Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

**CYFARFOD Y PWYLLGOR ANSAWDD, DIOGELWCH A PHROFIAD**
**QUALITY, SAFETY AND EXPERIENCE COMMITTEE**

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| **DYDDIAD Y CYFARFOD:**<br>**DATE OF MEETING:** | 05 December 2024 |
| **TEITL YR ADRODDIAD:**<br>**TITLE OF REPORT:** | Learning from the National Nosocomial COVID Review Programme |
| **CYFARWYDDWR ARWEINIOL:**<br>**LEAD DIRECTOR:** | Sharon Daniel, Interim Executive Director of Nursing, Quality and Patient Experience |
| **SWYDDOG ADRODD:**<br>**REPORTING OFFICER:** | Cathie Steele, Interim Assistant Director of Nursing Assurance and Safeguarding |

| **Pwrpas yr Adroddiad** (dewiswch fel yn addas)<br>**Purpose of the Report** (select as appropriate) |
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| Er Sicrwydd/For Assurance |

**ADRODDIAD SCAA**
**SBAR REPORT**

## Sefyllfa / Situation

The purpose of this report is to provide the Quality, Safety and Experience Committee (QSEC), with an update on the learning from the End of Programme Learning Report for the National Nosocomial COVID-19 Programme (NNCP).

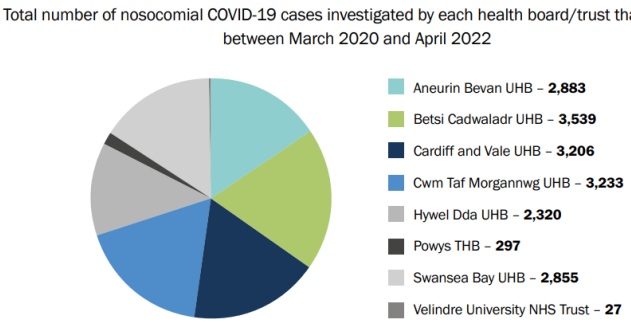
## Cefndir / Background

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.

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.

Over the course of the two-year programme, the framework has supported NHS Wales organisations to assess and investigate a total of 18,360 cases of nosocomial COVID-19 where they met the definition of a patient safety incident.

Within Hywel Dda UHB 2,320 patients were reviewed as part of the framework. The local (Hywel Dda UHB) end of programme closure report was shared with QSEC in February 2024 and Listening and Learning Sub-Committee in March 2024. An improvement and learning action plan has been developed to address the learning identified during the local programme.




"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"

Welsh Government (July 2022)

## Asesiad / Assessment

NHS Wales has published its National Nosocomial COVID-19 Programme End of Programme Learning Report, providing an overview of the programme and summarising national learning themes that have been identified during the investigation process.

The full report can be found nhs.wales/sa/national-nosocomial-covid-19-programme/nat-noso-files/end-of-programme-learning-report-national-nosocomial-covid-19-programme-eng-final-pdf/

The learning themes 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
- Communication with families and carers

**Patient safety incidents and concerns**

- Patient safety incidents outside of NHS Wales settings
- 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
- Clinical record keeping
- Staffing and resource

**Infection prevention and control**

- Publication and distribution of guidance
- Outbreak management
- Discharge planning
- Hospital environments

Many of the recommendations made within the national report link with work already underway within the Health Board. Attached as appendix 1 are the recommendations and how the recommendation is being taken forward within the Health Board.

