St Helens and Knowsley Teaching Hospitals NHS Trust

Trust Public Board Meeting

TO BE HELD ON WEDNESDAY 23rd FEBRUARY 2022
VIRTUALLY, BY MS TEAMS

AGENDA				Paper	Purpose	Presenter
09.30	1.	Employee of the Month - December 2021 - February 2022		Verbal	Assurance	Chair
09.40	2.	Apologies for Absence		Verbal	Assurance	Chair
09.45	3.	Declaration of Interests		Verbal		
09.50	4.	Minutes of the Board Meeting held on 26th January 2022		Attached		
		4.1	Correct Record and Matters Arising	Verbal		
		4.2	Action Log			
Performance Reports						
10.00	5.	Integrated Performance Report		NHST(22) 006	Assurance	Anne-Marie Stretch
		5.1	Quality Indicators			Anne-Marie Stretch
		5.2	Operational Indicators			Gareth Lawrence
		5.3	Financial Indicators			Gareth Lawrence
		5.4	Workforce Indicators			Anne-Marie Stretch
Committee Assurance Reports						
10.20	6.	Committee Report – Executive		NHST(22) 007	Assurance	Ann Marr
10.30	7.	Committee Report – Quality		NHST(22) 008	Assurance	Rani Thind
10.40	8.	Committee Report – Finance & Performance		NHST(22) 009	Assurance	Jeff Kozer

AGENDA			Paper	Purpose	Presenter
Other Board Reports					
10.50	9.	Committee Report – Audit	NHST(22) 010	Assurance	Ian Clayton
11.00	10.	Committee Report – Charitable Funds	NHST(22) 011	Assurance	Paul Growney
11.25	11.	Freedom to speak up – annual board self-assessment	NHST(22) 012	Approval	Anne-Marie Stretch
11.35	12.	Updated IPC Board Assurance Framework	NHST(22) 013	Assurance	Nicola Bunce OBO Sue Redfern
Closing Business					
11.45	13.	Effectiveness of Meeting	Verbal	Assurance	Chair
	14.	Any Other Business		Information	
	15.	Date of Next Meeting – Wednesday 30th March 2022		Information	

St Helens and Knowsley Teaching Hospitals NHS Trust

Minutes of the St Helens & Knowsley Teaching Hospitals NHS Trust Board Meeting held on Wednesday 26th January 2022
Held via Microsoft Teams

PUBLIC BOARD

Chair:	Mr R Fraser (RF)	Chairman
Members:	Ms A Marr (AM)	Chief Executive
	Mr J Kozer (JK)	Non-Executive Director
	Mr P Growney (PG)	Non-Executive Director
	Mr I Clayton (IC)	Non-Executive Director
	Mrs G Brown (GB)	Non-Executive Director
	Mrs V Davies (VD)	Non-Executive Director
	Mrs A-M Stretch (AMS)	Director of HR & Deputy Chief Executive
	Mrs S Redfern (SR)	Director of Nursing, Midwifery & Governance
	Mr N Khashu (NK)	Director of Finance
	Mr R Cooper (RC)	Director of Operations and Performance
	Mrs C Walters (CW)	Director of Informatics
	Ms N Bunce (NB)	Director of Corporate Services
	Prof R Pritchard-Jones (RPJ)	Medical Director
	Dr R Thind (RT)	Associate Non-Executive Director
	Mr G Appleton (GA)	Board Advisor
	Mr A Sharples (AS)	Board Advisor
	Mrs L Knight (LK)	Associate Non-Executive Director
	Alan Lowe	Halton Council
In Attendance:	Miss K Fielding (KF)	Executive Assistant (Minute Taker)
	Yvonne Mahambrey (YM)	Quality Matron Patient Experience (for item 1)
	LC	Patient (for item 1)
	Jordan Howard	Observer

1. Patient Story

1.1. YM introduced the patient to the Board.

1.2. The patient was young women who had previously been fit and worked as a hairdresser. On 7th September 2021, she had a stroke and spent 2 weeks in Intensive Care and 2 weeks in Walton Neurological Hospital before being transferred to the neuro rehabilitation unit at St Helens Hospital.

1.3. Due to COVID restrictions, no visitors were permitted on the unit, and the patients on the ward had to remain in their rooms. This was very isolating, and the patient missed her children and became depressed at the prospect of spending a further three months away from her family. She felt this was impacting on her recovery and considered discharging herself from the unit.

1.4. The patient wrote to the ward manager explaining how the restrictions were impacting on her. The ward staff then worked with the Infection Prevention Control team and the patient to try and find a way that she could safely have weekend home leave. Together they developed a plan with responsibilities for all parties that would enable the patient to have home leave at the weekend, but then return to the unit during the week, but minimise the risk of introducing COVID onto the ward.

1.5. The patient explained the impact that being able to have home leave had on her mental health and the speed of her physical recovery and rehabilitation. In the end the patient was able to be discharged earlier than planned as was able to be home for Christmas and continue her rehabilitation journey as an outpatient.

1.6. VD reflected that the impact of COVID went far beyond the acute wards where sufferers were treated and asked if the learning from this case had led to any changes in practice? YM confirmed that the success of the partnership agreement with this patient had led to the unit adopting the same approach for other patients.

1.7. AM agreed that the psychological toll of restricting visiting was immense, and the Trust always had to find the right balance of risk for all the patients under our care and for the staff, whilst also complying with the national guidance to prevent nosocomial infections.

1.8. RF thanked the patient and YM for bringing this story to Board; it had illustrated the dilemma faced by the Trust and the importance of family in supporting recovery. RF wished the patient well in her continued recovery.

2. Employee of the Month

2.1. The Employee of the Month for December 2021 was Janet Powell, Ward Clerk Gynae. A video of Janet receiving her award was shared with the Board and will be published to the staff intranet.

3. Apologies for Absence

There were no apologies for absence.

4. Declaration of Interests

4.1. No new declarations were made

5. Minutes of the Board Meeting held on 24th November 2021

5.1. Correct Record and Matters Arising

5.1.1. The minutes of the meeting held on 24th November were approved as a correct record.

5.2. Action Log

5.2.1. Actions 30 and 36 remained deferred due to the pandemic.

5.2.2. Action 39 – RC reported that he was giving a presentation about the outcome of the perfect week at the February Quality Committee meeting. The action was therefore closed

5.2.3. Action 40 – NK confirmed that the IPR revision progress report had been circulated to all members following the November Board meeting. The action was therefore closed

6. Integrated Performance Report

6.1. Quality Indicators

6.1.1. SR presented the report

6.1.2. There were 0 Never Events in December 2021. Year to date (YTD), there has been 1. There were 0 cases of MRSA in December 2021. YTD, there has been 1. There were 2 C.Difficile (CDI) positive cases reported in December 2021 (2 hospital onset and 0 community onset). YTD, there have been 43 cases (23 hospital onset and 20 community onset). During the month of November 2021 there were 2 falls resulting in severe harm. YTD, there have been 15 falls resulting in severe harm. There were no grade 3 hospital acquired pressure ulcers with lapse in care in October 2021. YTD, there has been 1. The overall registered nurse/midwife safer staffing fill rate for December 2021 was 93.0% and the YTD position was 92.3%. YTD (April – August) reported HSMR was 97.2.

6.1.3. SR commented that the CCG had indicated that they had a high level of assurance in the Trusts internal investigation and review processes for C.Difficile and were proposing not to continue the appeal process. There were currently 9 of the reported cases subject to appeal and although the backlog of RCAs was being reduced there were still a number outstanding.

6.1.4. SR also reported that although VTE reporting had been suspended nationally since the start of the pandemic the trust was undertaking a review of hospital acquired VTE, which would then be reported to a future Quality Committee meeting.

6.1.5. In relation to nosocomial infections (NCIs) SR reported that the incidence had now dropped, reflecting community prevalence of COVID, but the Trust had instigated a review of all deaths since NCI reporting started, where COVID is mentioned on the death certificate to understand the impact. This would also be reported at a future Quality Committee meeting.

6.2. Operational Indicators

6.2.1. RC presented the report

6.2.2. The 31-day target was achieved in November 2021 with 99.0% performance in month against a target of 96%, YTD 98.2%. The 2-week rule target was not achieved in November 2021 with 75.4% in month and 87.2% YTD against a target of 93.0%. The deterioration in performance for 2-week rule, is related to the 43% increase compared to the same period in 2019, coupled with capacity challenges.

6.2.3. Accident and Emergency Type 1 performance for December 2021 was 55.3% and YTD 57.2%. The all type mapped STHK Trust footprint performance for December 21 was 77.3% and YTD 77.8%.

6.2.4. The Trust saw average daily attendances of 300, which is down compared to November, at 324. Total ED attendances in December 2021 were 9,305.

6.2.5. The ambulance turnaround time target was not achieved in December 2021 with 49 mins on average. There were 2,297 ambulance conveyances compared with 2,299 in November 2021.

6.2.6. The average daily number of super stranded patients in December 2021 was 109 compared with 112 in November. RC noted that this excluded the intermediate care bed base. Work continues both internally and externally, with all system partners, to improve the current position with acute bed occupancy remaining high and the subsequent congestion in ED.

6.2.7. The 18-week referral to treatment target (RTT) was not achieved in November 2021 with 72.4% compliance and YTD 72.4% (Target 92%). Performance in October 2021 was 72.9%. There were (1377) 52+ week waiters. The 6-week diagnostic target was not achieved in November 2021 with 81.5% compliance. (Target 99%). Performance in October 2021 was 80.5%.

6.2.8. PG asked how the Trust compared to others locally in respect of delayed discharges and RC explained that although it was an enormous pressure for the Trust many others were in an even worse position.

6.2.9. GB asked if the system monitored and reported the number of care home beds that were closed and how this was impacting on discharges. RC

confirmed that each Local Authority collected and shared information on its care home bed capacity each day and this included beds closed to admissions. Discharges also depended on other factors such as packages of domiciliary care for people being discharged to their own home. The greatest impact currently was beds and care homes shut because of COVID outbreaks. **ACTION - RC to share an example of this information with GB.**

6.3. Financial Indicators

6.3.1. NK presented the report

6.3.2. The Trust had submitted a breakeven plan for H2. This included risk of approximately £13m relating to; ERF income that was dependent on system performance (£6m) and other unidentified income required to offset planned expenditure to give a breakeven plan (£7m). NK was able to report that following confirmation of Targeted Investment Fund (TIF) allocation expected slippage, the forecast deficit against the H2 breakeven plan is now £5.0m. This includes £1.25m of additional support from St Helens CCG. The year-to-date element of this results in a reported deficit at Month 9 of £4.1m. This is due to the profiling of the ERF plan, with £4.8m income planned for M7-M9 and the remaining £1.4m planned in M10-M12. Mitigation of this deficit is dependent on receipt of the planned ERF income for the activity that the Trust will undertake.

