GIG CYMRU NHS WALES

Interim Learning Report

National Nosocomial COVID-19 Programme

March 2023

GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

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The glossary of terms in section 8.2 provides more information on some of the terms used.

1. Introduction

The National Nosocomial COVID-19 Programme (NNCP) wishes to extend its sincere condolences to those who lost loved ones after acquiring COVID-19 in healthcare settings. It has without a doubt been an extremely difficult time for many families, carers and staff alike and the impact cannot be underestimated.

The purpose of the Interim Learning Report is to outline the early learning that has emerged as a result of the nosocomial investigations and the wider programme of work.

It is important to recognise that the programme is not a nationally led investigation into nosocomial (hospital-acquired) COVID-19 in Wales, nor does it seek to detract from the role of the UK COVID-19 Inquiry. The NNCP has been established to support NHS Wales organisations undertake their duty to investigate patient safety incidents in a proportionate way - whilst reflecting the complexities of COVID-19 which caused unusually high numbers of incidents.

2. Background

In response to the pandemic, NHS Wales rapidly adapted and altered its operational focus to minimise the harmful impact of COVID-19 as far as possible, at a time of high levels of uncertainty and anxiety. It is widely acknowledged that NHS staff worked tirelessly through the most challenging period in the history of the NHS to maintain high standards of clinical care and minimise risk to patients. Despite best efforts, the requirement for the NHS to shift operational focus to respond to the pandemic severely disrupted routine healthcare activity.

On an international level, COVID-19 was a new and unpredictable infection of which little was known, beyond the fact it posed a serious threat to global population health. Whilst infection prevention and control (IP&C) measures are routine practice for the NHS, the spread of COVID-19 in healthcare settings proved challenging, particularly at times when community prevalence was high, and hospitals had significantly high levels of patient complexity, demand and occupancy.

The scale of the pandemic meant that, despite being in a healthcare environment, patients in hospitals and other in-patient settings inevitably faced an increased risk of contracting nosocomial COVID-19. Whilst Health Care Acquired Infections (HCAIs) - now including COVID-19 - are a recognised risk in healthcare settings, learning and developing our understanding of how to investigate such matters of patient safety is important to help inform IP&C design and implementation.

3. What is the National Nosocomial COVID-19 Programme?

The NNCP was established in April 2022 to support NHS Wales organisations to conduct proportionate investigations into patient safety incidents of nosocomial COVID-19, which occurred between March 2020 and April 2022. It is a collective membership of all NHS organisations across Wales, working together to implement as consistent an approach as feasible, to investigate nosocomial patient safety incidents.

Beyond the commitment by NHS Wales to investigate and answer as many questions as possible, the programme also provides a timely opportunity to consider how NHS Wales manages and undertakes patient safety investigations; particularly how service users, families and carers are supported and engaged in the process.

All NHS Wales organisations have a duty to manage and proportionately investigate patient safety incidents in line with the NHS Wales The Duty of Candour Procedure (Wales) Regulations 2023 (the Regulations).

Patient safety incidents are any unintended or unexpected incident which could have or did lead to harm for one or more patients receiving NHS-funded care. HCAIs, including COVID-19, will in certain circumstances be considered a patient safety incident, depending on how and when the infection was acquired.

To assist NHS organisations investigating patient safety incidents of nosocomial COVID-19, a National Framework for the *Management of Patient Safety Incidents following Nosocomial Transmission of COVID-19* was developed, to ensure as consistent an approach as feasible was followed and investigations were done once and done well. To date, the framework has supported NHS Wales organisations to assess and investigate over 5,000 cases of nosocomial COVID-19 where they met the definition of a patient safety incident.

Acknowledging the impact of COVID-19 on service users, families, carers and NHS Wales staff, the programme has adopted a learning approach that seeks not to place blame but maximise the opportunity for learning and improvement.

4. How has learning been identified?

As organisations work hard to progress the completion of their patient safety investigations at pace, learning is identified through various quantitative and qualitative methods including investigation findings, the experiences of people (service users, families, carers and NHS Wales staff), incidental findings, and through collaboration with internal and external partners. Learning has also emerged through organisational scrutiny panels, which are conducted independently of investigations.

Combined learning from across organisations is collated into national themes to further support the identification of areas for improvement in the quality and safety of services, enhancing provision and people experience.

