Processes for reviewing patient harm in the context of COVID-19

Author: Andrew Furlong, UHL Medical Director

Trust Board paper G

Purpose of report:

This paper is for:	Description	Select (X)
Decision	To formally receive a report and approve its recommendations OR a particular course of action	
Discussion	To discuss, in depth, a report noting its implications without formally approving a recommendation or action	
Assurance	To assure the Board that systems and processes are in place, or to advise a gap along with treatment plan	X
Noting	For noting without the need for discussion	

Previous consideration:

Meeting	Date	Please clarify the purpose of the paper to that meeting using the categories above
CMG Board (specify which CMG)		
Executive Board		
Trust Board Committee		
Trust Board		

Executive Summary

Context

The COVID-19 pandemic has put unprecedented strain on the NHS and has meant that at the height of the pandemic waves elective activity was significantly reduced in order to redeploy resources to care for patients unwell with COVID-19. Whilst the outcomes for COVID-19 patients have been well-documented, there is increasing recognition of harm that may occur to non-COVID patients as a result of the pandemic particularly in relation to extended waiting times for planned services.

This paper describes the approach that UHL has taken to identify the risks to patients, the actions taken to reduce the likelihood of harm occurrence, and our approach to recording harm that is thought to have occurred due to the unintended consequences of diverting capacity to treat COVID-19 positive patients. It also outlines our approach to managing hospital onset healthcare associated COVID-19 infection.

Input Sought

We would welcome the Trust Board's input regarding the approaches we are taking to identify and record potential harm in the context of the COVID-19 pandemic and where possible, to mitigate these risks.

For Reference

This report relates to the following UHL quality and supporting priorities:

1. Quality priorities

Safe, surgery and procedures	[Yes]
Improved Cancer pathways	[Yes]
Streamlined emergency care	[Not applicable]
Better care pathways	[Yes]
Ward accreditation	[Not applicable]

2. Supporting priorities:

People strategy implementation	[Not applicable]
Investment in sustainable Estate and reconfiguration	[Not applicable]
e-Hospital	[Not applicable]
Embedded research, training and education	[Not applicable]
Embed innovation in recovery and renewal	[Not applicable]
Sustainable finances	[Not applicable]

3. Equality Impact Assessment and Patient and Public Involvement considerations:

- What was the outcome of your Equality Impact Assessment (EIA)? N/A
- Briefly describe the Patient and Public Involvement (PPI) activities undertaken in relation to this report, or confirm that none were required N/A
- How did the outcome of the EIA influence your Patient and Public Involvement? N/A
- If an EIA was not carried out, what was the rationale for this decision? N/A

4. Risk and Assurance

Risk Reference:

Does this paper reference a risk event?	Select (X)	Risk Description:
Strategic: Does this link to a ***Principal Risk*** on the BAF?		
Organisational: Does this link to an ***Operational/Corporate Risk*** on Datix Register		
New Risk identified in paper: What ***type*** and ***description***?		
None		

5. Scheduled date for the **next paper** on this topic: [TBC]
6. Executive Summaries should not exceed **5 sides** [My paper does comply]

Processes for reviewing patient harm in the context of COVID-19

Author: Andrew Furlong, UHL Medical Director

1 Introduction:

1.1 The COVID-19 pandemic has put an unprecedented strain on the NHS and has meant that at the height of the pandemic, elective activity was significantly reduced in order to redeploy resources to care for patients unwell with COVID-19. Whilst the outcomes for COVID-19 patients have been well-documented, there is also increasing recognition that harm can occur to non-COVID patients as a result of the pandemic.

1.2 This paper describes the approach that UHL has taken to identify the risks to patients, the actions taken to reduce the likelihood of harm occurrence, and our approach to recording harm that is thought to have occurred due to the unintended consequences of diverting capacity to treat COVID-19 patients. It also details the approach we are taking to identify, investigate and to learn from hospital-onset healthcare associated COVID-19 nosocomial infection.

2. Identifying harm:

2.1 Cancer patients:

The potential harm that can occur to cancer patients due to the pandemic is most likely to be due to delays in diagnostic procedures and/or postponement of planned treatment which could potentially result in tumour progression, increased risk of complications and a reduction in survival rates.

At the start of the COVID-19 pandemic, UHL ensured that all cancer pathways were aligned to recommended national, regional or specialist society guidelines for use in the COVID-19 pandemic. A COVID harm form based on the national cancer 104 harm process was developed to ensure a harm review was carried out on all patients whose care deviated from these pathways. This was in addition to the 104 harm process that is still in operation. The purpose of these two processes is to assess whether any patient has come to actual harm

All patients awaiting treatment are categorised into clinical priority groups 1 to 4 as per the national guidelines. Patients undergo regular clinical review with their priority status changed or alternative nationally agreed treatment regimens offered if required on clinical grounds. This ensures that those patients with the highest clinical urgency are prioritised for appropriate treatment.

A group chaired by a Deputy Medical Director with clinicians from all the CMGs and theatre management meet twice a week to ensure that theatre resource is allocated to these highest priority patients. These meetings are also attended by the UHL Cancer

Centre lead clinician. Patients that cannot be listed within an appropriate time frame by UHL and who are willing to travel are referred into the East Midlands Cancer Alliance surgical hub to see whether surgery can be offered in another Trust. In addition to the UHL theatre resource, capacity in the Independent Sector and the community is maximised for diagnostic procedures as well as surgery with priority again determined on the basis of clinical need with the Cancer Centre clinical lead input into this process.

In addition to the 104 and COVID harm forms, the Datix reporting system continues to be used to report patient safety incidents.

Governance oversight of these processes is provided by the Cancer Centre who seek ongoing assurance from the MDT leads that the recommended pathways are being followed and that a regular clinical review process is in operation.