6.3.3. At the end of Month 9 the Trust has received income of £392.4m and incurred expenditure of £396.6m.

6.3.4. Year to date agency staff expenditure is £7.4m, including agency costs incurred in relation to COVID and the Mass Vaccination Centre (£0.8m).

6.3.5. At the end of Month 9, the cash balance was £66.7m. The current NHSE/I assumption is for providers to utilise cash balances before accessing Emergency PDC to fund their capital programmes. This is expected to deteriorate the Trust's cash balance over time.

6.3.6. AS asked why STHK and S&O were the only two Trusts in Cheshire and Merseyside reporting a deficit against plan. NK responded that he felt it depended on the risk appetite. He understood that across the system there was sufficient income for each organisation to breakeven, however until he was confident that this income was secured for the Trust it did not feel responsible to report breakeven. RF commented that he would prefer a realistic forecast rather than have bad news at the last minute and felt it was better for the Board to understand the financial risks facing the organisation. IC confirmed that the financial position had been discussed in detail at the Finance and Performance Committee and the Non-Executive Directors had supported the approach being taken.

6.4. Workforce Indicators

6.4.1. AMS presented the report

6.4.2. In December overall sickness had increased from 7.0% to 8.5%. Front line Nursing, Midwifery and HCA's sickness had increased 11.3%. These figures include COVID related sickness but not other COVID related absences e.g., self-isolation, or pregnant staff over 28 week who are medically suspended.

6.4.3. Appraisal compliance continues to slowly improve, however is below target at 67.6%. Mandatory training compliance has remained unchanged at 74.3%. The biggest issue to improving performance for both mandatory training and appraisals is releasing staff to undertake them as a result of the operational pressures. The focus as remained on encouraging managers to have “check in” conversations with staff, even if there is not time for a full appraisal.

6.4.4. GB reflected that the “big thank you week” that was happening in the Trust was a timely gesture to support staff after a very difficult period and all Board members agreed and supported the continued efforts to ensure staff understood that they were appreciated.

6.4.5. RF commented that he found the IPR format and reports extremely useful and clear and asked for the Boards thanks to be passed to all the managers who provided the information and to the Business Intelligence Team for producing it.

7. Committee Report - Executive

7.1. AM presented the report

7.2. There have been 7 Executive Committee Meetings in November and December.

7.3. AM highlighted the investment decisions that had been made;

7.4. Whiston Additional Theatres Capacity
The Executive Committee had discussed and reviewed the business case for two additional theatres at Whiston hospital which were part of the agreed strategic estate capital development plan. The uncertainty about the future NHS financial regime put the revenue assumptions for 2023/24 at risk. The committee supported the case for change based on the capacity and demand modelling which demonstrated that the need for increased capacity was on the acute site. The complexity of vacating the proposed development space and finding suitable alternative accommodation for displaced staff was also recognised but it was agreed the adjacency to the existing

theatre complex made this the best location for the development. The business case was subsequently presented and approved at the November Trust Board (closed) meeting.

7.5. Mandatory Training & Appraisals
The committee had agreed a package of measures to remove reported barriers to staff being able to complete their mandatory training and appraisals, including improving the interface between Moodle and ESR, developing an e-learning package for the remaining training subjects, e.g., safeguarding level 2, and increasing the capacity to ensure ESR was up to date with staff moves and contractual changes which could impact their individual training matrix. It was acknowledged that operational pressures and time remained the biggest issue to releasing staff but making the system as streamlined and easy to access as possible would mean that when time was available it would be productive.

7.6. Cellular Pathology Equipment Replacement
The Executive had approved a business case to replace obsolete tissue processing equipment with newer equipment which would increase capacity and improve turnaround times. The capital for the replacement had already been approved as part of the 2021/22 capital programme, but the preferred equipment resulted in a cost pressure of £108k per annum mainly for reagents. There were other non-cash releasing benefits for the Histopathology service that would modernise and help future proof the department.

7.7. Emergency Department (ED) – Low Rise Trolleys
A business case to purchase low rise trolleys with knee breaks for the Emergency Department was approved to improve patient safety for those at risk of falls or pressure ulcers.

7.8. RT asked for more information about point 5.4 of the report relating to outcomes data for Fractured Neck of Femur and Emergency Laparotomy. RPJ advised that an acute abdominal pathway was in place. The Trust can face challenges securing an ICU bed for high-risk patients but there is now a formal process in place with the ICU consultants to ensure appropriate patients are escalated. In relation to Fractured Neck of Femur, the Trust had been flagged as an outlier, but investigation had revealed that national audit collects the comorbidity and coding information on the first of 3 parts of a patient's journey and the Orthopaedic Surgeons are offering palliative surgery to stabilise the Fractured Neck of Femur in patients were unlikely to survive. This is about quality of care for the patient and relieving pain in the short term.

7.9. RT also asked if there was an agreed timescale for re-establishing the appropriate use of NEWS2 as part of the deteriorating patient project. RPJ provided assurance that NEWS2 is being used everywhere to record observations but that these observations are still being taken at standard intervals as part of the ward routine. Work is currently being undertaken on one ward to understand the challenges of individualised schedules before rolling out across the whole Trust. This has been delayed due to the staffing challenges in December and January, but RPJ was confident the pilot would

be completed and reported by the end of February. Updates on the deteriorating patient project were regularly reported to the Quality Committee.

7.10. The remainder of the report was taken as read and noted by the Board.

8. Committee Report – Quality – 11.52 on Whiston Hospital 3

8.1. RT presented the report and highlighted key points for the Board.

8.2. The results of the 2020 inpatient survey report were received, which highlighted that the Trust's results showed an improvement in several key areas, including the information questions that were targeted for improvement in the Trust's annual objectives following last year's survey results. The Trust ranked 4th nationally when compared to other acute trusts on the question relating to overall quality of the care provided, with a score of 8.7/10. An action plan has been developed to address areas where further improvements are required, which will be overseen by the Patient Experience Council with escalation to the Quality Committee if necessary. These improvements were very welcome, and RT congratulated all the staff who contributed to all aspects of patient care.

8.3. The committee had received additional assurance in respect of the way incidents were reported, particularly those that had resulted in severe harm or death and some changes to the way information was reported had been agreed for future reports.

8.4. There had also been discussion about falls and the challenges of providing supplementary care (additional one to one care for patients at high risk of a fall) with the current levels of staff absence. It had been agreed that the falls audits undertaken by the wards should review both the falls risk assessments and whether all the prescribed actions had been delivered. This would be reported back to Quality Committee in March.

8.5. The report was noted.

9. Committee Report – Finance & Performance

9.1. IC presented the report as he chaired the meeting on behalf of JK.

9.2. IC advised that the committee focused on the operational and finance sections of the IPR. In relation to cancer there had been a discussion about survival and outcome data as well as meeting the access targets.

9.3. As previously discussed in the meeting the financial position and the decision to report a deficit against the breakeven plan was supported by the committee.

9.4. Excellent progress on CIP delivery had been reported which provided assurance of how embedded the CIP process is across the whole Trust.

9.5. The committee had also received a detailed briefing on the 2022/23 operational planning guidance and the financial planning assumptions and had discussed the risks for the next financial year and what this might mean for CIP.

9.6. AS reported that he had attended a meeting where the future of Payment by Results (PbR) and how this would support collaborative system working. AM commented that there needed to be an incentive for Trusts that could do more work to reduce the waiting list backlog.

9.7. The remainder of the report was noted.

10. Committee Report – Strategic People Committee

10.1. LK presented the report.

10.2. LK explained that because of COVID-19 escalation level 4 the agenda for the meeting had been streamlined and focused on one of the NHS People Plan pillars; Equality, Diversity, and Inclusion (ED&I)

10.3. The Terms of Reference had been updated to reflect the expanded attendance at the meetings and these changes were noted.

10.4. There had been an update on the work to revise the Terms of Reference and annual work plan for the Workforce Council, which included increasing the frequency of meetings. There were to be reported at the next SPC meeting for formal ratification.

10.5. There had been a presentation from the Trust ED&I lead detailing performance against a range of ED&I benchmarks and committee had discussed how the Trust could move forward to make a difference in this area. Assurance was provided that the Executive were sighted on the issues and progress was being made to address priority areas of concern as identified from recent staff surveys and WDES and WRES reports.

10.6. RF commented that the new committee seemed to be developing well and he was sure it would help the Trust going forward.

10.7. The report was noted

11. Corporate Risk Register (CRR) Quarterly Report

11.1. NB presented the report.

11.2. NB explained that the CRR is reported to the Board four times a year to provide assurance that the Trust is operating an effective risk management system, and that risks identified and raised by front line services can be escalated to the Board.

11.3. The total number of risks on the risk register was 772 compared to 736 in October 58.15% (442) of the Trusts reviewed risks are rated as moderate or high compared to 60% (435) in October. 29 high/extreme risks were escalated to the CRR compared to 22 in October. This increase in escalated risks reflected the operational and staffing pressures that had been facing the Trust.

11.4. GA commented that he found this report very helpful in providing an overview of the issues and easy to read.

11.5. VD commented that so many risks seem to be about recruitment. She asked whether there was work being undertaken at system level to address some of these shortages. NB confirmed that there were work streams at where the system was looking at how services could be delivered and the workforce developed, e.g., advanced nurse practitioners. The Trust continued to do well at attracting staff but the pipeline of newly trained staff coming into a range of NHS professions was not sufficient to meet the growing demands for healthcare. AMS confirmed that in both ITU and Dermatology there are national shortages of staff, so the Trust was exploring different delivery models and be creative with how services are delivered across a system. There are limitations but mutual aid has worked between different providers during the pandemic.