Learning sources include:

- Set-up of the programme including preparatory work
- Test sample audit and subsequent impact assessment
- Investigations
- People's experiences (Service users, families, carers and NHS staff)
- Wider feedback and stakeholder engagement

Acknowledging that listening to and learning from people's experiences is integral to learning for the programme, a *Capturing Experience Through the National Nosocomial COVID-19 Programme* plan has been developed to further support and enhance people's voices in the process, particularly during the second year of the programme.

5. What are the learning themes so far?

The below sections identify the learning themes which have emerged through the first year of the programme and have been categorised as follows:

People's experiences

- Bereavement support and care-after-death services
- Supporting the service user during the investigation process
- Visiting restrictions

Patient safety incidents and concerns

- Patient safety incidents outside of NHS Wales hospitals
- Identification, reporting and investigation of Health Care Acquired Infections (HCAIs) as a patient safety incident
- Application of Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) decisions

National infection prevention and control guidance

- Roll out of guidance
- Outbreak management

5.1 People's experiences

5.1.1 Bereavement support and care-after-death services

Access to high-quality bereavement and care-after-death support services can be extremely helpful in managing grief. When the NNCP programme was established, consideration was made about how service users - particularly the bereaved - would be supported. It has been identified that there is a differentiation in pathways for signposting, referring and accessing bereavement support services across NHS organisations. Some NHS Wales organisations did not have dedicated services that offered support following a bereavement.

To help reduce variation in accessing bereavement support, a *National Framework for the Delivery of Bereavement Care* was launched in 2021. The framework highlighted the need for a consistent and equitable approach across Wales for accessing bereavement support. This has resulted in organisations now having a dedicated bereavement support service.

NHS Wales recognised that support should be available for all families contacted as part of the programme and worked collaboratively with Health Boards and Trusts to ensure bereavement support arrangements were in place for bereaved families when contacted. Learning has identified that this came too late for some families connected with the programme, and that the bereavement process for some families has been adversely impacted.

Good practice
The Development of the *National Framework for the Delivery of Bereavement Care* launched in 2021 has assisted in setting a standard of expectation to be implemented within all organisations for the provision of a bereavement support service. Organisations have worked hard to implement this requirement.

Key learning
Bereavement support services should be proactively made available to all families, particularly for those where there may be a link with an associated patient safety incident.

Families should be proactively signposted to information about bereavement services at the earliest opportunity.

5.1.2 Supporting service users during an investigation process

Navigating and understanding the concerns process and knowing who to contact when people have a question is sometimes the difference between understanding and trusting the process, or dissatisfaction and lack of trust. In equal measure, listening to the experience of service users, families and carers is a fundamental principle of good concerns management, and key to ensuring learning opportunities are maximised.

Through contacting patients and their families impacted by the patient safety investigations, feedback emerged that patients and families found it confusing knowing how and who to contact to discuss a concern or seek clarification on the progress of their case.

To improve this experience, organisations established a dedicated five-day single point of access for service users, families and carers, when managing a concern.

Good practice
To ensure this principle was facilitated for service users, families and carers, a set of minimum standards were established by the NNCP for how services should engage the public. The provision supports a coordinated approach to handling queries about nosocomial COVID-19, with ease of access to address additional queries or broader concerns regarding nosocomial COVID-19.

Key learning
Every service user, family and carer should have timely access to a dedicated and easy-to-access single point of contact to provide feedback, and raise questions, concerns or queries. This is particularly key for patients and families involved in the concerns process.

Supporting information should be available and easily accessible to assist families in understanding the sometimes-complicated language linked to the concerns process.

5.1.3 Visiting restrictions

Visitors play an important part in a patient's recovery, with evidence continually highlighting the role visitors have on positive outcomes such as shorter stays and faster recovery times for patients. It is recognised that families and carers are often best placed to observe deterioration and identify a loved one's needs.

Visiting restrictions can be a tool used in response to infectious outbreaks in healthcare settings. Restrictions during COVID-19 were introduced to help reduce transmission from community settings into hospital environments, and particularly to minimise the risk for vulnerable patient groups.

The programme identified, through service user, family and carer feedback, that visiting restrictions had many adverse effects on the physical and mental health of patients - especially those in the vulnerable groups that the restrictions were intended to safeguard, many of whom were not able to fully understand the decisions made. The limited alternative opportunities for making contact and communicating with loved ones, also negatively impacted the experience for many other service users, families and carers.

