An Investigation Report for Systems Learning: COVID-19 Outbreak Control Team Weston General Hospital

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University Hospital Bristol and Weston NHS Foundation Trust (UHBW) in July 2020

on behalf of the Outbreak Control Team (OCT) made-up of system[1] partners.

Acknowledgements

To staff at University Hospitals Bristol and Weston NHS Foundation Trust and system partners who took part in the Review. Significant recognition goes to the number of people who offered to be interviewed, their openness, transparency and willingness to collaborate was noted and emphasises a system willingness to 'learn'.

[1] Throughout this Report/ Investigation, the term 'system' is used to referrer to Bristol, North Somerset and South Gloucestershire (BNSSG) geographic locality and constituent organisations within. 'Region' refers to those organisations in the South West outside of BNSSG.

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Executive Summary

This Independent Review was commissioned by University Hospitals Bristol and Weston NHS Foundation Trust (UHBW) in July 2020 on behalf of the Outbreak Control Team (OCT) made-up of system partners in response to the COVID-19 pandemic.

Context
This Review has been carried out during a time of significant, unprecedented change within the NHS and Social Care due to the rapid escalation of critically ill patients as a result of the first outbreak of the COVID-19 pandemic. The learning across the Bristol, North Somerset and South Gloucestershire (BNSSG) system has been immense since the outbreak of COVID-19. This coincided with the decision to temporarily close Weston General Hospital on the grounds of evidence of probable nosocomial, acquired COVID-19 infection in patients and staff.

Purpose
A retrospective independent Investigation process was commissioned in July 2020 in order to identify 'system learning' drawn from recurring themes that have emerged throughout the review period, 24th May – 18th June 2020.

Review Process
The Review has followed the Terms of Reference (Appendix 1) and has focused on the system learning, both on the lead-up and reopening of Weston General Hospital on the 18th June 2020.

Members of the OCT and wider system involved in the temporary closure of Weston General Hospital have been interviewed, focusing on their involvement and experiences of COVID-19 impact during the period from the 24th May – 18th June 2020.

Findings
The Review identified a number of examples of notable system working and collaboration that included:

1. Leadership and collective decision making through OCT systems, structures and processes.
2. Engagement of all system stakeholders through the OCT structure, and chairing that facilitated collective system decision making, action and oversight.
3. Coordinated bed management and patient flow across the system involving all partner organisations.
4. Immediate response to the closure of Weston General Hospital with system partner organisations 'stepping-up' to minimise the impact of the closure on patients and the local population.

Those interviewed identified areas for system learning from the closure of Weston General Hospital that included:

1. All parts of the system had a part to play in identifying that there was an emerging 'problem' early on. It is reported that how the data was presented potentially masked the emerging issue at Weston General Hospital.
2. Lack of clarity about how system data was being used by different parts of the system with no clear agreement for sharing or collective analysis.
3. Lack of understanding by those who had agreed the 'plan' prior to the weekend of the closure and the subsequent rationale for closure of Weston General Hospital as the criteria (agreed by UHBW prior to the closure) had not been met.
4. OCT and system EPRR (Emergency Preparedness, Resilience and Response), processes were not sufficiently joined-up i.e. a lack of clarity concerning the interface between OCT and EPRR.

A thematic analysis from the interviews carried out identified themes for system learning:

1. Early system alerting/ warning signs.
2. System joint governance and accountability for system decision-making.
3. System working, culture and collaboration across all stakeholders.
4. Access and use of system data and information sharing.
5. System communication and a single narrative.
6. Interface between Surge Management, EPRR and Outbreak Control.
7. Utilising system Clinical leadership to its full.
8. Recovery post outbreak.

These themes for on-going system learning (Discussion of Findings) are presented in full on pages 14 – 17 of the Report/ Investigation.

Recommendations arising from the Review are presented on page 18 of this Report and are intrinsically linked to the emergent themes for system learning.

This review process has provided an opportunity for significant learning as a whole system with a focus on advancement in a culture of patient safety, collective leadership and engagement in future transformation and development.

1.0 Background: COVID-19 Pandemic

This Review has been carried out during a time of unprecedented and significant change within the UK's NHS and Social Care services, due to the rapid escalation of the COVID-19 pandemic outbreak across the UK during 2020.

The World Health Organisation (WHO) declared the COVID-19 pandemic outbreak on the 12th March 2020[2]. All aspects of the NHS and Social Care have been dramatically affected by COVID-19. There have been multiple 'front lines' during the pandemic in which Health and Care Staff are working hard to meet the challenges[3] with infrastructures and workforce demands altering as early into the outbreak the nation attempted to address the escalating infection and mortality rates (Willan et al, 2020). According to The Health Foundation (2020):

'Service shifts have affected the whole care pathway. This includes changes to health promotion and support for vulnerable people in the community; remote consultations in primary and hospital care; new ways of receiving emergency acute and mental health services; and new collaborations across health and care systems'.

The importance of organisation and system learning has been the cornerstone of a number of high profile Reports and Investigations. The Berwick Report (2013) encouraged all NHS services to '*promise to learn and commit to act*'. The learning across the system has been immense since the outbreak of COVID-19 and indeed since the temporary closure of Weston General Hospital.

