Meeting Date	**27 June 2023**	**Agenda Item**	**6.5**
Report Title	**Progress update on the review of cases of COVID-19 contracted in a healthcare setting**		
Report Author	Andrea Folland, Nosocomial Review Team Business Manager		
Report Sponsor	Richard Evans, Executive Medical Director and Deputy Chief Executive Gareth Howells, Executive Director of Nursing and Patient Experience		
Presented by			
Freedom of Information	Open		
Purpose of the Report	To provide the Quality & Safety Committee with a progress update on the review of cases of COVID-19 contracted in healthcare settings (nosocomial) and the communication with families of deceased patients.		
Key Issues	In line with national requirements on NHS organisations in Wales, reviews into nosocomial transmission of COVID-19, and related work to communicate review outcomes, continue within the Health Board. As the programme has entered its second and final year, the matters arising in relation to the programme, and related risks, have developed since the presentation of the last programme paper to Quality & Safety Committee.		
Specific Action Required ***(please choose one only)***	**Information**	**Discussion**	**Assurance**	**Approval**
	☒	☐	☐	☐
Recommendations	Members are asked to: • **NOTE** the progress made in reviewing nosocomial COVID-19 cases, including an update on communicating this work to patient families. • **NOTE** the risk for potential residual activity to occur following the disbanding of the Nosocomial Review Team in March 2024. • **NOTE** the approval, by Management Board held on 21.06.2023, of the recommended approach to rollout of a satisfaction survey to be conducted with those contacted via the Programme, outlined in 3.3.		

Progress update on the review of cases of COVID-19 contracted in a healthcare setting

1. INTRODUCTION

Health Boards in Wales are continuing to review cases of patients who contracted COVID-19 in healthcare settings (nosocomial cases.) As reported to Quality & Safety Committee previously, this work focussed initially on patients who definitely or probably contracted nosocomial COVID-19, and, subsequently, died. More recently, the Nosocomial Review Team (NRT) has been considering cases of nosocomial COVID-19 in patients who are living, ensuring wider progress across the Programme.

The National Nosocomial COVID-19 Programme (NNCP), led by the NHS Wales Executive, continues to monitor the work of Nosocomial Review Teams (NRTs). The NNCP enables practice-sharing and provides update reports to Welsh Government on behalf of Health Boards. In line with national requirements, engagement with families of patients who have died having contracted nosocomial COVID-19, continues.

2. BACKGROUND

A series of appendices, referenced throughout the paper, are included as a means of providing supplementary information on current key activity. These are as follows:

The NHS Wales Executive Proportionality Decision Tool which provides a guide for Health Boards on the level of investigation required for different categories of nosocomial COVID-19 patient safety incident. The Nosocomial Review Team references this guide to ensure the proportionality of its own processes **(Appendix 1)**.

The Ombudsman Information Sheet which outlines the process the official will follow in investigating complaints received about COVID-19 acquired in hospital, including those which are subject to review by the National Nosocomial COVID-19 Programme. The Health Board has formally acknowledged receipt of this information, providing assurance of its sharing and discussion with relevant colleagues and a commitment to working collaboratively with the Ombudsman, within the framework outlined, to facilitate robust and timely outcomes **(Appendix 2)**.

The National Nosocomial COVID-19 Programme Interim Learning Report which includes early learning that has emerged as a result of nosocomial COVID-19 investigations and the wider work of the programme. The Nosocomial Review Team contributed to the themes included in the report by drawing on those identified during Health Board reviews. The report has been highlighted to Service Group colleagues in order that lessons identified can be integrated into future practice to ensure improvement and progress. The report has also been shared on the Health Board website and SharePoint, to this end **(Appendix 3).**

3. KEY UPDATES

3.1 Reviewing progress:

As depicted in Figure 1, work is currently progressing at a rate which would, by July / August, meet and follow the trajectory required to complete the programme by its stipulated end-date, March 2024. This forecast, however, is predicated on the continued availability of the current workforce:

Figure 1: SBUHB Review Progress against Trajectory (NNCP Data Dashboard)

