AGENDA ITEM
3.2.6

QUALITY & SAFETY COMMITTEE

CTMUHB NOSOCOMIAL COVID-19 INCIDENT MANGEMENT PROGRAMME

Date of meeting	24/01/2023
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Carole Tookey, Nurse Director for Planned Care
Presented by	Carole Tookey, Nurse Director for Planned Care
Approving Executive Sponsor	Executive Director of Nursing
Report purpose	FOR NOTING

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	**Date**	**Outcome**
Nosocomial COVID-19 Incident Management Programme Group	29/12/2022	ENDORSED FOR APPROVAL

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
HCAIs	Health Care Associated Infections

IPC	Infection, Prevention and Control
NNCP	National Nosocomial COVID-19 Programme
PHW	Public Health Wales
PTR	Putting Things Right
RGH	Royal Glamorgan Hospital
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 Delivery pace has increased significantly in Quarter 3 now that the team is well established and the investigation approach embedded. A monthly completion target has been established to ensure that all investigations can be completed within the life span of the programme and this paper provides assurance that the team is currently delivering only slightly outside of the completion trajectory.

2.1 The Head of Programme will be leaving the Health Board for a new job role prior to the new financial year. Whilst delivery pace should be able to be sustained, their departure would leave governance and leadership weaknesses and therefore this position will be re-recruited to for the remainder of the programme.

2.2 Current programme spending is within allocated budget and the allotted funding for 2023/24 is fully accounted for in planned workforce spend. There is a small unfunded workforce spend at the beginning of 2024/25 but this has been reduced by recent staff turnover in the team as newly appointed posts will not extend past the end of financial year for 2023/24.

2.3 Nosocomial COVID-19 cases recorded after the 30 April 2022 will also be subject to the requirements of the National Framework and PTR regulations. The Delivery Unit has confirmed that the approach to managing and investigating HCAIs as patient safety incidents will be included in the refreshed version of their Nationally Reportable Incidents Policy.

WORK STREAMS

2.4 Establish team, investigation methodology and governance arrangements

2.4.1 A further clinical investigator has commenced in post and additional non-clinical support will also bolster the patient contact and support arm of the team in the New Year. An administrative position has become vacant however and a recent attempt at recruitment has been unsuccessful. This unfilled vacancy means that team resource is having to be diverted to complete necessary administrative tasks including physical selection of medical records.

2.4.2 Data validation activity against PHW reporting and the internal Nosocomial COVID-19 investigation database continues. This is being supported by PHW Epidemiology colleagues and CTMUHB Clinical Audit as part of hospital Mortality Review processes.

2.4.3 The Nosocomial database now allows for swift and accurate data reporting on completion figures for monthly national submissions.

2.4.4 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.

2.5 Investigations and quality assurance

2.5.1 The status of investigation work is presented in **Appendix 1.**

2.5.2 As of 30 November 2022, 16% of the total number of investigations have been completed.

2.5.3 Investigation delivery pace has increased significantly and care review panels have remained quorate in the face of heavy operational and frontline pressures. Scrutiny in these panels has helped to develop the quality of investigations and ensure that the investigation scope remains appropriate.

2.5.4 Audit work to provide assurance on the quality and consistency of the non-clinical aspects of the investigation process has demonstrated a pleasing level of accuracy and audits will be undertaken on a monthly cycle throughout the programme to provide continued assurance.

2.6 Stakeholder, patient and family contact

2.6.1 The Programme Communications Lead is ensuring that public facing information about the programme remains up-to-date on the Health Board website. The post-holder will also act as a point of liaison for the recently-appointed National Communications and Engagement officer.

2.6.2 Attendance at Care Review Panels from frontline clinicians ensures that important feedback and learning is being heard and allows for wider cascade and dissemination. It is likely however that frontline pressures have prevented wider engagement of less senior clinical members of staff. Invites and encouragement will continue to be offered and staff are updated via the intranet and staff briefings.

2.6.3 Proactive contact into the patient-facing helpline remains at a low level and to date, little feedback or engagement has been received following issue of investigation reports and PTR responses to patients or their relatives. This will continue to be monitored and if, team capacity allows, feedback may be sought through the use of the Civica Patient-Reported Experience Measure system.

2.6.4 All public-facing correspondence has been reviewed by the national CHC Lead for the programme, who also joined the team on site for a day to understand the team's investigation approach. Positive and constructive feedback was shared on how the team is ensuring the lived experience of patients and relatives is captured and learnt from.

2.7 Thematic learning and improvement

2.7.1 The team has been working through incidents of nosocomial acquisition of COVID-19 from the Royal Glamorgan Hospital during 'Wave 2' of the pandemic. 'Wave 2' was the time period from late summer 2020 to early spring 2021, one of the most pressured periods of the pandemic.

2.7.2 Thematic learning from clinical investigations and the care review panel process includes the following: the difficulties created by extreme levels of demand – this resulted in communication with families at times being below the standard we would ordinarily expect; laboratory testing capacity being overwhelmed, with delays in COVID-19 test results being available; very tight bed capacity meaning that risk-assessed decisions regarding the placement of individual patients were often needed; COVID-19 testing guidelines changing often and the rigorous testing regimes being challenging to maintain during periods of peak demand; possible evidence of divergence in medical prescribing practice between hospital sites. A reassuring picture has emerged about the level of clinical record-keeping, the quality of clinical care and the degree of consideration given to managing the logistical challenges associated with bed capacity and COVID-19 patient status.

2.7.3 Thematic learning from our discussions and correspondence with affected patients and families is largely focused on the importance and lasting impression created by the relationship and contact with the clinical teams. It has been disappointing to hear that a number of families were not kept updated when their relative was transferred between different wards and found it difficult to make contact, with phone calls going unanswered. Other families however have been keen to highlight the positive trusting relationships that were built with staff and the compassion shown, particularly in terms of end of life care.