11.6. The report was noted

12. Board Assurance Framework Quarterly Review

12.1. NB presented the report

12.2. NB advised that the BAF is the mechanism used by the Board to ensure it has sufficient controls in place and is receiving the appropriate level of assurance in relation to its statutory duties, strategic plans, and long-term objectives. In line with governance best practice the BAF is reviewed by the Board four times a year. The last review was in October 2021.

12.3. The Executive Committee had reviewed the BAF in advance of its presentation to the Trust Board the report included several proposed updates on actions and changes to ensure that BAF remained current. There were no recommended changes to the BAF risk scores in this report.

12.4. VD asked if risk 4 should include a reference to ethics, however RPJ reported that the external review which had been commissioned had not recommended the establishment of a Trust Ethics Committee because there were other processes in place to support decision making about patients i.e., MDTs and all clinical research studies had ethics approval from the appropriate governance bodies before they were allowed to commence.

12.5. IC commented that Informatics and cyber security did not currently have metrics reported in the IPR to provide assurance of performance in this area. IC was aware

that the metrics existed and were reported at the MMDA Board but felt there should also be accountability to the Trust Board for this. CW agreed to review and develop a dashboard that could be included in the new IPR. **ACTION: CW**

12.6. IC also felt that the risk score for risk 1 was potentially high and it was agreed that for the review in April this would be reviewed.

12.7. The Board approved the proposed changes to the BAF.

13. Quarter 3 Aggregated Incidents, Complaints and Claims Report

13.1. SR presented the report.

13.2. The total number of incidents reported in Q3 was 4292, with the total number of patient related incidents being 3642. The patient incidents graded as causing moderate/severe/death was 47. The highest numbers of incidents related to Pressure ulcers (783) and patient slips, trips or falls (652).

13.3. 64 first stage complaints were received in Q3, which was 12.3% decrease from pre pandemic levels. Clinical treatment was the main reason for complaints, in line with previous reports. The response performance (responses in the agreed timescale) had fallen to 70.3% in quarter 3. The Emergency Department received the highest number of complaints (22) which is consistently the case and reflects the high levels of activity. In quarter 3 a number of complaints were received relating to the loss of patients' property and in response a task and finish group has been established to review the process for recording and storing patients' personal processions. During quarter 3 the Trust had received the provisional results of PHSO investigation, these reflected the issues identified as part of the Trusts complaint response and actions had been put in place to improve the quality of information provided to patients and their relatives about end-of-life care.

13.4. There had been 1161 PALs contacts of which 95% were resolved without becoming formal complaints.

13.5. There were 56 new claims (pre action claims and NHSR instructed claims) in Q3 of which 47 are pre-action claims (requests for records from solicitors) and 9 NHS Resolution (NHSR) instructed claims.

13.6. 13 inquests were notified by the coroner in Q3, and 18 inquests were concluded. All had received narrative verdicts with no prevention of future deaths orders.

13.7. LK asked if the increase in PALS contacts since Quarter 1 of 2021 were related to COVID. SR confirmed that a high number of the PALS contacts concerned the visiting restrictions imposed because of COVID. SR also explained that PALS aim to respond to a contact within 24 hours and resolve them in 72 hours, but sometimes it takes longer if the officers need to gather information to be able to give a full response to the concern.

13.8. The report was noted.

14. Winter Staffing Assurance Framework

14.1. SR presented the report

14.2. SR advised the Board that the purpose of the paper was for the board to receive and approve the Trusts winter staffing assurance framework for nursing and midwifery staff. The framework was a self-assessment against recommended actions and processes that provided assurance the Trust had effective processes in place for managing staffing at times of operational pressures and high staff absence.

14.3. The aim of the framework is to ensure that Trusts focus on preparedness, decision making and escalation processes to support safer nursing and midwifery staffing. This was built on the previous guidance issued in relation to COVID-19 workforce models and the fundamental principles for the nursing and midwifery workforce as set out in the National Quality Board (NQB) Safe Sustainable and Productive staffing guidance.

14.4. The Trust can evidence it is compliant with all 29 of the assurance framework indicators but has identified 3 where additional action is required to provide higher levels of assurance.

14.5. GB felt that this provided the Board with a high level of assurance about how staffing was managed to ensure areas were safe, even at times of extreme pressure and felt the assurance self-assessment should be reviewed periodically by the Quality Committee to ensure that all the controls remained in place. SR advised that the tool would be used on an on-going basis and any exceptions reported via the safer staffing reports.

14.6. GA agreed that the completed self-assessment provided a high level of assurance for the Board that the right processes and systems were in place at the Trust.

14.7. The report was noted.

15. 2022/23 Priorities and Operational Planning

15.1. NK presented the report

15.2. NK advised that the national planning guidance had been published in December and had set 10 priorities for the NHS in 2022/23.

15.3. The paper detailed the perceived risk for the Trust in delivering the 8 priorities that applied to acute and community services. One of which was still subject to the

outcome of national consultation (reduce 12-hour trolley waits in ED) and three of the remainder were rated as high risk currently, with no management action to mitigate.

15.4. The planning guidance had also set out how the NHS funding system would operate and the new Aligned Payment and Incentive (API) scheme for activity delivered above the agreed elective activity plans.

15.5. There was a concern that inflation had been assumed at 2.8% but predictions were now that it would be much higher than this.

15.6. There was also a concern at the level of CIP that might be needed to achieve a breakeven position and if anything above 3% could realistically be achieved without impacting on patient care.

15.7. The detailed financial guidance had not yet been received but it was expected a draft plan would be ready for discussion at the February Finance and Performance Committee with a final plan and opening budget to be presented to the Board for approval in March.

15.8. IC asked if the methodology for allocating income to then ICS and then onto providers had been shared. NK reported that this had not yet been discussed but there were a series of meetings being arranged. Members discussed the apparent contradiction in the convergence adjustment which would reduce the allocations to Cheshire and Merseyside against the high level of health inequalities which suggested more resources were needed to tackle the health issues experienced by the population.

15.9. The report was noted.

16. Effectiveness of Meeting

16.1. RF asked AL to provide feedback on the effectiveness of the meeting.

16.2. Referring to the Patient Story, AL complimented the Trust on how they deal with stroke patients. He added that the patient managing to change processes shows the Trust listens to patients and responds to their needs.

16.3. AL confirmed he will investigate the delays with Widnes UTC contract and report back.

17. Any Other Business

17.1. RF notified the Board that his term as chair has been extended by NHSE/I for a further 2 years.

18. Date of Next Meeting

18.1. Wednesday 23rd February 2022.

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST PUBLIC BOARD ACTION LOG – 30TH MARCH 2022

No	Date of Meeting (Minute)	Action	Lead	Date Due
30	29.01.20 (12.4)	NB/NK to prepare a session on the Trust commercial strategy for the next Board Time Out. **DEFERRED**	NB/NK	TBC
36	26.02.20 (8.1.3)	Exec to Exec meeting (STHK Trust/St Helens CCG) to be arranged. **DEFERRED**	AM	TBC
37	26.01.22 (6.2.9)	RC to share an example of care home bed capacity and how this was impacting on discharges. GB confirmed this had been completed. **CLOSED**	RC	-
38	26.01.22 (12.5)	CW agreed to review and develop a dashboard to provide assurance of cyber security performance.	CW	30.03.22

INTEGRATED PERFORMANCE REPORT

Paper No: NHST(22)006
Title of Paper: Integrated Performance Report
Purpose: To summarise the Trusts performance against corporate objectives and key national & local priorities.

Summary

St Helens and Knowsley Hospitals Teaching Hospitals ("The Trust") has in place effective arrangements for the purpose of maintaining and continually improving the quality of healthcare provided to its patients.

The Trust has an unconditional CQC registration which means that overall its services are considered of a good standard and that its position against national targets and standards is relatively strong.

The Trust has in place a financial plan that will enable the key fundamentals of clinical quality, good patient experience and the delivery of national and local standards and targets to be achieved. The Trust continues to work with its main commissioners to ensure there is a robust whole systems winter plan and delivery of national and local performance standards whilst ensuring affordability across the whole health economy.

Patient Safety, Patient Experience and Clinical Effectiveness

The CQC rated the Trust as **outstanding** overall following its inspection in July/August 2018. The caring and well-led domains were rated as **outstanding**, with safety, responsive and effective rated as **good.**

There were no Never Events in January 2022. (YTD = 1).

There were no cases of MRSA in January 2022. (YTD = 1).

There were 4 C.Difficile (CDI) positive cases reported in January 2022 (3 hospital onset and 1 community onset). YTD there have been 47 cases (26 hospital onset and 21 community onset). There are a total of 21 RCAs currently in progress. The Trust has successfully appealed 3 cases, with a further 9 cases currently being appealed. The annual tolerance for CDI for 2021-22 has been set at 54.

The overall registered nurse/midwife Safer Staffing fill rate (combined day and night) for December 2021 was 93.0%. 2021-22 YTD rate is 92.3%.

During the month of December 2021 there were no falls resulting in severe harm or death category . (YTD severe harm or above category falls = 15)

There was 1 validated grade 3 hospital acquired pressure ulcer with lapse in care in November 2021. (YTD (validated incidents) 2021-22 = 2).

Community services recorded a total of 68 incidents in the month of December; 18 were low harm, one was moderate harm. This is a significant reduction on the previous month (106).

Performance for VTE assessment suspended by NHSE since March 2020.

YTD HSMR (April - September) for 2021-22 is 97.7

Corporate Objectives Met or Risk Assessed: Achievement of organisational objectives.
Financial Implications: The forecast for 21/22 financial outturn will have implications for the finances of the Trust
Stakeholders: Trust Board, Finance Committee , Commissioners, CQC, TDA, patients.
Recommendation: To note performance for assurance
Presenting Officer: N Khashu
Date of Meeting: 23rd February 2022

Operational Performance

Performance against the 62 day cancer standard was above the target of 85.0% in month (December 2021) at 85.02%. YTD 85.2%. The 31 day target was achieved in December 2021 with 98.2% performance in month against a target of 96%, YTD 98.2%. The 2 week rule target was not achieved in December 2021 with 78.5% in month and 86.3% YTD against a target of 93.0%. The deterioration in performance for 2 week rule, is related to the significant increase in referrals, compared to the same period in 2019, resulting in capacity challenges.

Accident and Emergency Type 1 performance for January 2022 was 55.7% and YTD 57.1%. The all type mapped STHK Trust footprint performance for January 22 was 78.1% and YTD 77.9%**.** The Trust saw average daily attendances of 298, which is down compared to December, at 300. Total attendances for January 2022 was 9,248.