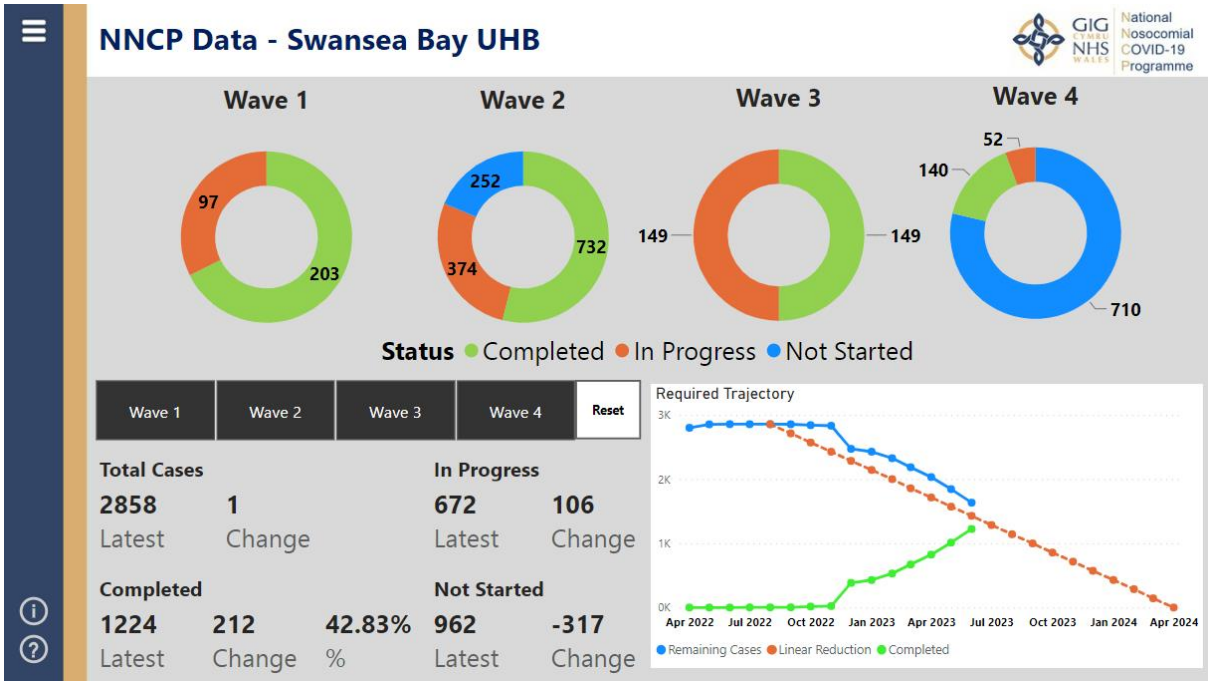

Table 2 provides a further breakdown of the progress depicted in Figure 1. A description of the data, by row, can be found in Table 3, which follows:

Table 2: Data as at 05.06.2023

		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)	Total:
1.	Total COVID-19 nosocomial incidents	300	1358	298	902	2,858
2.	Incidents under review	97	352	142	50	641
3.	Downgraded / Recategorised	52	146	48	139	385
4.	Referred to Scrutiny Panel	0	22	7	2	31
5.	Completed Investigations	151	586	101	1	839

Table 3: Data Description by Row

Row:	Data Description (relating to cases occurring within SBUHB healthcare settings):
1.	The total number of incidents of nosocomial COVID-19 which have occurred (regardless of outcome to the patient);
2.	The 641 cases under review all relate to definite and probable nosocomial COVID-19 acquisitions, some cases in which patients have, subsequently died, and some in which patients are alive.
3.	Cases in which patients acquired nosocomial COVID-19 and who have died, however, COVID-19 is not on their death certificates. Also, cases in which a review has commenced and found a non-nosocomial acquisition of COVID-19.
4.	The number of cases referred to forthcoming Scrutiny Panels; deaths in which COVID-19 was definitely and probably nosocomially acquired;
5.	The number of cases considered by Scrutiny Panels for which outcomes have been determined. These relate to deaths in which COVID-19 was definitely and probably nosocomially acquired and patients who definitely and probably acquired nosocomial COVID-19 and are alive.

