NHS GRAMPIAN

Clinical Governance Committee

Board Meeting
3 12 20
Open Session
Item 5.2

Objective 1 – Nosocomial Risk Reduction – Update Dec 2020

1. Actions Recommended

- The Board is asked to note progress made with respect to assuring the delivery of Objective 1.
- The Board is asked to note and support next steps.

2. Strategic Context

As we adapt to living with COVID-19 it is increasingly important to recognise nosocomial spread of infection is a significant risk in both healthcare and care home settings. This has further emphasised the importance of controlling these environments with respect to patient flow, staff measures and the physical configuration of our buildings. We continue to journey through re-mobilisation of services, which bring additional complex service provisions and requirements, and we do so while COVID specific services are maintained. This introduces new and challenging risks in service provision.

As part of the suite of nine 'Living with Covid' objectives agreed by the System Leadership Team (SLT), Objective 1 describes system arrangements for Nosocomial Risk Reduction. Achievement of this objective has been supported via the development of an Objective 1 Assurance Framework. This framework, developed in partnership, describes various levels of assurance:

- Self-assessment at site/building level
- Local Action Plans (regularly reviewed) to address deficiencies identified from the self-assessments
- Identification of Safer Workplace Champions and Safer Workplace Building/Service Managers
- Assurance visits undertaken at local operational level
- Assurance via independent supportive visits.

3. Key matters relevant to recommendation

Following the update report to NHS Grampian Clinical Governance Committee (13.11.20) progress has been achieved in both immediate and short-medium term priorities as summarised below, however, this remains work in progress and some challenges remain across the system.

3a – Progress Update Summary

The escalation of Objective 1 to level 3 of Operation Snowdrop Matrix Incident Response Scale has facilitated increased support and scrutiny. The prioritised focus has ensured that increased assurance visits were being undertaken within all Tranche 1 facilities (NHSG owned/leased secondary care sites), in particular within Aberdeen Royal Infirmary (ARI). Overdue Local Action Plans were requested of Chief Officers and site/building managers and this request provided additional clarity

on the expectations of sector/H&SCPs and assurance visit requirements. Now 93% of action plans for Tranche 1 facilities have been submitted, with 2 action plans awaited.

An electronic assurance visit recording template, based on the original self-assessment matrix, has been created by Acute Sector; this will be soft launched week 30.11.20 for use across all Tranche 1 (NHSG owned/leased secondary care sites) and Tranche 3 (NHSG owned/leased non-clinical) sites system wide. This will enable organisational oversight through the Safer Workplaces Group with all data in a central repository.

An external contractor has been appointed to complete a review and installation of all COVID related internal signage and posters; this commenced at ARI site 25.11.20. Wards/departments will be required to remove their own posters. A review of external signage at entrances/exits will take place to enable effective flow for staff, patients and public. Again work has been prioritised at ARI and Woodend before moving to other hospitals across NHS Grampian. This further roll out will be prioritised depending on self-assessment and action plan details. (For example, Dr Gray's Hospital reported this action was complete and assured).

Staffed entrances continue with additional support provided to emphasise the requirement for personal interactions while reminding those entering the buildings of the importance of mask wearing, using hand gel and maintaining physical distances.

Safe Workspaces Facilitators (4.0 WTE) are being recruited, with interviews scheduled for 14th Dec. Successful candidates will commence in these essential posts as soon as possible.

The table below provides a summary and update on assurance visits at 27.11.20:

Site/Sector/H&SCP	Visits completed	Visits planned	Visits scheduled
ARI	85%	15%	23.11.20 to 27.11.20
Woodend Hospital	25%	75%	23.11.20 to 27.11.20
Royal Cornhill Hospital	21%	79%	23.11.20 to 18.12.20
Dr Gray's Hospital	50%	50%	16.11.20 to 04.12.20
Moray Community Hospitals	17%	83%	25.11.20 to 04.12.20
Aberdeenshire Community Hospitals	0%	13%	

Assurance visit themes can be categorised into four key areas, all which remain challenges when trying to change behaviours. Actions underway to address these are detailed beside each category:

- Lack of shared learning
    - The Infection Protection Control Team have been reviewing the themes from Incident Management Team meetings (IMTs). It is anticipated that a format for sharing will be endorsed by the team on week 30th November for sharing with Executive Lead and subsequent sharing and learning across the system.