1.1 Context

Local context is important. The closure of Weston General Hospital fell some seven weeks after Weston Area Health Trust merged with University Hospitals Bristol NHS Foundation Trust on the 1st April 2020. This followed a reported significant period of 'uncertainty' about Weston General Hospitals future and 'challenges' in relation to operational delivery of services, workforce (vacancy rates), the use of temporary staff, quality, performance and finance.

The Care Quality Commission (CQC) inspected the Trust in February and March 2019 and gave an overall rating for the Trust as 'Requires Improvement'. There were a number of 'Goods' within the ratings and an 'Outstanding' in End of Life Care; Urgent and Emergency Services received an 'Inadequate' for 'Safe' and 'Well-led' and Specialist Community Mental Health Services for Children and Young People received an 'Inadequate' for 'Safe', 'Responsive' and 'Well-led'[4]. Following the

[2] https://www.who.int/emergencies/diseases/novel-coronavirus-2019 (last accessed 29/9/2020)
[3] https://www.kingsfund.org.uk/press/press-releases/health-social-care-committee-report-NHS-services-covid-19 (last accessed 1/10/200)
[4] https://www.cqc.org.uk/provider/RA3 (last accessed 29/9/2020
The Health Foundation (2020). Understanding & Sustaining the Healthcare Service, Shifts Accelerated by COVID-19. https://www.health.org.uk/publications/long-reads/understanding-and-sustaining-the-health-care-service-shifts-accelerated-by-COVID-19 (last accessed 1/10/2020)
Willan, J., King, A. J., Jeffery, K., & Bienz, N. (2020). Challenges for NHS hospitals during covid-19 epidemic. *BMJ* 2020; 368 doi: https://doi.org/10.1136/bmj.m1117 (Published 20 March 2020)
Choudhury, T., Debski, M., Wiper, A., Abdelrahman, A., Wild, S., Chalil, S., More, R., Goode, G., Patel, B. and Abdelaziz, H.K., 2020. Covid-19 Pandemic: Looking after the Mental Health of our Healthcare Workers. *Journal of occupational and environmental medicine*, *62*(7), pp.e373-e376.
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/226703/Berwick_Report.pdf

Inspection, a Section 29A Warning Notice was served in April 2019 in Urgent and Emergency Care and Specialist Community Mental Health Services for Children and Young People which outlined an expectation that the Trust would make significant improvements.

NHS England and NHS Improvement (NHSE/I) visited Weston General Hospital in January 2020 to 'test' the Trust's assurance in relation to the actions from the Emergency Department CQC Warning Notices. Whilst there were no actions in relation to Infection Prevention and Control (IPC), it was noted the feedback to the Trust dated the 5th February 2020 stated with regards to IPC and the management of Norovirus, that there was *'good local ownership by the Directorate of the IPC agenda',* however*, 'the impact of lack of patient flow in the hospital has impacted on the management of IPC … that could lead to outbreaks'.*

It was reported that pressure related to capacity was felt to be more 'challenging' due to the complexity and the size of the organisation, due to the numbers of beds on the site to effectively manage patient flow. From an Estates perspective there were a small number of side rooms and wards operated a 'swing ward' model to manage capacity and patient flow. Historical 'fragility' was not only described within the context of patient flow, but staff fulfilling a number of different key roles across the organisation coupled with the number of non-permanent staff covering key posts.

The former Trust (pre-merger) had become very self-reliant (by necessity) with a culture of working that appeared to keep escalation internal to the Trust.

Due to the size (and capacity) of Weston General Hospital the governance and oversight was described as 'complex'. It could be suggested that this was temporarily made more so (in the short term) as governance systems started to integrate with UHBW as a newly merged organisation.

Under the merged organisation, from the 1st April 2020 the Weston General Hospital site was managed as a Weston Division of UHBW and although IPC was being run separately on both UHB and Weston sites there was an alignment between the two organisations of IPC structures pre-merger. At the time of the 'incident' it is reported that two IPC policies had been fully amalgamated to a single UHBW policy and that the remaining Weston and UHB IPC policies did not indicate significant variation in practice or procedure.

1.2 Closure of Weston General Hospital

A system decision was made, which was enacted by UHBW to close the Weston General Hospital site to all new admissions and attendances on the 24th May 2020. This system decision was made on the grounds of evidence of probable nosocomial acquired COVID-19 infection in patients and staff. The system governance underpinning the decision making involved the BNSSG Clinical Cabinet, on-call Executive Directors from the System, UHBW and NHSE/I South West Region.

The site remained closed until the 18th June 2020 when the Accident and Emergency Department reopened during the daytime (pre temporary closure normal hours of operation). The decision making and oversights came from the OCT, the UHBW Board, BNSSG Clinical Cabinet and NHSE/I South West Region.

In line with Public Health England (PHE) Guidance an OCT was established. This was chaired by the Chief Operating Officer (COO)/ Deputy Chief Executive of UHBW at which the UHBW Director for Infection, Prevention and Control was a member. Between the 28th May and the 17th June OCT Meetings were held, with a further 'lessons learnt' meeting held at the beginning of July 2020.