The cases of living patients who definitely and probably acquired nosocomial COVID-19, referred to above, have been subject to a desktop review. Where it is found that no referral to the Long COVID-19 Service has been made for these patients, cases have been deemed to be of no / low harm. In line with the NNCP Proportionality Tool (Appendix 1), these cases have, subsequently, been closed and are being logged on Datix, in accordance with healthcare acquired infection reporting requirements.

3.2 Communicating with patient families

81 reviews have been conducted relating to patients who died having definitely or probably contracted nosocomial COVID-19 during wave 1. In relation to these:

- Successful contact was made with 70 families;
- Contact was not possible with 11 families despite thorough attempts to trace them via E-Systems, GP surgeries and the Care After Death Service;
- 2 families did not wish further communication beyond notification of review;
- 6 families are due to receive outcome letters in coming weeks;
- 62 families have received review outcome letters.

Some requests have been received for follow-up contact from the NRT following receipt of outcome letters. 4 families requested further clarification on issues relating to their relatives' care. The Clinical Investigators answered queries relating to the COVID-19 review with 3 of the 4 families having been referred to Service Groups for discussion of queries about general care. 1 family awaits an additional, follow-up response having met with an Investigator and wider NRT members, recently.

The Ombudsman has opened an investigation into a case at the request of a family who has received an outcome letter. The NRT is working to compile further information

in response to initial queries about this case. The NRT will work with the Ombudsman in line with the recently published information sheet regarding complaints about healthcare acquired COVID-19 (Appendix 2).

A similar request for clarification and further detail on a review outcome letter has also been received by the NRT from the Community Health Council (CHC).

Any learning that emerges from the Ombudsman and CHC will be promptly actioned and integrated into the Health Board processes and communication methods.

The next phase of communications will continue chronologically as contact with families of deceased patients who acquired nosocomial COVID-19 during wave 2 is due to commence. Communication will occur as follows:

1. Telephone call to notify relatives that a COVID-19 review is underway. Overall feedback on the phone-first approach implemented to date has been positive;
2. Follow-up letter sent within 3 working days of the call;
3. Outcome letter sent within 6 months of the initial call.

3.3 Assurance of compliance with national programme requirements

Health Board alignment with NNCP requirements continues as follows:

- Monthly data submission and highlight reports to the programme team;
- Scrutiny Panels to determine outcomes for cases of medium harm or above;
- Lessons learned reported via the Patient Stakeholder Experience Group;
- Contribution to the recently published Interim Learning Report (Appendix 3). The report has been distributed to Service Groups for action in line with findings, where appropriate.

In addition to the above ongoing activity, a national survey is to be conducted to gauge patient and relatives' satisfaction with the COVID-19 review process. The survey will be hosted on CIVICA, a first in terms of use of the platform to reach a national audience via local Health Boards. The survey has come as a national directive for local implementation, and as such, health boards can determine how rollout should occur, with adherence to agreed key principles from the National Programme.

The following approach by the Health Board is proposed:

1: Rollout of the survey with those affected by Wave 2. This approach is timely as initial communication with this cohort is about to commence, allowing information about the survey to be added into existing communications. Contacts will be made aware, at this point, that they will be invited to feedback at a later stage, should they wish.

2: As part of the outcome letter to be sent to families include both digital and hard copy access to the survey. This will ensure that everyone contacted via the Programme, from this point onwards, has an opportunity to share their feedback.

3: Completed surveys received after March 2024, which will be after the disbanding of the NRT, will require a different handling process that will need to be agreed.