Total ambulance turnaround time was not achieved in January 2022 with 53 mins on average. There were 2,159 ambulance conveyances (2nd busiest Trust in C+M and 4th in North West) compared with 2,297 in December 21.

The UTC had 4,689 attendances in December 2021, which is a decrease of 3% (141) compared to the previous month. Overall 98% of patients were seen and treated within 4 hours.

The average daily number of super stranded patients in January 2022 was 132 compared with 109 in December. Note this excludes Duffy and Newton IMC beds. Work is ongoing both internally and externally, with all system partners, to improve the current position with acute bed occupancy remaining high with subsequent congestion in ED as a result.

The 18 week referral to treatment target (RTT) was not achieved in December 2021 with 70.7% compliance and YTD 70.7% (Target 92%). Performance in November 2021 was 72.4%. There were (1383) 52+ week waiters. The 6 week diagnostic target was not achieved in December 21 with 74.9% compliance. (Target 99%). Performance in November 2021 was 81.5%.

Referrals into the District Nursing Service increased marginally in December (572 in December in comparison with 543 in November). In comparison, the Community matron caseloads have seen a further decrease in the month of December 143 compared to 161 in November. A caseload review has taken place to ensure capacity is available for the most complex patients.

The covid crisis has had a significant impact on RTT and diagnostic performance, as all routine operating, outpatient and diagnostic activity had to be cancelled. All patients have been, and continue to be, clinically triaged to ensure urgent and cancer patients remain a priority for treatment.

Financial Performance

The Trust submitted a breakeven plan for H2. This included risk of approximately £13m relating to ERF income dependent on system performance (£6m) and other unidentified income required to offset planned expenditure to give a breakeven plan (£7m). Following confirmation of Elective Restoration funding and expenditure slippage, and including ERF income expected to be received from the C&M system allocation, the Trust is now forecasting a breakeven outturn position.

Surplus/Deficit - At the end of Month 10 the Trust has reported a breakeven position, with £438,554k income and expenditure year to date.

CIP - The 21/22 system CIP target of £10m has been achieved. We continue to work towards the Trust's internal target of £15m.

Cash - At the end of Month 10, the cash balance was £66.1m. The current NHSE/I assumption is for providers to utilise cash balances before accessing Emergency PDC to fund their capital programmes. This is expected to deteriorate the Trust's cash balance over time.

Capital - A capital programme of £10.97m (excluding PFI lifecycle expenditure), supported by £5.43m Emergency PDC, was submitted to NHSE/I. Emergency PDC must be agreed by DHSC before the Trust is able to draw funds. Currently, the Trust does not expect this to be agreed, as there is an assumption that providers utilise cash balances before accessing PDC funding.

Human Resources

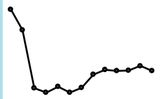
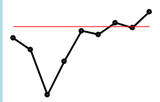
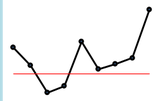
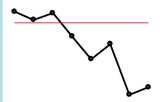
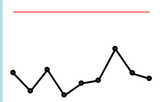
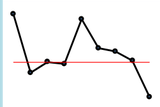
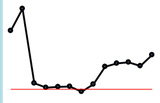
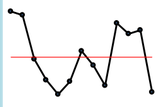
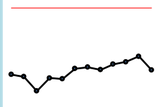
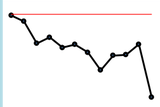
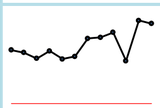
In January 2022, the absence rate (excluding COVID related absences) decreased to 6.16% from 6.70% in December 2021. However the overall absence rate (including COVID related absences) increased to 9.6% from 8.5% in the previous month. The Additional Clinical Services staff had the highest absence rate at 14.8%.
N.B. This includes normal sickness and COVID19 sickness reasons only. These figures do not include, covid absence reasons for staff in isolation, pregnant workers over 28 weeks on medical suspension.
Mandatory Training Compliance remains below the target at 73.5%. Appraisal compliance is at 66.9%.

The following key applies to the Integrated Performance Report:

▲ = 2021-22 Contract Indicator
▲£ = 2021-22 Contract Indicator with financial penalty
● = 2021-22 CQUIN indicator
T = Trust internal target
UOR = Use of Resources

Jan-22

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

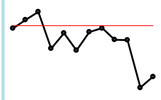
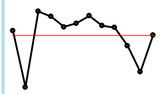
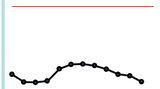
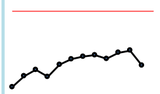
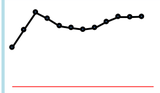
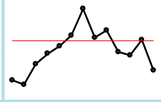
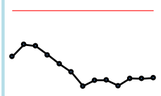
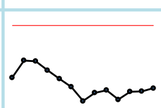
	Committee		Latest Month	Latest month	2021-22 YTD	2021-22 Target	2020-21	Trend	Issue/Comment	Risk	Management Action	Exec Lead
CLINICAL EFFECTIVENESS (appendices pages 32-38)												
Mortality: Non Elective Crude Mortality Rate	Q	T	Jan-22	2.9%	2.6%	No Target	3.1%		Post wave 3 of COVID, performance is encouraging.	Patient Safety and Clinical Effectiveness	The current HSMR is within expected limits. We continue to independently benchmark performance using CRAB data.	RPJ
Mortality: SHMI (Information Centre)	Q	▲	Sep-21	1.07		1.00						
Mortality: HSMR (HED)	Q	▲	Sep-21	106.2	97.7	100.0	92.7					
Mortality: HSMR Weekend Admissions (emergency) (HED)	Q	T	Sep-21	128.7	108.6	100.0	101.1					
Readmissions: 30 day Relative Risk Score (HED)	Q UOR	T	Aug-21	92.1	95.0	100.0	98.8		The trust historically has a relatively high percentage of readmissions, but when adjusted for 'expected' falls within national norms.	Patient experience, operational effectiveness and financial penalty for deterioration in performance	Performance remains within expected range.	RPJ
Length of stay: Non Elective - Relative Risk Score (HED)	F&P	T	Sep-21	88.0	88.3	100.0	90.3		Sustained reductions in NEL LOS are assurance that Trust patient flow practices continue to successfully embed.	Patient experience and operational effectiveness	Drive to maintain and improve LOS across all specialties. Increased discharges in recent months with improved integrations with system partners,	RC
Length of stay: Elective - Relative Risk Score (HED)	F&P	T	Sep-21	85.6	102.3	100.0	104.7					
% Medical Outliers	F&P	T	Jan-22	3.5%	2.0%	1.0%	1.6%		Patients not in right speciality inpatient area to receive timely, high quality care.	Clinical effectiveness, ↑ in Loss, patient experience and impact on elective programme	The current number of medical outliers is above target owing to the full occupancy of the medical bed base. Robust arrangements to ensure appropriate clinical management of outlying patients are in place.	RC
Percentage Discharged from ICU within 4 hours	F&P	T	Jan-22	35.5%	49.9%	52.5%	58.8%		Failure to step down patients within 4 hours who no longer require ITU level care.	Quality and patient experience	Critical care step down patients discussed at all Emergency Access Meetings. Targeted senior manager support to ensure patients are listed and transferred out of ICU in a timely manner although overall medical bed occupancy >95% is recognised as a significant factor in step down delays.	RC
E-Discharge: % of E-discharge summaries sent within 24 hours (Inpatients) - TOTAL	Q	▲	Dec-21	76.2%	76.6%	90.0%	74.8%		IP discharge summaries remain challenging and detailed work has gone on to identify key areas of challenge. The IT team also being involved to find a sustainable solution particularly in A&E. OP attendance letters - deterioration reflects staff sickness and increased activity pressures has caused a backlog in typing. Action plan is in place with operational colleagues.		Specific wards have been identified with poor performance and staff are being supported to complete discharge in a timely manner. All CDs and ward managers receive daily updates of performance. The most challenged area in SDECC is moving discharges to the Medway system to support rapid, detailed discharges. We are working with CCG colleagues to confirm the change in policy before go-live with action plan in place to monitor impact and quality of summary being sent out	RPJ
E-Discharge: % of E-attendance letters sent within 14 days (Outpatients) - TOTAL	Q	▲	Dec-21	47.7%	71.7%	95.0%	88.3%					
E-Discharge: % of A&E E-attendance summaries sent within 24 hours (A&E) - TOTAL	Q	▲	Dec-21	97.9%	97.2%	95.0%	96.8%					