1.3 Outbreak Control Team (OCT)

The OCT was established in line with PHE's Operational Guidance for Communicable Disease Outbreak Management[5]. According to the afore mentioned Operational Guidance:

'An OCT may be a formal meeting of all partners to address the control, investigation and management of an outbreak, or a discussion between two or more stakeholders following the identification of a case or exposure of concern. All such discussions should be appropriately recorded. The principles outlined in this guidance apply at any level. Communicable Disease Outbreak Management: Operational guidance Page 12 of 66 4.4 NHS funded healthcare providers should involve both the commissioner of the service and the local PHEC to obtain appropriate advice and assure staff and patients of a robust response. As above this advice may take the form of a formal OCT or a one off conference call but should be appropriately recorded so that there is an audit trail of advice sought and control measures taken. It should be noted that the terms incident management team and outbreak control team are often used synonymously, however both have very similar aims, membership and procedures to an OCT'.

5 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/343723/12_8_2014_CD_Outbreak_Guidance_REandCT_2__2_.pdf

The first virtual OCT occurred on the 28th May 2020 and was Chaired by the UHBW COO/ Deputy Chief Executive. The stakeholders invited to attend OCT meetings are recorded in Appendix 1.

2.0 Incident Description

The purpose of this Independent Review (referred to hereafter as the 'Review') is to identify 'system learning' drawn from recurring themes that have emerged throughout the Review period (July – September 2020) focusing on the time from the 24th May – 18th June 2020.

The Review was commissioned by the COO/ Deputy Chief Executive of UHBW in July 2020 on behalf of the OCT made-up of system partners.

This Review was not intended to examine specific cases related to any aspects of clinical care nor was its intent to hold any individual or organisation to account, the focus being to support system learning.

Interviews were carried out with members of the OCT and wider system stakeholders (Appendix 2) involved in the closure of Weston General Hospital on the 24th May 2020 on the grounds of probable nosocomial acquired COVID-19 infection in patients and staff.

2.1 Scope of the Review

On the 24th May a 'Major Incident'[6] was declared in line with the national, regional and system Emergency, Preparedness, Resilience and Response (EPRR) Policy[7]. The focus of this review is on OCT and system learning, however it is important to note the synergy between both strands given they were running in parallel and interfaced with each other. Outside of the scope of this Review are areas covered in the Trust's Root Cause Analysis (RCA).

The commissioned Review aims as set out through the Terms of Reference (Appendix 1) to:

1. Review the approach taken by the OCT in investigating and controlling the outbreak with a focus on system learning.
2. Undertake a constructive debrief as part of the Review process to support the identification of lessons learned by the OCT in managing the outbreak
3. Undertake activities to support the population of the template Outbreak Investigation Report acknowledging that this Review would sit alongside the Trust's Root Cause Analysis Investigation (RCA) Report and further work being undertaken by Public Health England.

[6] A Major Incident was declared on the 24th May, however reference thereafter has been made to 'Incident (Major or System Critical)'

[7] https://www.england.nhs.uk/ourwork/eprr/

2.2 Process and Methodology for the Review

System stakeholders were interviewed as part of the retrospective Review (Appendix 2) between the 22nd July 2020 – 21st September 2020 along with a site visit to Weston General Hospital on the 29th July 2020.

Stakeholders were members of OCT and a wider group of system partners who had been involved in the closure of Weston General Hospital and subsequent oversight. The majority of interviews were set-up and managed by UHBW.

Interviews occurred in person, via WebEx or over the telephone. Papers and minutes were reviewed as part of the Review to provide additional context and understanding of guidance and policy followed and actions taken by the system and OCT (Appendix 3).

Appreciative Inquiry underpinned the approach used to the Interviews [8] with a focus on system learning and outcomes.

OCT and system stakeholders were asked a set of questions (2.3.1 – 2.3.3) that aimed to explore their learning as aligned to the Scope of the Lessons Learned Review (2.1) and Terms of Reference (Appendix 1).

The evidence presented in the Report has been taken from the interviews carried out (Appendix 2) and the documents reviewed (Appendix 3).

There were three Key Lines of Enquiry (KLoE) that were used during the interviews:

2.2.1 KLoE1 – Background and Context

As a member of OCT or the wider system stakeholder group was there any background information interviewees would like to share?

As a member of OCT or the wider system stakeholder group what was their role in the system at the time of the Outbreak?

2.2.2 KLoE 2 – System and OCT Learning

As a member of OCT or the wider system stakeholder group what worked well from a system perspective?

As a member of OCT or the wider system stakeholder group what could have been done differently from a system perspective?

[8] Bushe, G.R. and Kassam, A.F. (2005) When is appreciative inquiry transformational? A meta-case analysis. *The Journal of Applied Behavioral Science*. Vol. 41. No. 2. pp 161-181.

Is there any system learning from their involvement/ perspective?

2.2.3 KLoE 3 – Further Background

Anything they would suggest the Reviewer should look at/ would help the Review and subsequent system/ OCT learning?

Field notes from all the interviews were transferred onto a core document and themes from a 1st level analysis were identified to support lessons learned and system learning.