2.7.4 Themes will be monitored as the team progresses onto reviewing other CTMUHB hospital sites, as well as being alert to novel site-specific learning.

2.7.5 This local-level learning is supplemented by national-level learning around issues such as DNACPR completion, the availability of bereavement services and the impact of COVID-19 within commissioned services and care placements. A national Learning and Experience Collaborative has been established to share these themes.

2.7.6 Learning is being shared and implementation overseen through the Shared Listening and Learning Forum, IPC Committee and the Bereavement working Group

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

3.0 To receive assurance that delivery pace is now reaching the target level for full programme completion by April 2024.

3.1 To note the emerging learning from Royal Glamorgan Hospital 'Wave 2' reviews which has been shared through care review panels and will be brought forward into wider Health Board learning settings.

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

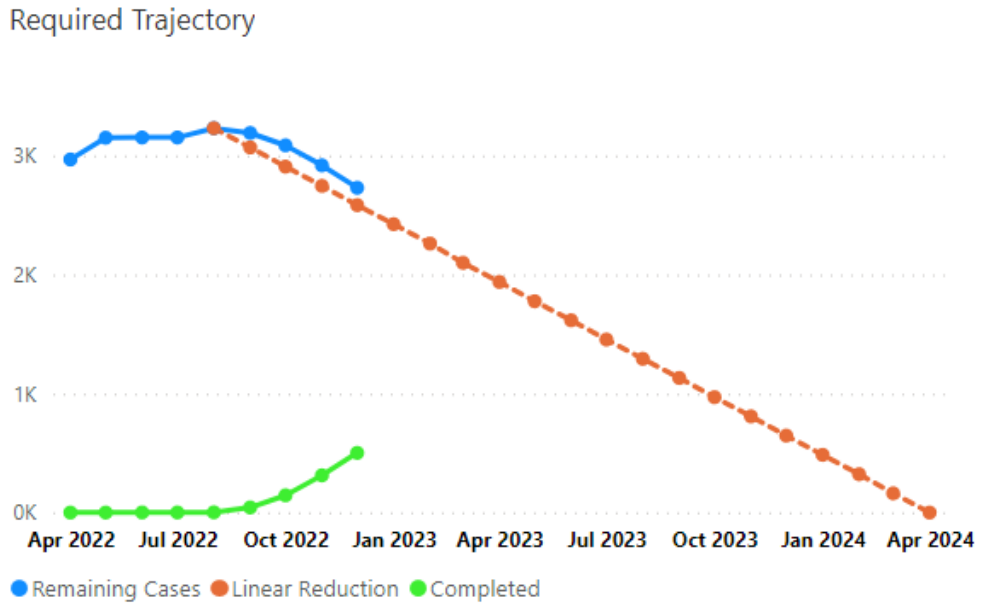
Quality/Safety/Patient Experience implications	Yes (Please see detail below)
	Large numbers of our population were affected themselves or lost relatives as a result of nosocomial COVID-19 infection. This report details key steps in addressing their concerns and learning for future infection management 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 <u>all</u> 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

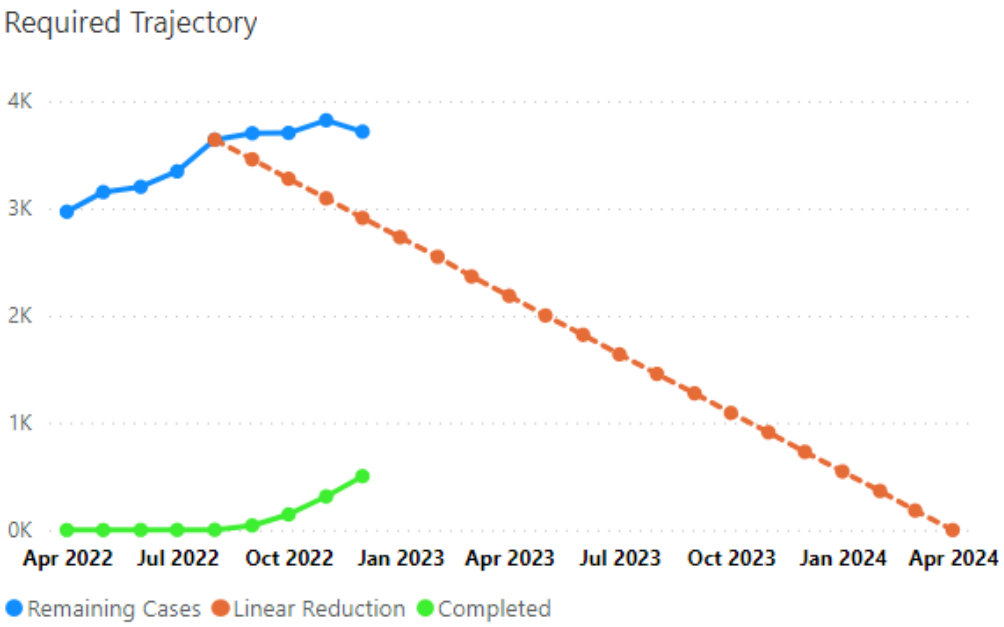
5.1 The Quality & Safety Committee is asked to **NOTE** this report.

Appendix 1

CTM Nosocomial Dashboard (Waves 1-4)



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



*Data correct as of 15/12/22

CTM Case status

	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)	Live 01/05/2022 -
Total Incidents	479	1488	314	952	985
Not Started	316	589	233	831	849
Under Investigation	155	385	81	121	136
Downgraded / Recategorised	0	6	0	0	0
Referred to Scrutiny Panel	0	20	0	0	0
Completed Investigations	8	488	0	0	0

*Data correct as of 30/11/22