4. GOVERNANCE AND RISK ISSUES

4.1 Continuing risks previously reported to Quality & Safety Committee:

Risk:	Risk score:	Mitigation:
Distress caused to families resulting in receipt of additional complaints and/or negative media attention following commencement of the communication phase of the programme.	**16**	Briefing key stakeholders, including those providing family support. Regular debriefs with relevant parties, such as the CHC and the Care After Death Service ensure alignment of priorities.
Failure to provide outcome responses to families within 6-months from initial contact, in line with the NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011.	**12**	The high volume of cases for review is monitored and the communications process balanced against reviewing progress. Regular appraisal of both determines whether modification of either is required.
Potential loss of staff as they seek more permanent work than can be offered by the Programme.	**15**	The score has increased from a risk rating of 12 due to the loss of a 0.53wte Band 8a Senior Clinical Investigator. The post has been re-advertised due to failure to recruit. Bank and secondment opportunities are also being explored.

4.2 Future risks requiring mitigation planning:

The finite nature of the Programme presents a risk for potential residual activity to occur following the disbanding of the NRT from March 2024, as set out below:

Likelihood of occurrence:	Risk:
Certain	National expectation that from 01.04.2023, healthcare acquired COVID-19 infections, occurring beyond 01.05.2022 (the end of wave 4), and which meet the definition of a Patient Safety Incident (PSI), will be considered within business as usual processes.
Likely	In line with Ombudsman guidance (Appendix 2), patients / families may raise issues with cases within one year of first becoming aware of them. Continuing initial contact with families over coming months would put such potential contacts well beyond Programme end, March 2024.

Possible	National expectation that a satisfaction survey be conducted with those contacted via the Programme. Should this be implemented during every phase of communication, responses may be received post-Programme.

5. FINANCIAL IMPLICATIONS

For nosocomial COVID-19 cases, qualifying liability is considered with reference to a four stage test:

1. It must be established the Health Board owed the individual a duty of care.
2. Whether the Health Board has breached its duty of care in the context of the pandemic.
3. Whether the COVID-19 was caused by that breach of duty.
4. Whether the COVID-19 caused the patient to suffer harm, injury or death.

Where all tests outlined above are satisfied and it is accepted in a case that there is a qualifying liability, the Health Board must, under the Regulations, consider making an offer of Redress. Redress can include financial compensation.

Under the Regulations, where financial redress is offered, this would be below £25,000. It is for Health Bodies to decide, at the outset, whether the likely value of any financial redress would exceed £25,000, were liability to be established. If yes, qualifying liability should not be investigated and a Regulation 24 response should be sent (factual account with no conclusion as to Breach of Duty or Qualifying liability). A clinical negligence case would, subsequently, be pursued.

In relation to nosocomial COVID-19 cases, the Welsh Risk Pool has a mandatory requirement that Health Bodies seek advice from NWSSP Legal & Risk Services before any admission of breach of duty or qualifying liability is made.

6. RECOMMENDATIONS

Members are asked to:

- **NOTE** the progress made in reviewing nosocomial COVID-19 cases, including an update on communicating this work to patient families.
- **NOTE** the risk for potential residual activity to occur following the disbanding of the Nosocomial Review Team in March 2024.
- **NOTE** the approval, by Management Board held on 21.06.2023, of the recommended approach to rollout of a satisfaction survey to be conducted with those contacted via the Programme, outlined in 3.3.

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 continue to be prioritised for full review. Methods by which to circulate lessons identified have been updated, including monthly reports to the Patient Stakeholder Experience Group.		
Financial Implications		
Limited financial implications are anticipated, in terms of the NRT, 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 progress to redress or clinical negligence. Further information will be provided to the Quality & Safety Committee should this become pertinent.		
Staffing Implications		
There may be an ongoing requirement to recruit a small number of staff to continue with the work of the programme as those currently involved defect from the NRT due to the fixed-term nature of the work.		
Long Term Implications (including the impact of the Well-being of Future Generations (Wales) Act 2015)		
To be considered following completion of reviews.		
Report History	Management Board Meeting, 21st June, 2023	
Appendices	1. NNCP Proportionality Decision Tool 2. Ombudsman Information Sheet Regarding Complaints about COVID-19 Acquired in Hospital 3. NNCP Interim Learning Report	