Following this initial analysis, the emerging themes (findings) from the interviews were discussed with a small number of system stakeholders in draft form, in order to achieve a stakeholder verification or 'sense check'.

In parallel a number of Reports and Minutes were made available and were also considered as part of the Review process (Appendix 3).

2.3 Review/ Feedback

All members of OCT and system stakeholders interviewed as part of this Review identified how rapid the learning has been and that the understanding of systems, processes and value of embedded collaborative working in April/ May 2020 were different to where they are today. For this reason, if a similar scenario occurred today, it is the Reviewers view that it is probable that responses would be different (building-upon areas of notable practice) based on the fluidity of embedded learning and better understanding of COVID-19 compared to in May 2020. It could also be suggested that this learning will enable strengthened system decision making in the event of any other Incident (Major or System Critical) as a result of an outbreak.

2.4 Areas of Notable Practice within the System

There were many examples of notable practice, in terms of those identified as having worked well, as cited by members of the OCT and system stakeholders. These included:

1. **Leadership and collective decision making through OCT systems, structures and processes**. It was reported that once established there was a strong 'grip' through the OCT leadership with all system partners being able to participate in decision making and planning. OCT was very clear about its purpose, underpinning remit, governance, openness and transparency. Members of OCT came together with a focus on collaborative working in which there was a focus on delivering outcomes. Once decisions were made it was clear what was needed to deliver them. Engagement of all system stakeholders through the OCT structure and the approach to chairing facilitated collective system

decision-making, action and oversight. It was reported that the system response felt 'good' and 'supportive'.

2. **Coordinated bed management and patient flow across the system involving all partner organisations**. It was reported that new clinical pathways were set-up quickly with involvement of all system partners. All parts of the system worked well together to address potential risks and reduce the impact on patients. This included Minor Injury's, Diagnostics and Outpatients in which services were provided on new sites. Diverts and repatriation was also seen as working well in which patients were diverted to the most appropriate place for care and treatment along with being given the choice to move back into the system from neighbouring Trusts, primarily North Bristol NHS Trust and Somerset NHS Foundation Trust. It was reported that there was a '*coming together as a system'* with a focus on '*what can we do together*'?

3. **Immediate response to the closure of Weston General Hospital with system partner organisations 'stepping-up' to minimise the impact of the closure on patients/ the local population**. South West Ambulance Service NHS Foundation Trust was cited as providing an immediate response in setting-up a Receiving Centre at Weston General Hospital. Similarly, Primary Care, Social Care and Community Services played a key role in maintaining patient flow both at the Receiving Centre and for on-going, community-based care. System partners responded based on the patients they were able to take to minimise the impact of the closure.

4. **OCT structure brought system stakeholders together and supported collective decision making with a focus on coming and working together to bring the 'issue' under control**. System stakeholders came together through the OCT structure with a clear focus on cross system working and collaboration. Being '*respectful of each other and the roles that they had to play*' was cited as a key behavioural characteristic. Through OCT links were 'forged' which led to better patient flow, this included both the immediate comprehensive closure risk assessments and the agreed criteria for the reopening of Weston General Hospital.

5. **A strong sense of 'grip' through the OCT with governance structures set-up around the local system**. BNSSG CCG were cited as supporting the structure and actions in which they helped to deliver the Risk Register and Risk Assessment of Services. People were seen as stepping outside of their normal roles to support the system in its response to the closure.

6. **System stakeholders worked together which was facilitated by IT and the use of WebEx acknowledging that this required a different approach to engagement and involvement**. Flexibility in approach was taken, in which outcomes were delivered through a different approach compared to regular-face-to face meetings, requiring skill and ability to Chair and lead.

7. **The OCT Terms of Reference focussed on system working and collaboration with a strong sense of system readiness**. Through the OCT structure, links were forged which improved/ led to better patient flow with a strong sense of system readiness and collaborative working.

8. **OCT 'held the ring' with a sense of openness and transparency**. This was reported as being a key characteristic that enabled collaborative decision making across system partners.

2.5 Areas of development for system learning

Reflecting on learning, OCT participants and system stakeholders also identified what could have been different from a system perspective, noting that the focus was wider than OCT alone:

1. **All parts of the system had a part to play in identifying that there was an emerging 'problem' early on. It is reported that how the data was presented potentially masked the emerging issue**. It was reported that too much time was taken in accessing reliable data, as a result people started to make assumptions and speculate about what the situation really was. There appeared to be a lack of clarity concerning how organisational, system (encompassing population health) and regional data was being used as a whole with no clear agreement for sharing or collective thematic trend analysis. It was reported that the system should have been alerted sooner that there was an emerging 'issue' through the data being collected.

   It was perceived that there were a number of different 'data' requests. When data was being requested, it was not always clear for what purpose it was needed. The 'data' was cited as being the 'biggest difficulty' with a lack of granularity coupled with an inability to interrogate it in a format that could be easily used. Analytics was identified as a 'problem,' however it was recognised that Field Epidemiology support had been offered to enable a rapid on-site investigation for timely intervention.