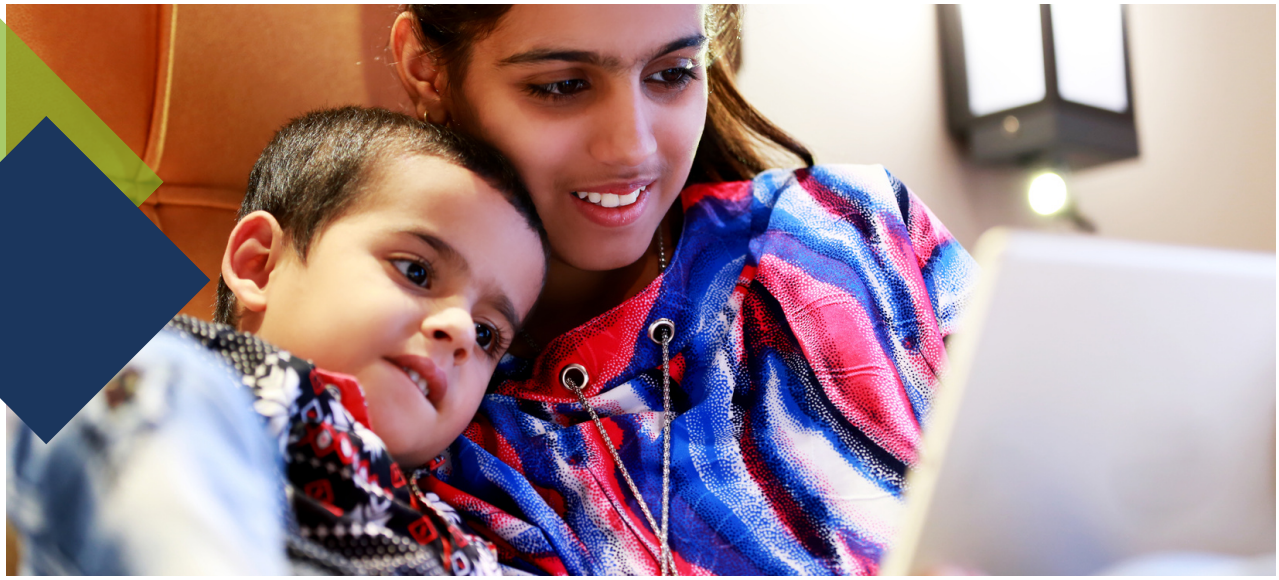
Investigations highlighted that families often relied on clinical teams and ward staff to connect with their loved ones. Whilst this communication in the main has been highlighted as positive, there are instances where communication was below the expected standards, especially the inability to make contact during busy periods.

Good practice
Organisations developed many innovative ways to minimise the impact of the visiting restrictions. These included examples such as virtual visiting via tablet devices, outdoor visiting and utilising ward-based patient support teams to bridge the gap.

Volunteers also played a key role in bridging the gap, particularly later in the pandemic. Many organisations have continued to strengthen these services and enhanced staff training.

Key learning
All services and wards should have named dedicated patient support teams and volunteers to support service users, families and carers who may be finding it difficult to visit a loved one in hospital.

Future visiting guidance should pay particular reference to the role carers have as an important part of a patient's care team.



5.2 Patient safety incidents and concerns

5.2.1 Patient safety incidents outside of NHS Wales hospitals

Patients often receive NHS-funded care in other settings, for example, their own homes, care homes, and facilities outside of Wales. Whilst NHS Wales organisations, under the duty of candour, have a responsibility to ensure any patient safety incidents that occur to their local population are reported to them, the requirement to undertake investigations can alter.

In applying the *National Framework for the Management of Patient Safety Incidents Following Nosocomial Transmission of COVID-19*, it has been identified that how the Regulations are applied in different parts of the health and social care system, as well as other sectors such as independent providers (private and public service), is variable and confusing.

Learning has identified that whilst the Regulations require an investigation for concerns relating to the transmission of COVID-19 during NHS-funded healthcare, there are a number of differences when care has been provided by a non-NHS organisation. For example, who undertakes the investigation, how the investigation is progressed, the requirement to compensate and how NHS Wales organisations who fund the care are notified.

The programme identified that the Regulations create variability and inequity for service users, families and carers who receive NHS-funded healthcare via another provider when a concern is raised. On this basis of the Regulations, the current programme does not extend to investigating all instances of nosocomial COVID-19 which occurred through an independent provider setting under NHS-funded care, including care homes.

Evidence from the experience of service users, families and carers connected to the programme to date, suggests they are not routinely informed of these differences.

