Assessing level of harm, undertaking detailed IPC reviews of care, identified
PTR Manager	1	Oversight of PTR responses, seniority and expertise in complaints management
Patient contact, PTR support and investigatory support	3	Triage of cases and creation of patient journey timelines, patient contact and organisation of PTR responses
Administrative support	2	Meeting coordination, datix upkeep, medical records provision
Redress Officer	1	Provision of specialist advice and liaison with Legal and Risk
Medic	0.4	Mortality reviews and assessments of medical care or service delivery problems
Communications officer	0.2	External stakeholder engagement and public messaging

In addition to the workforce resource above, there is 0.5 WTE Epidemiological Scientist funded by PHW who will contribute to data provision and investigations.

Relationships and engagement

2.12 There has been close collaborative working with the NHS Wales DU and their operational delivery group. Early engagement with the CHC has also taken place with further contacts planned.

2.13 The Nosocomial COVID-19 Incident Management Team, once recruited, will proactively engage with patients and families who have been affected by incidents of nosocomial COVID-19, including advocacy through the CHC. The necessary infrastructure to provide a dedicated point of contact for supporting families five days a week will be established.

2.14 Patients and families will be contacted at the point that investigation of their case commences however, the usual PTR route remains accessible for patients and families who wish to contact the Health Board proactively ahead of this time.

2.15 The Health Board recognises that this contact will be hugely distressing for some patients and families and will ensure that support and sign-posting can be offered. We hope however that families will want to engage with us and find the team approach sensitive and supportive in its own right.

Quality Assurance

2.16 Nationally agreed templates are being adapted for local use wherever possible to ensure consistency of approach and messaging across Wales.

2.17 Relevant internal assurance mechanisms such as scrutiny panels will be utilised to ensure a high standard and completeness of investigations. The NHS Wales DU has published a document outlining minimum standards and requirements and this is being adhered to when developing our Terms of Reference for scrutiny panels.

2.18 The membership of scrutiny panels and governance groups will be carefully developed to ensure independence from the service or clinical area in which incidents occurred.

Governance arrangements

2.19 A CTMUHB programme oversight group will be established, chaired by the Executive Director of Nursing. The group will meet bimonthly and a highlight report submitted to this committee for assurance. There will be appropriate representation from internal and external stakeholders.

2.20 National oversight and monitoring is being led by the NHS Wales DU with monthly progress reporting having been commenced in April 2022.

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

3.0 The lack of identified accommodation presents a risk to meeting project timescales. Remote working is not feasible due to the requirement to staff a working hours public helpline.

3.1 Apart from this risk, the Health Board is on target to meet NCCP trajectory heading to Q2 (see Appendix 1). Recruitment is now progressing well, the investigation approach is being refined and necessary governance arrangements are being developed.

3.2 The committee should note the high number of affected patients in CTMUHB, significant understandable public interest and breadth of the programme work to include clinical investigation, patient and family contact, PTR requirements, governance and reporting requirements.

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
	Large numbers of our population were affected themselves or lost relatives as a result of nosocomial COVID-19 infection. This report details key steps in addressing their concerns and learning for future infection management or pandemic responses.
Related Health and Care standard(s)	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below: Relevant to all Healthcare Standards
Equality Impact Assessment (EIA) completed - Please note EIAs are required for all new, changed or withdrawn policies and services.	No (Include further detail below) Any new or altered services would have their own EIA undertaken.
Legal implications / impact	Yes (Include further detail below)
	Any incidents where a breach of duty or qualifying liability is believed to exist will

	follow appropriate legal process. The Health Board will work closely with NWSSP Legal and Risk services.
Resource (Capital/Revenue £/Workforce) implications / Impact	Yes (Include further detail below)
	Dedicated fixed term workforce will be recruited. The funding stream is confirmed and provided by Welsh Government. No additional financial impact is anticipated other than through existing legal Redress and Claims provision.
Link to Strategic Goals	Improving Health

5. RECOMMENDATION

5.1 The Quality & Safety Committee is asked to **NOTE** this report.