## Argymhelliad / Recommendation

The Quality, Safety and Experience Committee, is asked to receive assurance that the recommendations made within the End of Programme Learning Report for the National Nosocomial COVID-19 Programme have been considered and are being taken forward within the Health Board.

| **Amcanion: (rhaid cwblhau)**<br>**Objectives: (must be completed)** | |
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| Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol:<br>Datix Risk Register Reference and Score: | |
| Parthau Ansawdd:<br>Domains of Quality<br>Quality and Engagement Act (sharepoint.com) | 7. All apply<br>Choose an item.<br>Choose an item.<br>Choose an item. |
| Galluogwyr Ansawdd:<br>Enablers of Quality:<br>Quality and Engagement Act (sharepoint.com) | 1. Leadership<br>2. Culture and valuing people<br>Choose an item.<br>Choose an item. |
| Amcanion Strategol y BIP:<br>UHB Strategic Objectives: | All Strategic Objectives are applicable<br>Choose an item.<br>Choose an item.<br>Choose an item. |
| Amcanion Cynllunio<br>Planning Objectives | Not Applicable<br>Choose an item.<br>Choose an item.<br>Choose an item. |
| Amcanion Llesiant BIP:<br>UHB Well-being Objectives:<br>Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022 | 10. Not Applicable<br>Choose an item.<br>Choose an item.<br>Choose an item. |

| **Gwybodaeth Ychwanegol:**<br>**Further Information:** | |
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| Ar sail tystiolaeth:<br>Evidence Base: | |
| Rhestr Termau:<br>Glossary of Terms: | NNCP – National Nosocomial COVID-19 Programme |
| Partïon / Pwyllgorau yr ymgynghorwyd â nhw cyn Cyfarfod y Pwyllgor:<br>Parties / Committees consulted prior to In Committee Meeting: | |

| **Effaith: (rhaid cwblhau)**<br>**Impact: (must be completed)** |
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| **Ariannol / Gwerth am Arian:**<br>**Financial / Service:** | No financial impact identified at this time from the report itself. Each recommendation has been linked with current improvement work. |
| **Ansawdd / Gofal Claf:**<br>**Quality / Patient Care:** | The recommendations and actions will improve patient care and the quality of services within the Health Board. |
| **Gweithlu:**<br>**Workforce:** | No impact identified at this time from the report itself. Each recommendation has been linked with current improvement work. |
| **Risg:**<br>**Risk:** | |
| **Cyfreithiol:**<br>**Legal:** | No impact identified at this time. |
| **Enw Da:**<br>**Reputational:** | No impact identified at this time. |
| **Gyfrinachedd:**<br>**Privacy:** | No impact identified at this time. |
| **Cydraddoldeb:**<br>**Equality:** | No impact identified at this time. |

**Appendix 1: National Nosocomial COVID-19 Programme: End of Programme Report Recommendations**

| NNCP key learning | Health Board response |
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| Bereavement support services should be proactively offered to all families who are experiencing grief following the loss of a loved one. This is also an extremely important consideration as part of patient safety incident investigation processes.<br><br>Families should be proactively signposted to information about bereavement services at the earliest opportunity. | This learning was reflected within the Health Board's Nosocomial COVID-19 Review Programme.<br><br>Work is underway to strengthen the Health Board's bereavement/Care after Death arrangements to ensure that there are consistent and equitable services across the Hywel Dda region |
| 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.<br><br>Supporting information should be available and easily accessible to assist families in understanding the sometimes-complicated language linked to the concerns process. | Implementation of the Duty of Candour has strengthened the single point of contact arrangements where there has been a more than minimal harm patient safety incident.<br><br>The Health Board has a single point of contact for raising concerns and queries through the Patient Support Services.<br><br>Information is available on the Health Board website.<br><br>The Charter for Improving People and Community Experience was approved by Board in March 2024<br><br>The use of patient experience surveys is increasing through the roll out of CIVICA.<br><br>A revised Peoples Experience Framework is also being issued by Welsh Government as a Welsh Health Circular (expected shortly). This will enhance each team's responsibilities to encourage and receive feedback from people accessing our services and make improvements to enhance service quality and experiences. |