2. **Understanding by those who had agreed the 'plan' prior to the weekend of the closure the rationale for closure of Weston General Hospital as the criteria (agreed by UHBW prior to the closure) was not followed.** It was reported that a 'plan' was agreed prior to the Bank Holiday weekend, the identified triggers within the plan had not been met however the system decision had been taken to close.

3. **OCT and system EPRR processes were not sufficiently joined-up i.e. a lack of clarity concerning the interface between OCT and EPRR**. It was reported that EPRR systems were not sufficiently joined-up (to enable the flow of information) and that the interface between OCT and EPRR was not always clear with the same people attending multiple meetings.

4. **Working with and understanding the culture of two newly joined organisations . Systems, processes and policies had not been fully harmonised due to both organisations having merged seven weeks prior to the declared outbreak**. The infancy of the newly merged Trust meant that work to bring both organisations together was still in progress.

5. **No one or system to learn from, learning occurred in front of the world under immense scrutiny and attention**. The closure of Weston General Hospital led to immense scrutiny (local and national) and understandable concern. It was therefore not possible to learn from any other systems and that managing the rapidly changing 'messaging' was immense, complex and not experienced before.

6. **Creating a single system narrative and communication was problematic due to the timeline for closure**. It was recognised that communication needed to rapidly touch many points of the system and region. The rapid closure had not been planned, therefore the need for system, regional and national communication was immediate, the complexity and pace of which cannot be underestimated.

3.0 Discussion of Findings

Staff from Weston General Hospital in their communication with the Reviewer came across as being very committed to the Trust as their 'local hospital'.

Those people interviewed were asked to identify the system learning from their involvement and perspective either as a member of OCT or as a system stakeholder.

The recurring themes that emerged are presented in Appendix 4 and are as follows:

1. Early system alerting/ warning signs.
2. System joint governance and accountability for system decision-making.
3. System working, culture and collaboration across all stakeholders.
4. Access and use of system data and information sharing.
5. System communication and a single narrative.
6. Interface between Surge Management, EPRR and Outbreak Control.
7. Utilising system Clinical leadership to its full.
8. Recovery post outbreak.

3.1 Early system alerting/ warning signs

The week prior to the closure of Weston General Hospital (on the 24th May) was a vital period of time as the number of COVID-19 cases started to rise. A view expressed was that because of the way cumulative data was being presented the emerging local issues at Weston were being masked.

Different IPC software was being used across both sites with a reliance on manual data collection at Weston General Hospital. The lack of IPC capacity at Weston General Hospital due to a small team coupled with a lack of IT infrastructure and joined-up data analysis across the system did not support the early identification of arising issues and the subsequent system escalation and actions needed to respond quickly.

It is **not** suggested that any person or organisation purposefully withheld sharing data, however there is a lack of clarity as to how partners within the system were analysing and sharing the data that they were collecting and the wider interface with regional data collection and analysis. By bringing the data together earlier in one place, with both Epidemiology and Analytic support may have enabled more timely identification of organisational and system trends, issues and emerging themes. Potentially this would have indicated that the number of cases at Weston General Hospital were starting to rise compared to a reduction elsewhere.

This could have triggered an earlier initiation of the OCT which may have given a stronger sense of 'hold' and 'confidence' in the system and region of the actions that were being taken pre closure, which were subsequently enacted post closure as OCT took a lead system role to manage the outbreak.

3.2 System joint governance and accountability for system decision making

Whilst individual organisations had in place their own governance systems, it is not clear how these interfaced with system wide joint governance, collective decision-making and the link to individual statutory accountability for constituent organisations. This manifested itself in a view as to who was ultimately 'holding the ring' for the decision to close Weston General Hospital and where this fitted with system wide joint governance and statutory accountability. It is clear that once closure occurred, UHBW took the system lead for Outbreak Management and Control through the OCT and BNSSG for system EPRR. It was however identified that there needed to be greater clarity surrounding the system joint governance and interface between the two.

3.3 System working, culture and collaboration across all stakeholders

The situation that the system faced with the sudden closure of Weston General Hospital in such circumstances was unprecedented and had not been experienced or tested elsewhere. This rapidly brought system stakeholders together with a clear expectation that they would work and collaborate together. The challenge of this cannot be underestimated given the backdrop of the COVID-19 pandemic, the anxiety in the local community, system and nationally and the need to reassure and rapidly brief internal and external stakeholders multiple times. All meetings were held via WebEx, which did not allow for the 'usual' face-to-face interactions that would occur in pre COVID-19 'normal' meeting format. Therefore, the nuances of 'traditional' meetings that encompassed interpersonal communication did not occur.

How the system responded immediately to the closure should be commended, recognising that different stakeholders had key parts to play depending on the 'ask' and expertise required to respond. South West Ambulance Service NHS Trust, Primary Care, Social Care and Community Services were cited as responding immediately to setting-up, managing the Receiving Centre at Weston General Hospital and in developing (in collaboration with system partners) new pathways of care to minimise impact to patients. New ways of working were a recurrent theme, the importance of this and the value of system collaboration linked to sustainable transformation cannot be over emphasised.

