



**AGENDA ITEM**

3.2.10

**QUALITY & SAFETY COMMITTEE**

**CTMUHB NOSOCOMIAL COVID-19 INCIDENT MANGEMENT PROGRAMME**

**Date of meeting**

15/11/2022

**FOI Status**

Open/Public

**If closed please indicate reason**

Not Applicable - Public Report

**Prepared by**

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**Presented by**

Carole Tookey, Nurse Director for Planned Care

**Approving Executive Sponsor**

Executive Director of Nursing

**Report purpose**

FOR APPROVAL

**Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)**

**Committee/Group/Individuals**

**Date**

**Outcome**

Nosocomial COVID-19 Incident Management Programme Group

27/10/2022

Choose an item.

**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

DHCW

Digital Health and Care Wales

DU

NHS Wales Delivery Unit



IMSOP	Independent Maternity Services Oversight Panel
IPC	Infection, Prevention and Control
NNCP	National Nosocomial COVID-19 Programme
PTR	Putting Things Right
SRO	Senior Responsible Officer

## 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 assurance regarding the progress and delivery of the CTMUHB Nosocomial COVID-19 Incident Management Programme. This is linked to the National Nosocomial COVID-19 Programme (NNCP).
- 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 National Framework for 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)**

### **PROGRAMME OVERSIGHT**

- 2.0 At the end of Year 1, Quarter 2, the Health Board is compliant in meeting the milestones outlined on the National Roadmap for programme delivery. Another national self-assurance exercise is planned for future to re-assess programme delivery status.
- 2.1 There is now a full-time Head of Programme in post whose initial focus has been the refinement of the investigation approach and development of end-to-end processes for work flow as well as addressing urgent and escalating programme risks.
- 2.2 Current programme spending is within allocated budget however there is an unfunded workforce spend at the beginning of 2024/25. Finance colleagues have been unable to clarify funding requirements regarding in-year expenditure constraints and this information is now being sought by the national programme lead.
- 2.3 Rates of COVID-19 transmission are once again increasing across the nation and in our local communities. Cases of possible and confirmed nosocomial transmission of the virus continue to occur in our hospitals and healthcare settings with the associated consequences this has on affected patients and their loved ones.
- 2.4 Nosocomial COVID-19 cases recorded after the 30th April 2022 will also be subject to the requirements of the National Framework and PTR regulations. National discussions continue to reflect the recognised need for consistency of approach and equal resource commitments for all cases of nosocomial COVID-19, irrespective of acquisition date.
- 2.5 An updated version of the National Framework was issued in early October 2022, providing clarity on the application of PTR to commissioned care arrangements. The team will ensure that our commissioning responsibilities are fulfilled in accordance with the newly published framework where COVID-19 acquisition is concerned. The guidance is additionally applicable to other types of patient safety incidents and complaints (non-COVID-19 related) and has been shared with Health Board Quality and Governance colleagues for adoption in applicable circumstances.

- 2.6 The NHS DU undertook a site visit to the team on 20 October 2022 to review the programme progress in CTMUHB, the investigation approach and to observe an investigation scrutiny panel. This provided an important opportunity for the team to reflect critically on the programme approach and take on board national good practice. The feedback was overwhelmingly positive and the team is grateful for the constructive support offered.

## **WORK STREAMS**

### **2.7 Establish team, investigation methodology and governance arrangements**

- 2.7.1 A further clinical investigator post has been successfully appointed to and an additional non-clinical post in the team is progressing through the recruitment approval process. The additional resource this brings will support an increase in delivery pace.
- 2.7.2 The CTMUHB Nosocomial database which is being used to record investigation work has undergone a quality assurance review. This identified some minor data entry validation issues which are being addressed. Dependency on Information colleagues to support this can be challenging owing to existing workloads and priorities in the Information team.
- 2.7.3 The Nosocomial database has been further developed since the last update to this Committee to facilitate progress reporting. The ability to quickly and accurately report on the status of all investigations is critical to providing national monthly data submissions as well as internal data on areas of challenge in our in process flows so they can be promptly worked through.
- 2.7.4 Accommodation issues have been resolved and the team is working effectively from Dewi Sant Health Park site. A dedicated team base and sufficient storage for medical records will be needed throughout the duration of the programme.
- 2.7.5 The CTMUHB Nosocomial COVID-19 Incident Management Programme Group continues to run on a bi-monthly basis to ensure the Health Board's SRO is sighted on progress and risks.