Good practice
The learning from applying the *National Framework for the Management of Patient Safety Incidents following Nosocomial Transmission of COVID-19* has been shared with social care colleagues. A good practice guide is being developed for non-NHS support services in other sectors to apply a more consistent and standardised approach to concerns in social care and care home settings.

Key learning
All policies and procedures relating to the management of patient safety incidents which occur during NHS-funded care should set expectations of the standards required across all care settings to minimise confusion for service users, families and carers who may be receiving care across multiple complex care pathways.

5.2.2 Identification, reporting and investigation of Health Care Acquired Infections (HCAIs) as a patient safety incident

Learning from patient safety incidents is an important element to improve quality of care, and continually learn how to minimise the impact of HCAIs and the impact on patients.

Beyond the management of nosocomial COVID-19 as a patient safety incident, learning has identified that current arrangements within NHS Wales for the identification, reporting and investigation of all HCAIs that meet the definition of a patient safety incident are variable.

The programme also identified inconsistent approaches to the management and reporting of HCAIs across Wales and variations in the methodology used to investigate such incidents. It has also been established that the use of surveillance definitions in NHS Wales does not automatically indicate that a patient safety incident has occurred.

Good practice
As a result of this learning, the National Policy on patient safety incident reporting has been updated to reflect new national reporting requirements for HCAIs, including the reporting of nosocomial COVID-19.

Key learning
All health-acquired infections need to be assessed against the requirement to report as a patient safety incident, in line with national incident policy, and a proportionate patient safety investigation needs to be initiated.

5.2.3 The application of Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) decisions

DNACPR is designed to protect people from unnecessary suffering by receiving resuscitation that they do not want, that will not work, or where the harm outweighs the benefits. It is a key enabler in the promotion of a dignified death.

A common theme in the concerns raised by families and carers during the early part of the programme was the application of DNACPR decisions for patients who acquired COVID-19. Some of the themes in the concerns related to a view that there was a 'blanket approach' to applying the decision when somebody was diagnosed with COVID-19, and a lack of knowledge or consultation in the process of applying the decision.

Findings from investigations and other sources such as the Medical Examiners Service and mortality reviews have identified that there was a:

- Need to improve the description of patient's co-morbidities and their impact on the reason for a DNACPR being enacted
- Need to improve communication, especially around the rationale for DNACPR implementation and discussions with patients, families and carers
- Need to improve documentation related to discussions with patients, families and carers
- Need to improve the DNACPR document, particularly whether a decision should be reviewed if a patient's condition improves

Whilst a DNACPR decision does not strictly require consent from a next of kin or carer before application, unless the patient lacks capacity, learning from the investigations has recognised the importance of such communication, and the impact the management of this sensitive subject can have when managed well, and in these instances, not so well.

The analysis did not identify evidence or trends that DNACPR decisions had been placed inappropriately, or not in keeping with the current All Wales DNACPR Policy.

Good practice
There is an NHS Wales Strategic Advance & Future Care Planning group that includes representatives from NHS organisations. The group has agreed to strengthen the section in the policy relating to appropriate and timely communication with patients and families. This is seen as an important step to support clinicians to move beyond the formal process of DNACPR, providing helpful guidance and support in how, when and with whom to communicate to ensure understanding, and minimise upset.

Key learning
Service users, families and carers place great value on good communication around the DNACPR process and need to be involved as much as possible in the decision-making process.

Continued development and roll-out of an electronic advanced care planning document, is also seen as key to improvements which would support clinicians during the process and alleviate some of the potential issues around DNACPR documentation and broader communication.

5.3 Infection Prevention and Control

5.3.1 Roll out of guidance

National policy and guidance on IP&C are essential elements in supporting healthcare organisations to develop and implement local strategies which help to reduce the risk of infections. In response to the pandemic, the UK infection prevention and control guidance was co-produced across the UK's four nations and was published by the UK Health Security Agency (previously Public Health England).

Due to the need to respond rapidly to the significant population health risk that COVID-19 posed, guidance updates were published frequently, at short notice and often out of normal business hours. The rapid increase in the prevalence of COVID-19 and the high demand on health and social care, in addition to the emergence of new evidence, made it necessary to update guidance on an almost weekly basis, sometimes more frequently.

NHS Wales staff experience has shown that the frequency in which the guidance was updated, created challenges for already stretched IP&C teams, who are responsible for leading the necessary changes for all HCAIs across often large and complex organisations. Naturally, it can take time to assess and disseminate guidance which requires organisations to make significant adjustments to care delivery. For example, changes to care pathways, guidance on PPE (personal protective equipment), and testing processes.