The 'Peleton Programme' was sighted as a good example that brought system leaders together (pre pandemic), focussing on how leaders in different organisations were going to work differently in the future – the value of such programmes cannot be undervalued as part of a wider programme of sustainable system development.

The need to maintain professional respect for each other was highlighted as being evident when in the 'eye of the storm' with a focus on collective responsibility with confidence to make changes and to carry through and to be held accountable collectively as a system.

3.4 Access and use of data and information sharing

Access, use and understanding of data were vital in identifying the emerging issues at Weston General Hospital. Earlier sharing of system held data, information and the identification of higher markers could have indicated that there was an emerging issue that required action.

It was reported that across the system different data systems were being used which made it less easy to chart trends and emerging issues. From a system perspective it is not clear whom ultimately was reviewing the data as a whole and the part that the region was playing in charting wider regional trends that could have provided an earlier warning. It was reflected that within the 'local' system, 'historically' relationships related to data had focussed more predominantly on contractual and performance management with a recognition that in the future there needs to be a far greater emphasis on clinical quality reporting.

3.5 System communication and a single narrative

The immense complexity and fast-moving nature of developing a single narrative agreed by all stakeholders that met universal and multiple needs within the system, region and nationally cannot be underestimated.

It is recognised that there were a number of different streams of communication being reported that were external to the immediate control of the system. Such communication can be seen as leading to speculation and the potential for assumptions being made based on anecdote and personal opinion.

The context at the time cannot be ignored with national briefings running simultaneously that interfaced with the local communications. The impact on patients, staff, local and the wider community along with the population as a whole cannot be underestimated balanced against the 'national' message at that time. Many of the staff working within Weston General Hospital formed part of the local community with multiple networks and infrastructures, therefore communication needed to be focussed at many different levels that stretched across the system and region reaching into neighbouring systems.

3.6 Interface between Surge Management, EPRR and Outbreak Control

Both OCT and EPRR processes ran in parallel. What was less clear was how both processes systematically interfaced from a governance perspective and how this could be better aligned from a system and regional response with an embedded interface including greater clarity of the system joint governance and accountability.

It was recognised that previous 'tests' had focussed predominantly on EPRR scenarios rather than those related to the management of an outbreak that would have required a 'different,' longer term response. It was identified that protocols were needed for capacity escalation in light of the pandemic or a scenario where a divert needed to be sustained due to a prolonged closure – such protocols needed to be tested across a wider regional footprint rather than a system in isolation given patient flow to and from the system.

3.7 Utilising System Clinical leadership to its full

It is clear that those individual clinicians interviewed as part of the Review were very much aware of their line of professional accountability and responsibility within their employing organisation. What was less clear was the role of system clinical leadership from a joint governance perspective to oversee constituent organisations across the system and the embedded governance to take decisions on behalf of those constituent organisations. The view was expressed that in this case their needed to be a strengthening at a regional Level of clinical oversight that could provide 'clinical recommendations' with collaborative reference to system clinical escalation with a view to 'help'.

3.8 Recovery post outbreak

OCT and EPRR processes were running in parallel and coexisted as part of the system response to the outbreak. What was highlighted was the need for clarity concerning the joint governance as to who was 'holding' the line of accountability for system decision making with regards to recovery and the interface between EPRR and OCT roles and responsibilities.

4.0 Conclusion

The impact of COVID-19 pandemic cannot be underestimated. The effect on people's lives, working practices and psychological wellbeing is well documented and will continue to be better understood as time progresses.

The closure of Weston General Hospital was an unprecedented issue that arose amidst a context of rising mortality rates and COVID-19 infection across the NHS, Country and wider World as a result of the pandemic. At the time of the closure the heightened awareness of the issues that were emerging was in part due to the fact that there was not a defined approach to be able to identify, chart or articulate the likely course of the COVID-19 pandemic. Integral to this was how individuals also internalised and responded (personal and professional) to the emerging situations that were affecting their own lives and the community's in which they lived. On a daily basis new and emerging issue would arise requiring an immediate response.

There were some excellent areas of practice that are noteworthy:

1. Leadership and collective decision making through OCT systems, structures and processes.
2. Engagement of all system stakeholders through the OCT structure and chairing that facilitated collective system decision-making, action and oversight.
3. Coordinated bed management and patient flow across the system involving all partner organisations.
4. Immediate response to the closure of Weston General Hospital with system partner organisations 'stepping-up' to minimise the impact of the closure on patients/ the local population.

Much system learning has already taken place since the closure of Weston General Hospital. The impact of this system learning cannot be underestimated at all levels and the on-going impact of the COVID-19 pandemic on both individuals and the wider community.

4.1 Recommendations

4.1.1 Bringing together a standardised data set (encompassing population health) across the system to better support analysis, understand trends, issues and emerging themes. Action should be taken to ensure that joined-up data streams are available which focus on the micro and macro levels with an accompanying narrative that better describes what is being presented.

4.1.2 Review Incident (Major and System Critical) guidance to ensure a single system is in use and a single line of accountability and joint governance is clear for the management of an Incident (Major or System Critical) when both EPRR and OCT are running in parallel including agreed timelines for closure.