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

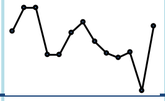
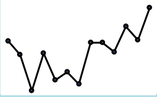
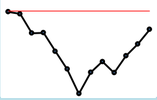
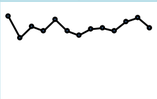
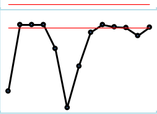
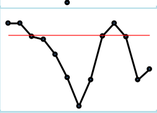
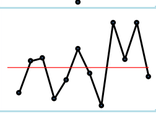
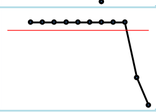
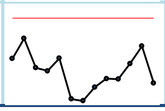
	Committee		Latest Month	Latest month	2021-22 YTD	2021-22 Target	2020-21	Trend	Issue/Comment	Risk	Management Action	Exec Lead
CLINICAL EFFECTIVENESS (continued)												
Stroke: % of patients that have spent 90% or more of their stay in hospital on a stroke unit	Q F&P	▲	Q3	84.9%	85.6%	83.0%	90.4%		Target is being achieved. With effect from April 2017, STHK is also treating patients from the Warrington Area.	Patient Safety, Quality, Patient Experience and Clinical Effectiveness	Continued achievement of required 80% of patients have spent 90% of their stay in the stroke unit	RC
PATIENT SAFETY (appendices pages 40-43)												
Number of never events	Q	▲ £	Jan-22	0	1	0	3		One never event reported in July 2021	Quality and patient safety	Investigation into previously reported incidents completed and actions in place to mitigate chances of recurrence. Local actions and monitoring procedures in place.	SR
% New Harm Free Care (National Safety Thermometer)	Q	T	Mar-20			98.9%			Safety Thermometer was discontinued in March 2020	Quality and patient safety	Reducing hospital acquired harm is a key priority for the quality and risk teams, the continued development of both risk assessments and harm mitigation strategies will further reduce the risk of harm to patients	SR
Prescribing errors causing serious harm	Q	T	Jan-22	0	0	0	0		The trust continues to have no inpatient prescribing errors which cause serious harm. Trust has moved from being a historic low reporter of prescribing errors to a higher reporter - which is good.	Quality and patient safety	Consistent good performance is supported by the EPMA platform.	RPJ
Number of hospital acquired MRSA	Q F&P	▲ £	Jan-22	0	1	0	2		There were no cases of MRSA in January 2022. YTD = 1.	Quality and patient safety	The annual tolerance for CDI for 2021-22 has been set at 54.	SR
Number of hospital onset and community onset C Diff	Q F&P	▲ £	Jan-22	4	47	54	28		There were 4 positive C Diff sample in January 2022. YTD there have been 50 cases of which 3 cases have been successfully appealed, leaving 47 cases.			
Number of Hospital Acquired Methicillin Sensitive Staphylococcus Aureus (MSSA) bloodstream infections	Q F&P		Jan-22	6	41	No Target	29		Internal RCAs on-going with more recent cases of C. Diff.			
Number of avoidable hospital acquired pressure ulcers (Grade 3 and 4)	Q	▲	Nov-21	3	6	No Contract target	1		2 validated category 3 pressure ulcer YTD, 4 incidents awaiting RCA panel.	Quality and patient safety	Improvement actions in place and completed based upon RCA findings from the incident identified in April 21.	SR
Number of falls resulting in severe harm or death	Q	▲	Dec-21	0	15	No Contract target	31		No falls resulting in severe harm category in December 2021. No falls resulting in death.	Quality and patient safety	Focussed falls reduction and improvement work in all areas being undertaken. Additional support provided to high risk wards.	SR
VTE: % of adult patients admitted in the month assessed for risk of VTE on admission	Q	▲ £	Feb-20			95.0%			**March 20 to January 22 submissions suspended.** VTE performance monitored since implementation of Medway and ePMA.	Quality and patient safety	Despite suspension of returns, we continue to emphasise the importance of thrombosis prevention. Large proportion of HAT attributed to COVID-19 patients - RCA currently underway with thematic review expected. All cases reviewed. Appropriate prescribing and care identified.	RPJ
Number of cases of Hospital Associated Thrombosis (HAT)		T	Jul-21	9	40	No Target	61					
To achieve and maintain CQC registration	Q		Jan-22	Achieved	Achieved	Achieved	Achieved		Through the Quality Committee and governance councils the Trust continues to ensure it meets CQC standards. Trust rated as outstanding following the 2018 inspection.	Quality and patient safety		SR
Safe Staffing: Registered Nurse/Midwife Overall (combined day and night) Fill Rate	Q	T	Dec-21	93.0%	92.3%	No Target	92.2%		Shelford Patient Acuity undertaken bi-annually	Quality and patient safety	Safe Care Allocate has been implemented across all inpatient wards. All wards are receiving support to ensure consistency in scoring patients. Recruitment into posts remains a priority area. Unify report has identified some specific training relating to rostering and the use of the e-Roster System. This is going to be addressed through the implementation of a check and challenge process at ward level.	SR
Safe Staffing: Number of wards with <80% Registered Nurse/Midwife (combined day and night) Fill Rate	Q	T	Dec-21	0	24	No Target	49					

Jan-22

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

	Committee		Latest Month	Latest month	2021-22 YTD	2021-22 Target	2020-21	Trend	Issue/Comment	Risk	Management Action	Exec Lead
PATIENT EXPERIENCE (appendices pages 44-52)												
Cancer: 2 week wait from referral to date first seen - all urgent cancer referrals (cancer suspected)	F&P	▲ £	Dec-21	78.5%	86.3%	93.0%	94.3%		2WW referrals remain high and this has been accepted as the new norm. A trend in GPs inappropriately expediting referrals as an attempt to speed up treatment has been noted.	Quality and patient experience	1. All DMs producing speciality level action plans to provide two week capacity, including communication with GPs around correct process and management of waiting lists/patient hot lines. 2. Capacity/demand review on going at speciality level 3. Trust continues to utilise Imaging capacity via temp CT facility at St Helens Hospital 4. Trust commenced Rapid Diagnostic Service early 2020 5.Cancer surgical Hub at St Helens to recommence 6. ESCH plans reignited 7. Funding approved to support RDS implementation aligned to CDC	RC
Cancer: 31 day wait for diagnosis to first treatment - all cancers	F&P	▲ £	Dec-21	98.2%	98.2%	96.0%	97.6%					
Cancer: 62 day wait for first treatment from urgent GP referral to treatment	F&P	▲ ●	Dec-21	85.0%	85.2%	85.0%	86.7%					
18 weeks: % incomplete pathways waiting < 18 weeks at the end of the period	F&P	▲	Dec-21	70.7%	70.7%	92.0%	70.6%		The covid crisis has had a significant impact on RTT and diagnostic performance, as all routine operating, outpatient and diagnostic activity had to be cancelled. Recovery plans are in place.	COVID restrictions had stopped elective programme and therefore the ability to achieve RTT is not possible.	RTT continues to be monitored and patients tracked. Long waiters tracked and discussed in depth at weekly PTL meetings. activity recommenced but at reduced rate due to social distancing requirements, PPE, patient willingness to attend and this has begun to be impacted upon as Covid activity increases again. urgent, cancers and long waiters remain the priority patients for surgery at Whiston with application of P- codes effectively implemented. Application of D-codes is delayed due to system challenges for some modalities. This is being worked through with IT &BI with support of the National Team. Removal of P5 & D5 Codes is on target.	RC
18 weeks: % of Diagnostic Waits who waited <6 weeks	F&P	▲	Dec-21	74.9%	77.2%	99.0%	67.6%					
18 weeks: Number of RTT waits over 52 weeks (incomplete pathways)	F&P	▲	Dec-21	1,383	1,383	0	1,469					
Cancelled operations: % of patients whose operation was cancelled	F&P	T	Jan-22	0.4%	0.78%	0.8%	0.4%		Year to date underperformance in cancelled ops has been due to staff sickness/absence, and theatre staff being re-deployed temporarily to support ITU. In December and January, a mixture of consultant and theatre staff sickness has impacted this metric. The team is confident that this will recover going forward, although performance remains at risk.	Patient experience and operational effectiveness Poor patient experience	Monitor cancellations and recovery plan when restrictions lifted	RC
Cancelled operations: % of patients treated within 28 days after cancellation	F&P	▲ £	Dec-21	100.0%	100.0%	100.0%	97.3%					
Cancelled operations: number of urgent operations cancelled for a second time	F&P	▲ £	Mar-20			0						
A&E: Total time in A&E: % < 4 hours (Whiston: Type 1)	F&P	▲	Jan-22	55.7%	57.1%	95.0%	78.0%		Accident and Emergency Type 1 performance for January 2022 was 55.7% and YTD 57.1%. The all type mapped STHK Trust footprint performance for January 22 was 78.1% and YTD 77.9%. The Trust saw average daily attendances of 298, which is down compared to December, at 300. Total attendances for January 2022 was 9,248. Total ambulance turnaround time was not achieved in January 2022 with 53 mins on average. There were 2,159 ambulance conveyances (2nd busiest Trust in C+M and 4th in North West) compared with 2,297 in December 21.	Patient experience, quality and patient safety	The urgent and emergency care transformation plan has several interconnected work streams designed to improve overall 4 hour access performance. Emergency Department/Front Door processes in place including 'walk in' streaming, Stretcher Triage streaming and internal departmental efficiencies and exit from ED. GP streaming in place as per NHSE recommendations. <u>Flow through the Hospital</u> COVID action plan to enhance discharges commenced in April 20 with daily discharge tracking meetings to manage patients who no longer meet the criteria to reside with all system partners promoting same day discharges on pathways 0, 1,2, 3 with strict KPI management to optimise bed capacity. The continued absence of face to face assessments from social workers is causing some delays.	RC
A&E: Total time in A&E: % < 4 hours (Mapped STHK Footprint – All Types)	F&P	▲	Jan-22	78.1%	77.9%	95.0%	86.8%					
A&E: 12 hour trolley waits	F&P	▲	Jan-22	0	0	0	0					

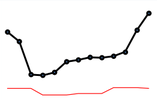
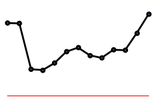
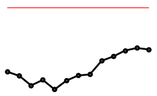
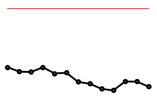
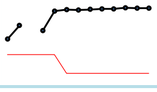
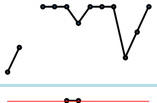
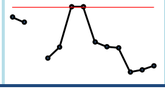
CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