The expectation that guidance should be implemented immediately, once published, was a significant challenge during the pandemic, particularly given the level of resources required to ensure training, communication and application across large workforce numbers and settings. It is worth noting that IP&C workforces responsible for COVID-19, also retained existing duties relating to other IP&C issues which continued throughout the pandemic. The implementation impacted staff who worked shifts and or were off sick, making it difficult to keep pace with changes in guidance that related to their practice.

Whilst acknowledging updates to IP&C policy are critical, the NHS in Wales should consider how updates are distributed and communicated when an evidence base is rapidly evolving in a future major incident scenario.

Good practice
Organisations developed extraordinary systems to respond to the rapid increase in the prevalence of COVID-19 and the high demand on health and social care. In addition, due to the emergence of new evidence, they also had systems in place to respond at pace to updating the necessary guidance on an almost weekly basis.

Key learning
NHS Wales organisations are encouraged to continue exploring and implementing digital communication methods that support timely and engaging communication with colleagues on updates to guidance.

5.3.2 Outbreak management

Testing can be an important mechanism in the identification and prevention of infectious diseases, including COVID-19. Access to appropriate testing and the timely turnaround of test results are crucial to mitigating and preventing the onward spread of infectious diseases.

Increased demand for COVID-19 testing during the pandemic posed a significant challenge to the existing testing infrastructure, which still had to manage routine provisions such as blood tests for in-patients. Demand exceeding capacity and the inability to test rapidly for COVID-19 during periods of 2020, meant that testing was somewhat ineffective as a mechanism for reducing infections, until the supply of consumables met demand and testing capacity increased.

Due to the testing capacity challenges early in the pandemic, service users were discharged into other care settings or their own homes without the ability to rapidly test for COVID-19. This was in line with national guidance at the time, which did not advise that negative tests were required before transfer/admission into residential settings.

Further UK guidance, especially early in the pandemic, actively encouraged the discharge of patients from hospitals into care home settings, to free up hospital capacity in order to manage the anticipated demand for services.

Whilst a testing strategy produced by Welsh Government was launched on 15th July 2020, significant challenges in applying the policy existed due to limited access to the volume of consumable items required to undertake tests, and laboratory capacity to manage the extreme demand. Additional capacity beyond the existing infrastructure was achieved with the launch of the lighthouse laboratory (IP5), towards the end of August 2020, this meant it became easier and quicker to test patients and staff for COVID-19.

As well as testing, isolation plays an important part in preventing and controlling the spread of infections, especially in healthcare settings. Timely testing, along with the ability to isolate suspected or positive patients can aid in preventing onward transmission. It is important to note that isolation is one of several control measures and must be used in conjunction with other measures to be effective.

It should also be noted that isolation for infection purposes brings additional risks to service users with other care needs, particularly for older and vulnerable people, such as falls. Decisions to isolate patients for infectious purposes, even when isolation is available, should be considered in a holistic risk-balanced way that does not introduce the risk of additional harm.

An aged estate and limited isolation facilities (such as access to single rooms) meant that patients were often unable to be isolated in single rooms, and co-horting was established to maintain operational flow through hospitals during extreme demand. The inability to isolate patients often meant that, in an attempt to reduce spread of infections, service users were subjected to multiple ward movements.

In line with UK guidance, the introduction of designated care pathways, which tried to prevent onward transmission (as far as reasonably practicable), played a significant part in multiple ward movements - especially in older estates.

Experience from families and carers found that they were often not informed of these movements, which resulted in additional communication difficulties when seeking updates.

Good practice
Organisations rapidly implemented increased point-of-care testing (POCT) to support clinical care delivery and assist in more timely diagnosis and clinical decision-making. This supported improved daily epidemic control by reducing patient movements and achieving early detection for treatment plans to be put in place which assisted in the safe timely transfer and discharge of patients into alternative care settings where necessary.

Key learning
Policies and procedures should reflect mechanisms that result in limiting the number of patient moves, ensuring patients are in the right place at the right time.

Where patients are moved, families should receive proactive and timely communication on the location and rationale for the move.

6. Looking forward

The NNCP will be working with NHS Wales organisations to further share and embed learning in the second year of the programme.