## 2.8 **Investigations and quality assurance**

- 2.8.1 A national dashboard has been developed to provide consistent monthly data sets and easily accessible oversight of completion trajectories. The Health Board is grateful to the data team at the DU for developing this. The status of investigation work correct as of 30<sup>th</sup> September 2022 is presented in **Appendix 1**.
- 2.8.2 Investigation delivery pace is now a key focus for the team whilst maintaining high quality and we recognise the challenge ahead of us. Additional recruitment and targeted training within the existing team is helping to build our delivery pace and ensure that the Health Board will be able to comply with programme timescales.
- 2.8.3 Whilst effective work has been undertaken to address some of the issues affecting the pace of investigation work such as team resource, Mortality Review completion rate and Scrutiny Panel quoracy, other influencing factors have been less amenable to influence despite efforts to do so. This includes the poor retrospective functionality of the CITO electronic medical records system, workforce issues in the Medical Records service and the empty COVID-19 Information Manager post.
- 2.8.4 Audit work to provide assurance on the quality and consistency of the entire investigatory process has been commenced by the programme's Clinical Lead.

## 2.9 **Stakeholder, patient and family contact**

- 2.9.1 A National Communications and Engagement officer is due to be appointed who will liaise closely with the Communications Lead in post.
- 2.9.2 Progress updates and engagement continues to take place in staff forums to inform and reassure staff about the purpose of the Review Programme. A staff well-being pathway is in place if needed, to support clinical staff who are required to contribute to the investigations.
- 2.9.3 A dedicated helpline as a point of contact for supporting families continues to be available to any member of the public wishing to contact the team.
- 2.9.4 A number of FOI requests have been responded to in the appropriate timescales. The requests have largely been enquiries about the number of investigations and completion rates.

- 2.9.5 Enhanced quality assurance of the clinical investigations is ensuring that the individual PTR responses received by families will thoroughly address all aspects of qualifying liability and that the complex investigation process and findings are shared in a sensitive and comprehensible manner.

## 2.10 Thematic learning and improvement

- 2.10.1 As the clinical investigation and investigation scrutiny panel process is fully optimised, focus will be given to collating, analysing and sharing thematic and incident-specific learning from the programme. This will include examples of good practice as well as opportunities for improvement.
- 2.10.2 This will be undertaken in conjunction with national workstreams and learning repositories.
- 2.10.3 Learning will be shared and implementation overseen through a number of Health Board forums including the Shared Listening and Learning Forum and the IPC Committee.

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

- 3.0 To receive assurance regarding the Health Board's Quarter 1 and 2 position against the National Nosocomial COVID-19 Programme roadmap.
- 3.1 To note the challenging completion trajectory for investigations as the team build to full delivery pace. This is being addressed through additional recruitment however some factors, such as medical records service fragility and difficulties with the CITO electronic records system are not amenable to resolution.
- 3.2 To be advised that a full programme risk register is being reviewed bi-monthly at the Nosocomial COVID-19 Incident Management Programme Group and the overarching Programme risk is also reviewed at the Infection, Prevention and Control Group. Currently there are no risks that meet the threshold for escalation to the Organisational Risk Register.

## 4. IMPACT ASSESSMENT

<b>Quality/Safety/Patient Experience implications</b>	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.
<b>Related Health and Care standard(s)</b>	Governance, Leadership and Accountability
	Relevant to all Healthcare Standards
<b>Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.</b>	No (Include further detail below)
	Any new or altered services would have their own EIA undertaken.
<b>Legal implications / impact</b>	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.
<b>Resource (Capital/Revenue £/Workforce) implications / Impact</b>	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.
<b>Link to Strategic Goals</b>	Improving Care