	Committee		Latest Month	Latest month	2021-22 YTD	2021-22 Target	2020-21	Trend	Issue/Comment	Risk	Management Action	Exec Lead
PATIENT EXPERIENCE (continued)												
MSA: Number of unjustified breaches	F&P	▲ £	Jan-22	0	0	0			Return commenced again from October 2021	Patient Experience		RC
Complaints: Number of New (Stage 1) complaints received	Q	T	Jan-22	14	217	No Target	242		% new (Stage 1) complaints resolved within agreed timescales remains below the target, though improved to above 90% in January 2022.	Patient experience	The Complaints Team continue to focus on increasing response times with active monitoring of any delays and provision of support as necessary. Complainants have been made aware of the significant delays that will be experienced in receiving responses going forward due to current operational pressures, with continued focus on achieving the target of 90%. Additional temporary resources are currently in place to increase response rates within the Medical Care Group.	SR
Complaints: New (Stage 1) Complaints Resolved in month	Q	T	Jan-22	23	208	No Target	207					
Complaints: % New (Stage 1) Complaints Resolved in month within agreed timescales	Q	T	Jan-22	91.3%	79.8%	No Target	93.7%					
DTOC: Average number of DTOCs per day (acute and non-acute)	Q	T	Feb-20			No Target			**March 20 to January 22 submissions suspended.** In February 2020, the average number of DTOCS (patients delayed over 72 hours) was 24.		COVID action plan to enhance discharges commenced in April with daily discharge tracking meetings to manage patients who no longer meet the criteria to reside with all system partners promoting same day discharges on pathways 0, 1,2, 3 with strict KPI management to optimise bed capacity/reduce delays. The absence of face to face assessments from social workers is causing some delays.	RC
Average number of Stranded patients per day (7+ days LoS)	Q	T	Jan-22	342	310		257					
Average number of Super Stranded patients per day (21+ days LoS)	Q	T	Jan-22	132	103		72					
Friends and Family Test: % recommended - A&E	Q	▲	Jan-22	85.6%	78.8%	90.0%	88.4%		Year to date recommendation rates are above target for inpatients and postnatal ward , but remain below target for the remaining areas. Recommendation rates for ED have improved for each of the last three months.	Patient experience & reputation	The profile of FFT continues to be raised by members of the Patient Experience Team as a valuable mechanism for receiving up-to-date patient feedback. The display of FFT feedback via the 'You said, we did' posters continues to be actively monitored and regular reminder emails are issued to wards that do not submit the posters by the deadline. At least two members of staff have been identified in each area to produce the 'you said, we did' posters which are used to identify specific areas for improvement. Easy to use guides are available for each ward to support completion and the posters are now distributed centrally to ensure that each ward has up-to-date posters. Areas continue to review comments to identify any emerging themes or trends, and significantly negative comments are followed up with the contributor if contact details are provided to try and resolve issues. There were 20 responses for postnatal community, with 17 positive ratings and 1 negative rating, with 2 responses rating the care as neither good nor poor, which negatively impacted on the % recommendation rate, which has consistently been above the target previously.	SR
Friends and Family Test: % recommended - Acute Inpatients	Q	▲	Jan-22	95.7%	95.8%	90.0%	95.8%					
Friends and Family Test: % recommended - Maternity (Antenatal)	Q		Jan-22	98.5%	96.9%	98.1%	90.6%					
Friends and Family Test: % recommended - Maternity (Birth)	Q	▲	Jan-22	92.5%	93.7%	98.1%	99.0%					
Friends and Family Test: % recommended - Maternity (Postnatal Ward)	Q		Jan-22	94.1%	95.5%	95.1%	94.6%					
Friends and Family Test: % recommended - Maternity (Postnatal Community)	Q		Jan-22	85.0%	97.8%	98.6%	100.0%					
Friends and Family Test: % recommended - Outpatients	Q	▲	Jan-22	93.6%	93.8%	95.0%	94.2%					

Jan-22

St Helens and Knowsley Teaching Hospitals NHS Trust

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

	Committee		Latest Month	Latest month	2021-22 YTD	2021-22 Target	2020-21	Trend	Issue/Comment	Risk	Management Action	Exec Lead
WORKFORCE (appendices pages 54-61)												
Sickness: All Staff Sickness Rate	Q F&P UOR	▲	Jan-22	9.6%	7.0%	Q1 - 4.25% Q2 - 4.35% Q3 - 4.72% Q4 - 4.68%	6.6%		In January 2022, the absence rate (excluding COVID related absences) decreased to 6.16% from 6.70% in December 2021. However the overall absence rate (including COVID related absences) increased to 9.6% from 8.5% in the previous month. The Additional Clinical Services staff had the highest absence rate at 14.8%. N.B. This includes normal sickness and COVID19 sickness reasons only. These figures do not include, covid absence reasons for staff in isolation, pregnant workers over 28 weeks on medical suspension. Mandatory Training Compliance remains below the target at 73.5%. Appraisal compliance is at 66.9%.	Quality and Patient experience due to reduced levels staff, with impact on cost improvement programme.	The HR Advisory Team undertake a review of sickness absence daily to analyse the hotspots and provide targeted support to managers. HWWB are contacting employees who are absent with Covid to provide support. In addition, there's a bi-weekly review of absence matters between the HR Operations Team and the Clinical Lead to ensure that the wellbeing of staff remains a priority.	AMS
Sickness: All Nursing and Midwifery (Qualified and HCAs) Sickness Ward Areas	Q F&P UOR	T	Jan-22	13.1%	9.8%	5.3%	8.6%					
Staffing: % Staff received appraisals	Q F&P	T	Jan-22	66.9%	66.9%	85.0%	51.3%		Appraisal compliance has fallen by 0.7% and is below target by 18.1%. Mandatory training compliance has reduced by 0.8% and is below the target by 11.5%. In particular, Both continue to be impacted by operational activity, recovery plans and significant staff absence.	Quality and patient experience, Operational efficiency, Staff morale and engagement.	Recovery of both Appraisal and Mandatory Training continue to be impacted by operational pressures and high staff absence, with both remaining below target. For Mandatory Training a more detailed recovery plan to meet compliance has been developed by SMEs responsible for each area to be monitored through Workforce Council and Quality Committee.	AMS
Staffing: % Staff received mandatory training	Q F&P	T	Jan-22	73.5%	73.5%	85.0%	75.7%					
Staff Friends & Family Test: % recommended Care	Q	▲	Q2 2019-20			No Contract Target			NHSE/NHSI to resume from Q2 (July)	Staff engagement, recruitment and retention.	The annual staff survey closed on 26th November. Publication of results is expected in March 2022. No definitive date has as yet been confirmed.	AMS
Staff Friends & Family Test: % recommended Work	Q	▲	Q2 2019-20			No Contract Target						
Staffing: Turnover rate	Q F&P UOR	T	Jan-22	0.9%		No Target	12.9%		Staff turnover remains stable and below the national average of 14%.			AMS
FINANCE & EFFICIENCY (appendices pages 62-67)												
UORR - Overall Rating	F&P UOR	T	Jan-22	Discontinued	Discontinued	N/A				Delivery of Control Total	The 2021 financial plan has been put on hold and a system introduced where Trusts will breakeven for the first six months of 2021/22.	NK
Progress on delivery of CIP savings (000's)	F&P	T	Jan-22	9,692	9,692	15,000						
Reported surplus/(deficit) to plan (000's)	F&P UOR	T	Jan-22	-	-	-						
Cash balances - Number of days to cover operating expenses	F&P	T	Jan-22	30	30	10						
Capital spend £ YTD (000's)	F&P	T	Jan-22	7,200	7,200	17,600						
Financial forecast outturn & performance against plan	F&P	T	Jan-22	-	-	-						
Better payment compliance non NHS YTD % (invoice numbers)	F&P	T	Jan-22	78.1%	78.1%	95.0%						

APPENDIX A

			Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	2021-22 YTD	2021-22 Target	FOT	2020-21	Trend	Exec Lead
Cancer 62 day wait from urgent GP referral to first treatment by tumour site																					
Breast	% Within 62 days	▲ £	100.0%	96.3%	100.0%	97.4%	100.0%	94.7%	92.0%	89.5%	100.0%	96.3%	93.3%	100.0%	95.0%	95.6%	85.0%		91.1%		
	Total > 62 days		0.0	0.5	0.0	0.5	0.0	1.0	1.0	1.0	0.0	0.5	0.5	0.0	1.0	5.0			11.0		
	Total > 104 days		0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.5	0.0	0.0	0.5			0.0		
Lower GI	% Within 62 days	▲ £	82.6%	78.9%	58.6%	87.5%	61.1%	78.1%	100.0%	86.7%	82.8%	100.0%	68.4%	60.0%	76.0%	79.0%	85.0%		78.7%		
	Total > 62 days		2.0	2.0	6.0	1.0	3.5	3.5	0.0	1.0	2.5	0.0	3.0	4.0	3.0	20.5			22.0		
	Total > 104 days		0.0	0.0	2.0	1.0	0.0	0.0	0.0	0.0	1.5	0.0	0.0	1.5	1.0	4.0			6.0		
Upper GI	% Within 62 days	▲ £	83.3%	100.0%	100.0%	66.7%	100.0%	100.0%	100.0%	77.8%	62.5%	71.4%	100.0%	100.0%	77.8%	87.2%	85.0%		83.1%		
	Total > 62 days		1.0	0.0	0.0	3.5	0.0	0.0	0.0	1.0	3.0	1.0	0.0	0.0	1.0	6.0			11.5		
	Total > 104 days		0.0	0.0	0.0	0.5	0.0	0.0	0.0	1.0	1.0	0.0	0.0	0.0	0.0	2.0			4.0		
Urological	% Within 62 days	▲ £	88.2%	82.8%	92.3%	79.2%	80.0%	88.6%	75.7%	84.2%	77.5%	80.0%	92.6%	69.6%	96.0%	81.1%	85.0%		85.6%		
	Total > 62 days		2.0	2.5	1.0	2.5	2.0	2.0	4.5	1.5	4.5	2.0	1.0	3.5	0.5	21.5			21.0		
	Total > 104 days		0.0	0.0	0.0	0.5	0.0	0.0	0.0	0.0	0.5	2.0	0.0	0.5	0.5	3.5			6.0		
Head & Neck	% Within 62 days	▲ £	0.0%	33.3%	57.1%	50.0%	0.0%	14.3%	50.0%	0.0%	0.0%	66.7%	0.0%	0.0%	0.0%	20.6%	85.0%		51.4%		
	Total > 62 days		1.0	1.0	1.5	1.0	1.0	3.0	1.0	2.0	1.0	1.0	2.0	0.5	2.0	13.5			9.0		
	Total > 104 days		0.0	0.0	0.0	0.0	1.0	0.0	0.0	0.0	0.0	0.0	1.0	0.0	0.0	2.0			0.0		
Sarcoma	% Within 62 days	▲ £	100.0%	100.0%	100.0%		100.0%	100.0%		100.0%						100.0%	85.0%		83.3%		
	Total > 62 days		0.0	0.0	0.0		0.0	0.0		0.0						0.0			1.0		
	Total > 104 days		0.0	0.0	0.0		0.0	0.0		0.0						0.0			0.0		
Gynaecological	% Within 62 days	▲ £	66.7%	55.0%	60.0%	57.1%	83.3%	100.0%	90.9%	100.0%	44.4%	60.0%	80.0%	80.0%	50.0%	72.2%	85.0%		66.3%		
	Total > 62 days		1.0	4.5	1.0	3.0	0.5	0.0	0.5	0.0	2.5	2.0	1.0	0.5	3.0	10.0			17.5		
	Total > 104 days		0.0	1.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0			2.0		
Lung	% Within 62 days	▲ £	75.0%	100.0%	80.0%	100.0%	100.0%	63.6%	100.0%	78.9%	100.0%	66.7%	60.0%	76.9%	88.9%	80.3%	85.0%		83.9%		RC
	Total > 62 days		2.0	0.0	1.0	0.0	0.0	2.0	0.0	2.0	0.0	2.5	3.0	1.5	1.0	12.0			10.0		
	Total > 104 days		0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.0	0.0	0.0	0.0	0.0	0.0	1.0			1.0		
Haematological	% Within 62 days	▲ £	100.0%	50.0%		75.0%	57.1%	100.0%	37.5%	37.5%	100.0%	100.0%	100.0%	50.0%	50.0%	57.1%	85.0%		77.9%		
	Total > 62 days		0.0	3.0		1.0	3.0	0.0	5.0	5.0	0.0	0.0	0.0	1.0	1.0	15.0			8.0		
	Total > 104 days		0.0	0.0		0.0	1.0	0.0	1.0	2.0	0.0	0.0	0.0	0.0	0.0	4.0			1.0		
Skin	% Within 62 days	▲ £	100.0%	96.8%	86.0%	94.6%	92.9%	89.3%	92.8%	100.0%	97.1%	90.3%	89.9%	89.0%	91.4%	92.7%	85.0%		93.6%		
	Total > 62 days		0.0	1.0	4.0	2.5	2.5	3.0	3.0	0.0	1.0	3.5	4.0	4.5	3.0	24.5			25.5		
	Total > 104 days		0.0	0.0	1.0	0.5	0.0	1.0	0.0	0.0	0.0	0.5	0.0	0.0	0.0	1.5			3.0		
Unknown	% Within 62 days	▲ £	100.0%	100.0%	100.0%	80.0%			50.0%		100.0%		100.0%	100.0%		84.6%	85.0%		92.3%		
	Total > 62 days		0.0	0.0	0.0	0.5			1.0		0.0		0.0	0.0		1.0			1.0		
	Total > 104 days		0.0	0.0	0.0	0.5			0.0		0.0		0.0	0.0		0.0			0.5		
All Tumour Sites	% Within 62 days	▲ £	90.4%	85.3%	82.0%	86.4%	86.1%	85.5%	85.7%	86.2%	85.6%	85.5%	84.4%	82.9%	85.0%	85.2%	85.0%		86.7%		
	Total > 62 days		9.0	14.5	14.5	15.5	12.5	14.5	16.0	13.5	14.5	12.5	14.5	15.5	15.5	129.0			137.5		
	Total > 104 days		0.0	1.0	3.0	3.0	2.0	1.0	1.0	4.0	3.0	2.5	1.5	2.0	1.5	18.5			23.5		
Cancer 31 day wait from urgent GP referral to first treatment by tumour site (rare cancers)																					
Testicular	% Within 31 days	▲ £	100.0%	100.0%	100.0%	100.0%			100.0%		100.0%	100.0%	100.0%		100.0%	100.0%	85.0%		100.0%		
	Total > 31 days		0.0	0.0	0.0	0.0			0.0		0.0	0.0	0.0		0.0	0.0			0.0		
	Total > 104 days		0.0	0.0	0.0	0.0			0.0		0.0	0.0	0.0		0.0	0.0			0.0		
Acute Leukaemia	% Within 31 days	▲ £															85.0%				
	Total > 31 days																				
	Total > 104 days																				
Children's	% Within 31 days	▲ £															85.0%				
	Total > 31 days																				
	Total > 104 days																				