- Inconsistent approach to COVID-19 related signage
    - External contractor appointed to rectify signage – prioritised phase on ARI and Woodend site due to complete 14th December
- Lack of staff rest/changing areas (ARI focussed)
    - Additional changing/locker areas y has been identified to provide 400+ additional lockers within the existing estate – completed
    - A second canteen area will be available 24hrs following Estates and contractor reprioritisation of works
    - Adaptation of Board Room as a staff haven following Estates reprioritisation of works
    - Additional room identified to provide a further staff haven – will progress if positive impact form initial staff haven
    - Procurement of marquee to further increase staff rest areas – from week beginning 7th December
    - Service ownership to lead local control measures (for example - local guidance for existing changing room facilities) – ongoing
- Inconsistent physical distancing
    - Revised signage and personal interaction at staffed entrances will act as reminders – prioritised signage work complete by 12th December; enhanced measures at staffed entrances from 30th November
    - Service ownership to ensure workplaces enable appropriate physical distancing where possible (for example – relocation of workstation computers if normally sitting side by side) – identification through ongoing local assurance visits

3b – Further Work

A whole system and multi-staff group approach, through SLT, is necessary to provide consistency, key-messaging, fairness and equity to our overall approach against Objective 1. A clear communication strategy is required to ensure individual staff members to senior leaders are aware of personal responsibility and available supporting resources. Work to progress this will commence week 30th November. A review of resources and updating to reflect current stage in pandemic and the active adoption of Safe Workplace Managers and Champions will form part of this plan.

The sharing of good/innovative practice as well as learning from causes of nosocomial spread from Incident Management Teams (IMTs) and Problem Assessment Groups (PAGs) is also integral to communication plan. Initial scoping of how this could occur commenced week commencing 16th November and endorsement in principle from Infection Prevention Control Team is awaited.

A further component is clear messaging to patients and their families as to how they must also take personal responsibility to support safer environments before, during and after entering healthcare facilities. The use of recorded messages at switchboard to remind visitors not to come to hospital if feeling unwell is already in place.

3c – Behavioural Change

A further strand that now requires immediate progression is to positively influence behaviour and behaviour change. This is perhaps the greatest challenge of all. Anecdotes from assurance visits suggest that individual local positive behaviour changes occur in areas after nosocomial spread, although there is no assurance this is maintained.

Across the healthcare system behaviours and habits have developed by staff to adapt and accommodate to their environment, often in a "make-do" approach; for example staff changing or rest rooms. Internal values, commitment to colleagues and patients and sense of guilt has seen staff attend for work when dealing with minor illnesses. Changing behaviours, habits and values/beliefs take time yet we are asking our staff to rapidly change while they continue in to work in the midst of a pandemic.

A consistent system wide approach will be required including Psychosocial Cell and People and Culture Directorate, although early discussions between Acute Sector and Psychological Cell has taken place. New messaging had already been developed by one of our Psychologists, the Safer Workplaces Group and Corporate Communications; it will be disseminated week beginning 30th November.

3d – Nosocomial Duty of Care

- Patients who develop nosocomial COVID-19 infection are almost always vulnerable as they are in hospital associated with an existing illness. COVID-19 infection may directly cause illness with the associated risk of long term morbidity or even mortality. In others it will be an adverse contributory factor to their existing condition and affect prognosis or access to treatment.
- It is important we understand patient related harm as a consequence of nosocomial infection. This allows us to focus our learning, meet our desire to be open and transparent with patients, families and the community. It also ensures we meet our obligations around appropriate reporting to the Procurator Fiscal, Health Improvement Scotland (Adverse Event Reviews) and involved individuals under Duty of Candour.
- We have established a detailed review process to look at all cases where patients have died following a possible or probably nosocomial COVID infection and COVID is thought to be a primary cause of death. This will be established through our Clinical Governance System and reported to the Board Clinical Governance Committee for review.
- Further work will consider how we review cases in circumstances where adverse oncomes are harder to measure or do not directly result in a serious outcome.
- A weekly update on possible and probable nosocomial patient infections will be built into the weekly Cross System Clinical Risk Management meeting.