## 5. RECOMMENDATION

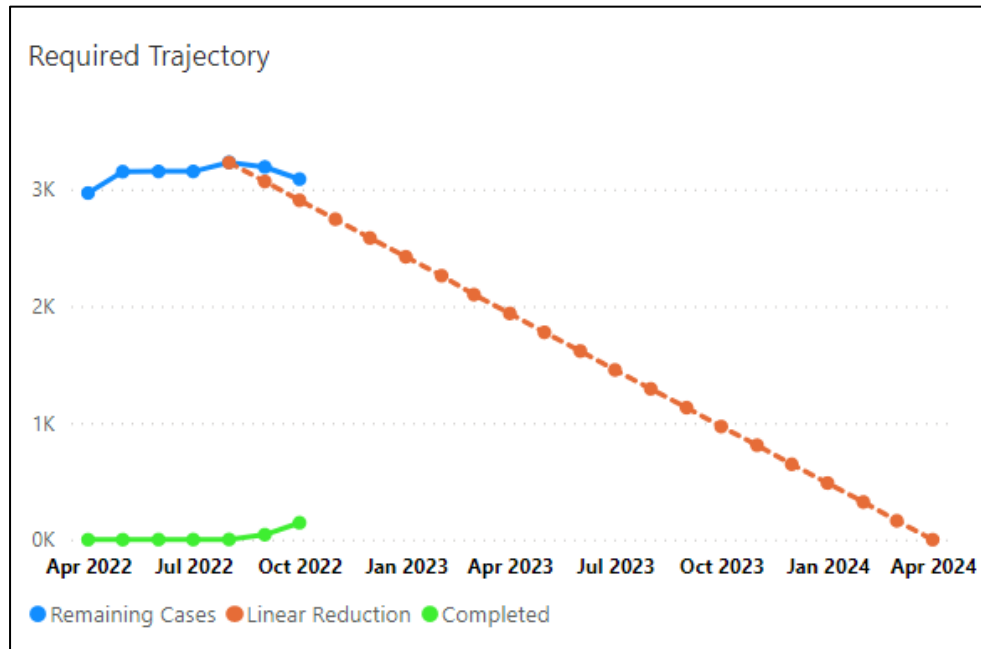
5.1 The Quality & Safety Committee is asked to **NOTE** this report.



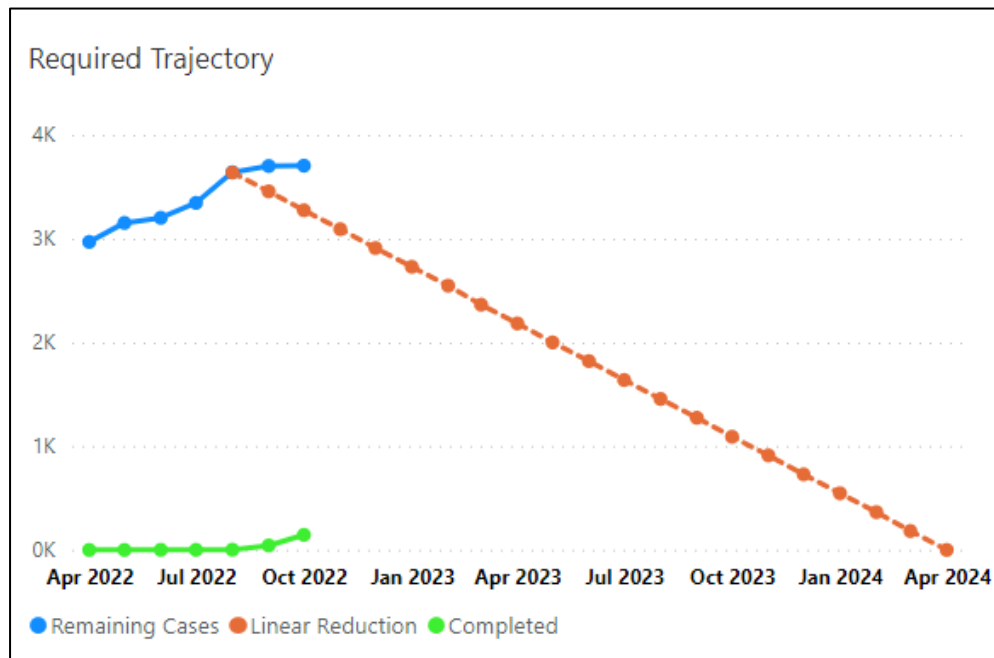


## Appendix 1.

### Nosocomial Dashboard (Waves 1-4)



### Nosocomial Dashboard (Waves 1-4 and live reporting)



\*Data correct as of 17/10/22



## Case status

	<b>Wave 1 (27/2/2020 - 26/7/2020)</b>	<b>Wave 2 (27/07/2020 - 16/05/2021)</b>	<b>Wave 3 (17/05/2021 - 19/12/2021)</b>	<b>Wave 4 (20/12/2021 - 30/04/2022)</b>	<b>Live 01/05/2022 -</b>
<b>Total Incidents</b>	479	1488	314	952	616
<b>Under Investigation</b>	133	444	81	121	82
<b>Not Started</b>	346	880	233	831	534
<b>Referred to Scrutiny Panel</b>	0	19	0	0	0
<b>Completed Investigations</b>	0	144	0	0	0
<b>Downgraded / Recategorised</b>	0	1	0	0	0

\*Data correct as of 30/09/22