St Helens and Knowsley Teaching Hospitals NHS Trust

Trust Board

Paper No: NHST(22)007
Title of paper: Executive Committee Chair's Report
Purpose: To provide assurance to the Trust Board on those matters delegated to the Executive Committee.
Summary: The paper provides a summary of the issues considered by the Executive Committee at the meetings held during January 2022. There were four Executive Committee meetings held during this period. The investment decisions made were: 1. To create a new position of Clinical Director of Research, Development and Innovation; 2. To create an endoscopy staff bank on behalf of the Cheshire and Merseyside Cancer Alliance. The Executive Committee discussed the COVID-19 pandemic and its impact on the Trust. There was a focus on preparations for the introduction of the vaccination as a condition of deployment regulations. In addition, the committee received weekly updates concerning the Log4j cyber threat and assurance on the actions being taken to protect the Trust IT systems. The Committee also considered regular assurance reports covering Risk Management Council and corporate risk register, the board assurance framework, and the Integrated Performance Report.
Trust objectives met or risks addressed: All Trust objectives.
Financial implications: None arising directly from this report.
Stakeholders: Patients, the public, staff, commissioners, regulators
Recommendation(s): That the report be noted
Presenting officer: Ann Marr, Chief Executive
Date of meeting: 23rd February 2022

CHAIR'S REPORT FROM THE EXECUTIVE COMMITTEE

1. Introduction

There were four Executive Committee meetings in January 2022.

At every meeting bank or agency staff requests that breach the NHSE/I cost thresholds are reviewed and Chief Executive's authorisation recorded.

2. 6th January 2022

2.1 Dental Foundation Trainees – Lead Employer Procurement

The Deputy CEO/Director of HR presented the report which detailed the procurement exercise being undertaken by Health Education England (HEE) to identify lead employers for dental foundation trainees. This was split into lots covering different regions of the country. Committee considered whether the Trust should bid for any of these lots and how this fitted with the objectives of the lead employer services that the trust already delivers.

2.2 Trust Board Agenda

The Director of Corporate Services presented the draft Trust Board agenda for review. The committee agreed a number of changes in light of the recent government guidance in response to the level 4 Omicron escalation.

2.3 COVID Issues

Approval was given to recruit temporary additional medical staff to support the enlarged medical bed base, including the COVID cohort wards and care of medical outliers, as part of the agreed winter plan.

The Director of Integration presented the latest COVID incidence figures which demonstrated that positive cases had tripled in 2 weeks. Knowsley had the 2nd highest incidence in England. However, community infection rates had not yet translated into a commensurate increase in hospital admissions.

The Director of Operations and Performance gave feedback from the weekly Gold Command meeting noting; the proposed changes to government self-isolation requirements for staff who had negative Lateral Flow Device (LFD) results; the work to identify and contact unvaccinated staff to prepare for the Vaccination as a Condition of Employment final guidance that was to be published by NHSE/I; and the review of visiting restrictions which had concluded they should remain in place because of the extremely high community infection rates.

It was also reported that in response to high levels of staff absence as a result of the Omicron variant, some elective orthopaedic activity had been cancelled for two weeks, but clinically urgent patients and emergencies would continue to be prioritised.

The Director of Corporate Services presented the most recent "reducing the burden of reporting and releasing capacity" guidance from NHSE/I which had been issued when the Omicron wave had been declared a level 4 incident by government. Members agreed that usual governance activities should be streamlined or stood down in January where this would release clinical and operational staff to care for patients. Active performance management of mandatory training and appraisals would also be suspended for January to enable staff to focus on clinical care.

The Director of Nursing, Midwifery and Governance presented the nosocomial infection (NCI) report which showed an increase in cases in December in line with the increase in community incidence and the transmissibility of the Omicron strain of COVID.

2.4 Annual Leave Carry Over 2022/23

The Deputy CEO/Director of HR presented a proposal to operate the same policy as 2021/22 in respect of annual leave that could not be taken by staff before 31st March 2022. It was agreed that wherever possible staff should be facilitated to take their leave to support health and wellbeing, but it was recognised that at times of extreme pressures managers had to ask staff to cancel planned leave to ensure safe staffing levels. Although supportive of the proposal, the Director of Finance and Information explained that national funding had not been made available to buy out leave in 2021/22 and the emergency provisions for the carryover of leave had not yet been extended to 2022/23. It was therefore important to fully understand the financial implications before a final decision could be made and guidance issued to managers.

2.5 Southport and Ormskirk Hospitals NHS Trust (S&O)

The Deputy CEO/Director of HR provided an update on the COVID situation and operational pressures at S&O. It was reported that S&O had recorded 13.5% staff absence including COVID sickness and self-isolation which was causing additional pressures.

It was noted that the Agreement for Long Term Collaboration quarterly joint meeting between the Trust, S&O and NHSE/I had been postponed due to the operational pressures facing the system and an alternative date was being sought in February. The S&O Board meeting would however still go ahead on 12th January.

The Director of Informatics provided an update on the support being offered to S&O and the joint bids that had been submitted for national technology funds.

2.6 Strategic Issues

The Chief Executive reported on the work being undertaken across the North West to identify potential additional surge capacity beds and to optimise the use of virtual wards to care for COVID patients, and that additional funding had been allocated to the region to support this increase in bed capacity.

2.7 Log4j Cyber Threat

The Director of Informatics briefed the committee on 'Operation Sawmill', which was being undertaken nationally in response to the level 2 cyber threat. The National Cyber Security Centre was monitoring NHS systems and advising the service on how to respond. So far there had been no breaches of the Trust's defences.

All 139 of the Trust's IT systems had been reviewed and work was ongoing with the suppliers to mitigate any threats if they had the Log4j software. Staff had been reminded of the importance of not opening email attachments from unknown sources and all services and departments had been asked to review their business continuity processes in case any IT system had to be taken out of use.

3. 13th January 2022

3.1 Winter Staffing Assurance Framework

The Director of Nursing, Midwifery and Governance presented the completed Trust self-assessment winter preparedness staff assurance framework that had been issued by NHSE/I. This covered five domains: planning, decision making and escalation, staff training, wellbeing and indemnity and regulation. The framework provided assurance that the Trust had processes in place to manage, monitor and mitigate the impact of extreme operational pressures and staff shortages, whilst keeping patients as safe as possible. The Trust self-assessment would be reported at the January Trust Board meeting.

3.2 Clinical Director of Research, Development, and Innovation Business Case

The Medical Director presented the business case to create a new post to lead the Trust in optimising the opportunities to participate in clinical research and support innovation in clinical practice. The new position would be 2.5 PAs per week and appointed for an initial fixed term period so the impact could be evaluated. The business case was approved.

3.3 Endoscopy Staff Bank

The Deputy CEO/Director of HR introduced a proposal to establish an endoscopy staff bank on behalf of the Cheshire and Merseyside Endoscopy Network to help support the elective recovery programme. The Trust had been approached because of its existing experience in running the collaborative bank for junior doctors. A common rate card would have to be agreed by all the providers for the bank to be effective. A trial of the endoscopy bank for 12 months was proposed to test the effectiveness and if the model was viable. The costs would be supported by the Cheshire and Merseyside Cancer Alliance. It was agreed that the Trust was best placed to facilitate and host this development and the proposal was approved.