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| All services and wards should have named dedicated patient support teams and volunteers to support families and carers who may be finding it difficult to visit a loved one in hospital.<br><br>Future visiting guidance should pay particular reference to the role carers have as an important part of a patient's care team. Health boards and trusts are now further recognising this in scenarios where visiting restrictions need to be implemented. | This learning has been shared with Directorate Teams and is noted should visiting be restricted in future. |
| The strain placed on ward staff had a negative impact on capacity which had an adverse impact on communication with patients' families and carers.<br><br>Under periods of extreme pressure, Patient Advice and Liaison Service (PALS) teams and volunteers, where appropriate, can be effective to support communications whilst ward staff prioritise patient care needs | The Health Board has a single point of contact through the Patient Support Services.<br><br>Information is available on the Health Board website.<br><br>The use of Family Liaison Officers was identified as good practice within the Health Board's Nosocomial COVID-19 Review Programme. |
| 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.<br><br>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 an appropriate patient safety investigation needs to be initiated. | The Health Board's Incident, Hazard and Near Miss Reporting and Management Policy has been reviewed and updated.<br><br>A programme for concerns investigation and management training is in place.<br><br>Directorates hold incident scrutiny meetings for specific incident types. The IP&C team give reminders about incident report when hospital-acquired infections are identified. |
| 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. | This learning was reflected within the Health Board's Nosocomial COVID-19 Review Programme and within the current EQIiP |

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| 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. | Programme a specific project is underway to improve DNACPR consideration and communication.<br><br>SharePoint has been updated to provide a single point for accessing information regarding DNACPR. A 7-minute briefing regarding DNACPR decision making has also been published.<br><br>An improvement and learning action plan has been developed to address the recommendations made by Healthcare Inspectorate Wales in the National DNACPR Review Report. |
| For clinical records to be completed to a high standard, clinical staff need the time to focus their attention on record keeping. There may also be wider value in reaffirming to clinical staff the value in record keeping and how it supports the patient safety agenda and investigation processes.<br><br>Digital solutions for clinical record keeping support good practice, enhancing legibility and timely access to notes. Work underway by Digital Health and Care Wales and NHS Wales organisations to embed systems such as the online Welsh Nursing Care Record will enhance the quality of record keeping and improve patient safety. | This learning was reflected within the Health Board's Nosocomial COVID-19 Review Programme - a 7-minute briefing on the value and importance of good record keeping is in draft and will be issued shortly.<br><br>The Health Board uses the Welsh Nursing Care Record. |
| 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. | The Health Board has recently introduced Viva Engage.<br><br>SharePoint is also used as a central resource.<br><br>Board rounds and safety huddles are in use on wards and clinical areas. |

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| Policies and processes should reflect mechanisms that result in limiting the number of patient moves, ensuring patients are in the right place at the right time.<br><br>Where patients are moved, families should receive proactive and timely communication on the location and rationale for the move. | This learning was noted within the Health Board Nosocomial COVID-19 Review Programme and was shared as learning in outbreak meetings during the pandemic.<br><br>This learning has been shared with Directorate Teams |
| Patients who experienced delayed discharge were at an increased risk of deterioration and infection. It should be acknowledged that delayed discharges were arguably a symptom of unprecedented wider system pressures (secondary, primary and community care) including different ways of working, high levels of seriously ill patients, staffing pressures and limited patient movement due to IP&C precautions and national guidance regarding discharge arrangements and community support | This learning was reflected within the Health Board's Nosocomial COVID-19 Review Programme.<br><br>A Pathway of Care Delays (PoCD) delivery group has been established with membership from health, social care & Mental health & LD. and agreed ToR. Group meets monthly to review themes from POCD and ensure that actions to improve delays are in place and monitored through an action plan which is reported quarterly to Welsh Government through the NHS Executive via Policy Goal 6 Lead of the national 6 Goals programme. The group has documented the PoCD process. |
| An aging healthcare estate in Wales presents a number of challenges, especially around IP&C in a pandemic scenario. Where possible, health boards and trusts should continue make improvements that enhance IP&C measures and use learning from the pandemic to inform future hospital design. | This learning was reflected within the Health Board's Nosocomial COVID-19 Review Programme.<br><br>Any new build will comply with HTMs/Standards https://nwssp.nhs.wales/ourservices/specialist-estates-services/publications-and-information/welsh-health-technical-memoranda-whtms-health-technical-memoranda-htms/ |