4.1.3 A regional ‘tabletop’ exercise should be considered within the wider system for those other organisations that support in an Incident (Major or System Critical) in which protocols that bring EPRR and Outbreak Management together are tested ensuring clear understanding of joint system governance, decision making and accountability.

4.1.4 Ensure the process of clinical system leadership and decision-making is clear and the joint governance underpinning decisions provides clarity of accountability and responsibility.

4.1.5 Review the role of outward facing, coordinated communication (system, regional and national) to the Outbreak Management plan. Making explicit and recognising the intensity, complexity and multifaceted nature of briefing multiple stakeholders ensuring a single narrative when the context is continuing to rapidly change and evolve.

4.1.6 In light of the development of new clinical pathways and patient flow as a result of the temporary closure of Weston General Hospital, optimise system learning and transformation linked to quality focussed patient outcomes.

It is recommended that the outcomes arising from this review are used to support ongoing learning and system transformation underpinned by joint governance and oversight of accompanying, system owned actions.

APPENDIX 1 – Terms of Reference for the Review/ Investigation

Outbreak Control Team - Investigation

Terms of Reference

[Date]

1. Background

1.1. Following an increase in the number of patients with Covid-19 at Weston General Hospital between 24 May 2020 – 17 June 2020, and outbreak was declared and an Outbreak Control Team (OCT) constituted to oversee and coordinate the response. The OCT was convened in line with the Public Health England Communicable Disease Outbreak Management - Operational guidance, published in August 2014 (the guidance), and the Trust's internal operational policy.

1.2. In line with the guidance the OCT has commissioned and independent review to review the response and identify any lessons learnt. The review will seek to use the approach identified within the guidance above but will ensure it is tailored to a hospital outbreak.

2. Scope:

2.1. The review will seek to:

- review the approach taken by the OCT in investigating and controlling the outbreak.
- undertake a constructive debrief to support the identification of lessons learned by the OCT in managing the outbreak.
- undertake activities to populate the template outbreak investigation report.

3. Sources of Information:

3.1. The investigator will use their own judgment when determining the sources of information, but the following list provides a starting point for the investigation:

- Membership of the OCT
- OCT records including reports, notes, actions and decisions
- The RCA being undertaken by UHBW into the outbreak
- The PHE epidemiology review
- Records of the weekly NHSE/I assurance oversight meetings

4. Methodology:

4.1. The investigator is expected to follow the guidance where probable which includes, but is not limited to:

- Interviews with OCT members

- Development of a chronology of events
- Review of risk assessments undertaken
- Review of any investigations and analysis undertaken during the outbreak
- Review of control measures and action plans, and the monitoring of these
- A constructive debrief to include:
  The principle issues
  The root causes of these issues
- Review of any communications issued

5. Stakeholders:

5.1. The following are key stakeholders to the investigation

- University Hospitals Bristol and Weston NHS Foundation Trust (UHBW)
- Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group
- Somerset NHS Foundation Trust
- North Bristol NHS Trust
- North Somerset Council
- Bristol City Council
- Public Health England
- NHS England and Improvement
- South West Ambulance Service NHS Foundation Trust
- Sirona CIC
- BrisDoc

6. Governance of the Investigation

6.1. UHBW is the lead for the investigation given the outbreak occurred in Weston General Hospital.

6.2. Mark Smith, Deputy Chief Executive and Chief Operating Officer of UHBW, is the Incident Director.

6.3. In ensuring the independence of the investigator, NHS England and improvement were asked to suggest an individual who would be qualified and with appropriate independence to complete the review. The appointed investigator Jonathan Webster.

6.4. UHBW will pay for the investigator's time and any other usual expenses, but their appointment and oversight of the investigation will remain with the OCT.

6.5. The incident Director will be the day-to-day contact for the investigator, and the Incident Director's PA will provide administrative support to the investigator.

6.6. The OCT has convened a sub-group to coordinate the day-to-day activities of the review and ensure progress against the Terms of Reference.

6.7. Stakeholders identified in section 5, will receive the draft report for factual accuracy checking only. It is expected that stakeholders will identify the necessary review arrangements within their own organisations and ensure

that this does not impact on the overall timelines for the finalisation of the investigation report. Stakeholders will have two weeks to return any factual accuracy comments.

6.8. Each stakeholder will be asked to sign off the final report, and develop an action plan associated with the report, if required.

6.9. All stakeholders will own the report. Any queries regarding the report should be first directed to the Incident Director.

7. Expected Duration

7.1. It is expected that the investigation will be completed in 60 days and a draft report available for stakeholders to review at this time. The final investigation report is expected to be available in 90 days.