In addition to progressing the learning on the subjects listed in this report, the programme will continue to identify and explore new and emerging topics. The below list represents topics which are currently emerging and will be reported upon further in the final report:

- Staff experience to help further inform learning themes
- Service user experience of the NNCP to date
- Healthcare environments (estates and ventilation in relation to IP&C)
- Consideration of safeguarding in the emergency response to COVID-19
- Discharge planning

7. Closing remarks

Thank you to the NHS Wales staff who are delivering the programme, and for the valuable feedback from service users, families and carers, through whom we are identifying many areas for improvement. The wealth of positive feedback and areas of good practice are equally as valuable in demonstrating positions we should continue to take and develop.

Some of the content in this report may be upsetting for many. However, it is imperative that this programme offers transparent insights that will lead to meaningful change. Please be conscious of NHS Wales staff, service users, families and carers who are involved in this programme when discussing findings.

The extent of the work that still lies ahead should not be underestimated. The NNCP will continue to identify learning in the second year of the programme, with a view to sharing findings in Spring 2024.

8. Additional information

8.1 Accessing support

People involved in the programme are encouraged to reach out to their designated Health Board/Trust contact if they feel like they need a conversation about some of the findings. Mental health and wellbeing support can be accessed 24/7 via the CALL Mental Health Listening Line, call 0800132737 or text “help” to 81066.

A number of organisations that provide bereavement support can be found on the Health Education and Improvement Wales website.

Access to mental health and wellbeing support for NHS Wales staff is available through wellbeing services and occupational health in each Health Board/Trust in the first instance. Additional mental health and wellbeing support can be accessed through the CALL Mental Health Listening Line.

Media requests should be directed via the typical channels.

Aneurin Bevan University Health Board	Call: 0300 373 0652 Email: abb.covidinvestigationteam@wales.nhs.uk
Betsi Cadwaladr University Health Board	Call: 03000 846992 Email: BCU.HCAICovid19@wales.nhs.uk
Cwm Taf Morgannwg University Health Board	Call: 01443 443084 Email: CTM.NosocomialCV19@wales.nhs.uk
Cardiff and Vale University Health Board	Call: 02921 836407 Email: Cav.Covidsupport@wales.nhs.uk
Hywel Dda University Health Board	Call: 0300 303 8322 Email: covidenquiries.hdd@wales.nhs.uk
Swansea Bay University Health Board	Call: 01639 684440 Email: SBU.NosocomialReviewTeam@wales.nhs.uk
Powys Teaching Health Board	Call: 01874 442918 Email: PTHBNosocomialReviewTeam@wales.nhs.uk
Velindre University NHS Trust	Call: 02920 196161 Email: HandlingConcernsVelindre@wales.nhs.uk

8.2 Glossary of terms

Co-horting	Defines groups of people with shared characteristics from health data being placed together where demand exceeds capacity. In the context of this report, co-horting relates to suspected COVID-19 diagnosis and other health related issues.
Concern	A concern is any patient safety incident, or any expression of dissatisfaction raised by a member of the public and can be verbal or written.
Consumable items	Goods used by individuals and businesses that must be replaced regularly such as needles / swabs etc. In the context of this report, 'consumables' refers to items used for COVID-19 testing.
DNACPR	This refers to a specific process of discussion and documentation NOT to initiate future CPR (Cardio-Pulmonary Resuscitation) in the event of a future cardiac arrest and natural and anticipated dying event. A DNACPR decision does not have repercussions on any other element of treatment and care.
Independent providers	Services delivered by organisations that are not NHS Health Board/ Trust services. Examples include independent care providers such as care homes, local authority social services, charities and Third Sector organisations.
Nosocomial infections	Nosocomial infections, also referred to as 'healthcare-associated infections' (HAI), are infection(s) caught during the process of receiving health care, and where that infection was not present during the time of a person's admission to hospital or healthcare setting. They may occur in different areas of healthcare delivery, such as in hospitals, long-term care facilities, and ambulatory settings. The infection may also appear after discharge from a healthcare setting but are attributed to the time a person was in contact with the healthcare setting.
Patient safety incident	An unintended or unexpected incident which could have or did lead to harm for one or more patients receiving NHS-funded care.
PPE (Personal protective equipment)	Protective face coverings, clothing, helmets, goggles, or other garments, designed to protect the wearer from injury or infection.
Service users	Anybody using NHS Wales healthcare funded services.
Surveillance definitions	Surveillance of Health Care Acquired Infections refers to the monitoring and reporting of these events. Surveillance definitions are used to categorise these events as part of investigations.