2.2 Non-cancer elective patients:
The Trust has a process whereby all services must locally agree and record a review period for patients on their waiting lists based on their procedure type and clinical urgency using the national categorisation framework (categories P1-4).

This categorisation is agreed between senior medical and administrative teams and recorded on our Patient Administration System. When patients exceed this date, then a further review is undertaken by their responsible clinician. This also includes cancellation of waiting lists for procedures that are no longer required, updated urgency codes, changes to procedure and patient decisions to delay their procedure based on national clinical categorisation codes 5 and 6 (patients wishing to suspend treatment due to the risks of undergoing treatment during the pandemic). The patient's GP is informed of any changes.

As we restore our planned care clinical services, we are actively reviewing our clearance times by patient priority categorisation and for those patients whose waits exceed 52 weeks. On-going work is being undertaken to validate our waiting lists to ensure that those patients categorised as most clinically urgent are being given priority.

Where possible, use of East Midland networks for mutual aid and the Independent Sector are also used to support.

2.3 Responsive actions to prevent harm:
Theatre Scheduling:
When theatre sessions became a scarce resource due to redeployment of staff to help care for COVID-19 patients during the 1st and 2nd waves, a process was put in place to flex available theatre resource and capacity to patient priority based on national priorisation categories.

Clinically-led weekly Session Allocation Scheduling meetings were enhanced during the pandemic and used to support surgical services and theatre teams to ensure prioritisation and allocation of patients to available operating theatre sessions was fair and equitable throughout the Trust, the Alliance and the Independent Sector.

These meetings have continued as we restore and recover our services and are chaired by a Deputy Medical Director with clinical representation from all CMGs. An action orientated log is maintained and the process is supported by a Trust Standard Operating Procedure (SOP).

2.4 Recording harm: Incident reporting:
We have an established robust incident reporting process within UHL and staff are actively encouraged to report both patient safety incidents and prevented patient safety incidents onto Datix (our incident reporting system).

Those incidents reported and graded moderate harm, major harm or death are reviewed by the Corporate Patient Safety team who link with the speciality involved within the CMG to undertake an initial review and to confirm grading and agree what level of investigation is required. In addition to this, there are specific process for review of harms related to falls, Hospital Acquired Pressure Ulcers (HAPUs), hospital acquired infections (separate to COVID-19), sepsis, imaging discrepancies, delays in image reporting and delays in cancer pathways. Each month a report is provided to our Executive Quality Board and Quality Outcomes Committee with patient safety data and themes, including reported harms and finally approved harms. During the COVID-19 first and second waves, a weekly report was provided to the Executive Boards that provided information and assurance about harms during that period.

A strengthened process for capturing actual harm as a result of a delay in treatment or follow up due to COVID-19 has been implemented. As with our usual incident reporting process, we report these into Datix as an incident but have established a bespoke template within the Datix system for this purpose. This ensures that an appropriate level of investigation is undertaken and Duty of Candour requirements are met where harm has occurred to a patient due to delays caused by the COVID-19 pandemic.

We also triangulate the harm themes we are seeing from incidents with those identified from our Learning from Deaths (LFD) process so that we can understand what the chief issues of concern are that are causing patient harm and build them into our priorities of work going forward. We continue to measure mortality outcomes, rate of harm and patient experience through feedback and complaints.

3 COVID-19 Nosocomial infections:
3.1 Identifying harm:
All in-patients are regularly tested for COVID-19 in line with national guidance.

During the first and second waves of the pandemic, there were daily reports to Tactical Command on the number of patients who may have potentially acquired COVID-19 in our hospital wards.

Robust Infection Prevention & Control processes to manage any COVID-19 outbreaks are in place in line with Public Health England guidance overseen by the Chief Nurse/Director of Infection Prevention & Control.

The criteria for identification of hospital-onset healthcare associated COVID-19 infection are set nationally and defined as:

Community Acquired ≤ 2 days after admission
Hospital-onset **indeterminate** - 3-7 days after admission
Hospital-onset **probable** healthcare associated - 8-14 days after admission
Hospital-onset **definite** healthcare associated ≥15 days after admission

In February 2021, guidance was received that required all Trusts to introduce processes that where regardless of the harm caused, a probable or definite hospital-onset healthcare associated COVID-19 infection occurs, the care that was provided should be reviewed to identify any aspects of care or treatment that could be improved. Actions to address issues identified through this process should be subject to a clearly documented action plan.

In response to this, an aggregated COVID-19 outbreak report detailing learning and actions taken was reviewed by the Trust Board's Quality Outcomes Committee (QOC) on 29 April 2021; details of which were included in the QOC report to the public Trust Board on 6 May 2021.

The February guidance also detailed that where the result of a probable or definite hospital-onset healthcare associated COVID-19 infection was thought to be moderate harm or worse, then the Duty of Candour is engaged. Furthermore, where the outcome for the patient of a probable or definite hospital-onset healthcare associated COVID-19 infection was thought to be severe harm or death, then that incident meets the definition of a Serious Incident and should be reported onto the Strategic Executive Information System (StEIS).

In response to this, UHL set up a Task & Finish group to develop and agree a process for both retrospective cases and for any ongoing future cases. This process has now been discussed and agreed with the Regional NHSE&I team to ensure that UHL is applying the process in a similar way to other Trusts within the Midlands and nationally and will commence from early June 2021.

Conclusions:
UHL has robust and established processes to identify and report patient harm. However, in response to the risks of patient harm as a result of the COVID pandemic, UHL has introduced further processes to identify, respond to and report harm.

We would welcome the Trust Board's input regarding the approaches we are taking to identify and record potential and actual harm in the context of the COVID-19 pandemic and where possible, to mitigate these risks.