8. Publication

8.1. It is anticipated that the report will be made available to the public once it has been finalised.

8.2. The actual date and approach to publication will be subject to agreement by the OCT.

8.3. The report will be reviewed prior to publication to ensure compliance with the Data Protection Act 2018.

9. Approval of the Terms of Reference

9.1. The signatures of individuals from each of the key stakeholders, duly authorised to approve these Terms of Reference, are below:

[Insert spaces for signatures for each key stakeholder]

APPENDIX 2 – Stakeholders Interviewed as Part of the Review/ Investigation (Alphabetically ordered)

Organisation	Role	Member/ Attendee of OCT
BNSSG, CCG	Chief Executive Officer	N
BNSSG, CCG	Director of Commissioning	Y
BNSSG, CCG	Director of Nursing & Quality	Y
BNSSG, CCG	Area Director, North Somerset	Y
Bristol City Council	Principle Public Health Specialist	Y
NHSE/I SW Region	Director of Quality	N
NHSE/I SW Region	Locality Delivery Director	N
NHSE/I SW Region	Deputy Medical Director	N
NHSE/I SW Region	Assistant Director of Nursing - IPC	Y
North Bristol NHS Trust	Deputy Chief Operating Officer	N
North Somerset Council	Director of Public Health	Y
Public Health England (SW)	Lead Consultant in Public Health	Y
Sirona Care & Health	Director of Nursing	Y
Somerset CCG	Director of Nursing & Quality	Y
Somerset CCG	Fit for Future Programme Director	N
Somerset CCG	Deputy Director of Nursing & Quality	Y
Somerset Council	Consultant in Public Health	Y
SWAST NHS FT	Senior Clinical Lead	Y
Somerset NHS FT	Operations ADN	Y
UHBW NHS FT	Chief Operating Officer/ Deputy Chief Executive	Y
UHBW NHS FT	Chief Nurse	Y
UHBW NHS FT	Medical Director	Y
UHBW NHS FT	Deputy Medical Director	N
UHBW NHS FT	Director for Infection Prevention & Control	Y
UHBW NHS FT	Director of Communications	Y
UHBW NHS FT	Former Divisional Director (Weston)	Y
UHBW NHS FT	Deputy Chief Operating Officer (unplanned Care)	Y
UHBW NHS FT	Head of Patient Flow & Integrated Discharge Service	N

APPENDIX 3 – Documents Reviewed as Part of the Review/ Investigation (Published Date ordered)

Document	Published Date	Owner
National & Regional Guidance & Policy		
COVID-19: Infection Prevention & Control Guidance	18th June 2020	Public Health England
Operating Framework for Urgent and Planned Services in Hospital Settings during COVID-19	14th May 2020	NHSE/ NHSI
Second Phase of NHS Response to COVID-19	29th April 2020	NHSE/ NHSI
The Government's Revised 2019-20 Accountability Framework with NHS England and NHS Improvement	March 2020	Department of Health
Communicable Disease Outbreak Management	August 2014	Public Health England
Organisation Specific Reports, Guidance & Policy		
Incident Response Plan (IRP) – Part One	July 2020	UHBW NHS FT
Hospital Outbreak of Infection Policy	June 2020	UHBW NHS FT
COVID-19 Healthcare Setting Outbreak Framework	26th June 2020	UHBW NHS FT
North Somerset Council Outbreak management Plan	24th June 2020	North Somerset Council
Standard Operating Procedure – COVID-19 Protocol	March 2020	Weston Area Health NHS Trust
Clinical Review Letter	5th February 2020	NHSE/ NHSI
Facilities – Infection Control Report	December 2019	Weston Area Health NHS Trust
Weston Are Health NHS Trust – Quality Report	17th December 2019	Care Quality Commission
Weston Are Health NHS Trust Inspection Report	26th June 2019	Care Quality Commission
IC22 Outbreak Control Policy (v4)	19th January 2017	Weston Area Health Trust
IC9 Infection Prevention & Control Operational Policy	22nd July 2014	Weston Area Health Trust
IC14 Isolation Policy	April 2004(?)	Weston Area Health NHS Trust

Minutes and Terms of Reference		
Outbreak Control Team Meeting Minutes	7th July 2020	UHBW NHS FT
Weston Outbreak Bronze Command Cell – Close Down Proposal	19th June 2020	UHBW NHS FT
Outbreak Control Team Meeting Minutes	17th June 2020	UHBW NHS FT
Outbreak Control Team Meeting Minutes	12th June 2020	UHBW NHS FT
Outbreak Control Team Meeting Minutes	8th June 2020	UHBW NHS FT
Outbreak Control Team Meeting Minutes	5th June 2020	UHBW NHS FT
Outbreak Control Team Meeting Minutes	3rd June 2020	UHBW NHS FT
Outbreak Control Team Meeting Minutes	1st June 2020	UHBW NHS FT
Outbreak Control Team Meeting Minutes	28th May 2020	UHBW NHS FT
COVID-19 Outbreak Control Team ToR	28th May 2020	UHBW NHS FT
COVID-19, Gold Command Group (Minutes)	23rd May 2020	UHBW NHS FT
Urgent system call Soft Divert from WGH	23rd May 2020	BNSSG CCG

APPENDIX 4 – Themes from the Review/ Investigation

Order	Theme	Number of Occurrences
1	Early system alerting/ warning signs	12
2	System joint governance and accountability for system decision making	11
3	System working, culture and collaboration across all stakeholders	10
4	Access and use of system data and information sharing	9
5a	System communication and a single narrative	5
5b	Interface between Surge Management, EPRR and Outbreak Control	5
6	Utilising system Clinical leadership to its full	2
6a	Recovery post outbreak	2