3e – Public Health

Reducing nosocomial transmission in healthcare facililities requires a combination of environmental and behavioural strategies. This section focuses on infection control behaviours and draws on recent literature with regard to Covid-19 to suggest a

number of positive strategies to help staff, patients and visitors adhere to infection control behaviours.

In general terms, people are more likely to respond well to practices which enable them to practice infection control behaviours, rather than a focus on compliance with rules and blame. For staff this includes:

- Promoting positive alternatives to restricted activities eg large screens vs small computers where people crowd around
- Helping people change their environments and manage risky situations eg short walks in ventillated spaces or getting outdoors during break time
- Focusing on reducing infection risk rather than assessing compliance eg reporting on outcomes, not proxy indicators
- Providing targeted information and practical support for adherence eg car sharing

When prevalence of COVID-19 increases in the community, data shows an increase in nosocomial infections. Whilst mitigations are applied in hospitals and care homes, these are less likely to be effective when prevalence in the community is high. Keeping community infections low is the most effective way of preventing spread in these settings in addition to infection prevention and control. Encouraging self-isolation as a means of reducing transmission is absolutely key.

Drawing on evidence, experience and learning, the British Psychological Society stress that people need to understand exactly what they need to do, why they need to do it, how they need to do it and when. It is important that people understand the difference between self-isolation and social isolation and encouraged to make plans for self-isolation in advance. Services should be able to support people to ensure that everyone has a suitable and safe place to self-isolate, access to food and essential supplies and assistance if they need to look after children or elderly relatives. Employers should be encouraged to make self-isolation a normal, valued and accepted thing to do.

Communication is key to all of this – for staff, patients and the general public. It needs to be:

- Tailored for population groups but only if the motivations are different, otherwise there is a risk of stigmatisation. In all cases, it must come from credible sources for that population (community champions)
- Centred on positive feedback about how good behaviour has been beneficial
- Practically focused on the support that is available to do the right thing

As we continue to learn from experience and evidence, our efforts will concentrate on the following:

- Public/staff information and communications, taking into account the approaches most likely to yield success (outlined above)
- Working within the Local Resilience Partnership to reach those who will benefit from financial, emotional and practical support so that they can minimise transmission and cross infection

- Providing a report of nosocomial infections in hospital and care homes since the beginning of the pandemic which looks at the journey of each individual and the collective learning across the health and care system.

4. Risk Mitigation

- Nosocomial incidents can be reduced through transparent and shared learning from assurance visits and IMT outcomes; however in a busy and tired system this needs to be communicated appropriately avoiding inappropriate blame or fear. This will be progressed through collaborative working with Psychosocial Cell and Communication Strategy.
- Delivery of interactive and reinforcing messaging at manned entrances adds a further element to support staff behaviours. However, this risks delays/queuing of staff at peak times; it must be acknowledged that not all staff groups enter through manned entrances and while some messaging opportunities are lost, this should continue to reduce footfall at the key entrances.
- Extension of staff rest and changing areas along with extension to catering facilities opening hours creates a positive response to what has been seen and heard.

5. Responsible System Leadership Team Member and contact for further information

If you require any further information in advance of the Board meeting please contact:

Responsible System Leadership Team Member	**Contact for further information**
Dr June Brown Interim Executive Nurse Director june.brown@nhs.scot	Elizabeth Wilson Senior Nurse Workforce/Safer Workspace elizabeth.wilson2@nhs.net

1 December 2020