3.4 Vaccination as a condition of deployment (VCOD)

The Deputy CEO/Director of HR presented the Trust plans to implement VCOD and deliver the phase 1 guidance that had been published in December. Staff ESR records and the National Immunisation System (NIMs) were being used to confirm the current vaccination status of every member of staff and those that were not yet doubly vaccinated had been contacted. The phase 2 guidance for employers had not yet been published but would set out the process for those staff that had not had a first vaccine and were not exempt after 3rd February. The Trust stance remained that it did not want to lose any staff because of VCOD but it would have to comply with the legal requirements that had now been approved by parliament. It was agreed there needed to be weekly updates on VCOD at the Executive Committee.

3.5 Risk Management Council (RMC) Assurance Report and Corporate Risk Register (CRR)

The RMC had not met in January due to operational pressures, but the Trust wide risk register report had been produced. There was a total of 772 risks reported across the Trust of which 29 had been escalated to the CRR. This included five new high/extreme risks reported in December; all of which related to the operational pressures and challenges for patient flow being experienced by the organisation.

3.6 Integrated Performance Report (IPR)

The Director of Finance and Information presented the December IPR and members agreed changes to the narrative to provide more information about the cancer 2-week wait performance. It was noted that 9 of the reported C-Diff cases were subject to appeal and there were more RCAs outstanding which could result in further appeals.

3.7 Southport and Ormskirk Hospital NHS Trust (S&O)

The Deputy CEO/Director of HR reported on the S&O Trust Board meeting and planning the S&O corporate objectives for 2022/23.

3.8 COVID Issues

The Director of Integration reported on the COVID incidence rates and hospital admissions across Cheshire and Merseyside. Case rates had started to fall from the peak on 4th January, but hospitalisations continued to increase although admissions to ICU had remained relatively low compared to the previous January.

The Director of Nursing, Midwifery and Governance reported that a review is taking place of all hospital deaths at the Trust which include COVID on the death certificate and this will be reported once completed to identify learning.

The Director of Operations and Performance reported that the national guidance had changed and asymptomatic staff testing positive with a LFD test no longer needed a confirmatory PCR test, this reflected the current prevalence of the Omicron strain in the population. There were also changes to the isolation period for inpatients awaiting discharge, which would help with patient flow.

Monoclonal antibody treatment had been implemented for vulnerable patients who met the eligibility criteria if they contracted COVID.

The Director of Nursing, Midwifery and Governance reported there had been 28 definite and 14 probable nosocomial infections reported in the previous 7 days.

3.9 Log4j Cyber Threat

The Director of Informatics presented a further update on 'Operation Sawmill' and provided assurance that all required remedial actions had been taken to protect the hospital systems, with further actions planned where potential vulnerabilities had been identified. The committee discussed the need for a system approach to cyber threat protection as services became more interconnected as a result of integration.

3.10 Strategic Issues

The Chief Executive reported on several external meetings and the national focus on increasing discharges from hospital to create capacity, particularly focusing on the pathway zero patients.

A £50m fund to develop community diagnostic hubs had been announced with bids to be submitted by 31st March 2022. The Hospital Cell will be reviewing and prioritising the bids from Cheshire and Merseyside.

4. 20th January 2022

4.1 Board Assurance Framework (BAF)

The Director of Corporate Services presented the draft BAF ahead of reporting to the Trust Board. The Executive Committee approved the proposed changes for recommendation to the Board.

4.2 VCOD

The Deputy CEO/Director of HR summarised the phase 2 VCOD guidance with had been issued on 14th January. There was also a requirement for Trusts to submit a weekly situation report detailing the number of staff that remained unvaccinated (1st dose) in the run up to 3rd February deadline.

The committee reviewed all staff groups that had been assessed as being "in scope" of the regulations based on the 9 categories agreed by the Cheshire and Merseyside HR Managers.

There were circa 100 staff across the Trust that had declined the vaccine and many more where vaccination status needed to be confirmed or who remained undecided.

Managers were having one to one conversations with staff in these groups with the aim of ensuring they understood the consequences, and that the Trust did not wish to lose any member of staff and would provide all support necessary for staff to be vaccinated.

Managers had received detailed guidance and FAQs along with materials to sign post staff to advice and support if they needed it. Additional vaccine clinics at Nightingale House had been arranged to make it as easy as possible for staff to be vaccinated.

A parallel process was also being undertaken for the Lead Employer doctors, working with their host Trusts.

The formal process leading to dismissal would commence on 4th February for any staff member who remained unvaccinated or were not otherwise exempt or out of scope.

NHSE had provided detailed guidance on how this process should be undertaken to ensure it was fair and legal.

The action plan and changes in the overall numbers would continue to be monitored daily.

5. 27th January 2022

5.1 Capital Plan 2022 - 2025

The Director of Finance and Information presented an overview of the capital allocations to the Cheshire and Merseyside ICS for the next three years and how it was proposed these should be distributed between the provider Trusts. Some capital pressures were noted including the backlog maintenance at S&O. It was also noted that additional capital may be available nationally to support elective recovery, improved diagnostics, and decarbonisation of the NHS estate which the Trust would be able to bid for.

5.2 VCOD

The Deputy CEO/Director of HR presented the latest Trust position and progress with the action plan. There continued to be staff who reported they had been vaccinated but were not recorded on NIMs. For these staff the proof of vaccination was being collected to update the records, but in some cases, e.g., for the International Nurses and other staff who had been vaccinated abroad this was not an easy process and additional support was being offered by Health Work and Wellbeing.

It was agreed a further personal letter should be sent to staff that had declined the vaccine, still had to produce their evidence or had still to make up their mind. This would be sent from the Director of Nursing and Medical Director and would be another attempt to offer support and advice to encourage staff to be vaccinated before the deadline of 3rd February. This would be followed up with an individual call from a senior member of the nursing or medical management team to reinforce the message that the Trust did not want to lose any of its current staff.

5.3 Southport and Ormskirk Hospital NHS Trust

The Deputy CEO/Director of HR reported that there were some temporary changes taking place to the senior management structure at S&O and outlined the proposed arrangements for providing cover.

5.3 Safer Staffing Report

The Director of Nursing, Midwifery and Governance introduced two papers which presented the safer staffing figures for October and November. For October, the overall Registered Nurse/Midwife fill rate had been 92.84% and in November it had been 96.5%. The committee acknowledged the hard work that went in to maintaining safe staffing levels and recognised that a deterioration was likely to be seen for December and January as the impact of Omicron was felt by the Trust.

Further work was being undertaken to ensure that areas not routinely covered by the safer staffing methodology e.g., the ED and theatres, were also included in future safer staffing reports. Additionally, work was also being undertaken to assess the impact of cancelling management days to move ward managers and matrons to fill staffing gaps on the wards. For example, appraisals and ward audits would all be affected, and the review would attempt to quantify this.

5.4 COVID Issues

The Director of Integration presented the latest COVID position, reporting that infection rates had reduced in all boroughs across Cheshire and Merseyside. The Trust continued to have circa 100 COVID positive inpatients.

The Director of Nursing, Midwifery and Governance reported that the nosocomial infection (NCI) rate was reducing in line with the community infection rate and in the previous 7 days had been 4.4%. For the year so far (April 2021 – 27th January 2022) the overall NCI rate was 8.4%.

The Director of Operations and Performance reported that guidance had been received which confirmed that COVID restrictions and IPC precautions were to remain in place for health care settings, even though these restrictions had been eased by the government for the general public.

5.5 Log4j Cyber Alert

The Director of Informatics reported that although still a threat, all planned mitigating actions had now been completed. It was important that all staff remained vigilant to the potential threat and reported any suspicious emails.

5.6 Strategic Issues

The Chief Executive briefed the committee on the outcome of a recent meeting with the local MP, ICS and NHSE/I relating to the strategic plans for S&O. The importance of the Quarterly Joint Meeting as part of the Agreement for Long Term Collaboration was acknowledged but a new date for the first meeting had not yet been offered by NHSE/I.

ENDS

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(22)008
Reporting from: Quality Committee
Date of Committee Meeting: 15th February 2022
Reporting to: Trust Board

Attendance:
Rani Thind, Non-Executive Director (Chair)
Gill Brown, Non-Executive Director
Sue Redfern, Director of Nursing, Midwifery & Governance
Rob Cooper, Director of Operations
Nikhil Khashu, Director of Finance
Debbie Stanway, Head of Nursing & Quality, Medical Care Group
Tracey Greenwood, Head of Nursing & Quality, Surgical Care Group

In Attendance:
Teresa Keyes, Deputy Director of Nursing and Quality
Rajesh Karimbath, Assistant Director of Patient Safety
Anne Rosbotham-Williams, Deputy Director of Governance
Sue Orchard, Head of Midwifery
Lynn Ashurst, Matron, Surgical Care Group - observing
Lisa Sams, Matron, Quality and Risk – observing
Louise Ford, Quality Nurse Specialist – observing
Susan Norbury, Assistant Director of Safeguarding - for Safeguarding report

Matters Discussed:

The Committee discussed Maternity Services in detail and noted the work being undertaken within Maternity Services and across Cheshire and Merseyside to ensure safe care is provided when there is increased demand and high acuity and/or staffing challenges, utilising mutual aid, and agreed escalation processes to implement a divert as required. All diverts are reported on StEIS and fully reviewed. It was reported that no harms had occurred following diverts granted in the latest reported period.

The Birth Rate Plus© report is due shortly and will outline if there are any required changes to the current establishment to ensure safe staffing levels, including triage area. Future maternity quarterly reports will include details about activity and incidents from other Maternity Units across Cheshire and Merseyside.

The Chair provided an update from the Medical Director on the work being undertaken in the Emergency Department (ED) and with the ambulance service to increase the number of stroke patients thrombolised within 1 hour, noting 100% of patients eligible for thrombolysis received this to date.

Assurance was provided that a root cause analysis (RCA) is completed for all needle-stick incidents with the outcomes to be included in future Infection Prevention reports to the Committee.

Integrated Performance Report highlighted:

- No new Never Events or MRSA bacteraemia
- 4 hospital onset C difficile, with 47 cases reported year to date; 20 have been successfully appealed with 13 RCAs in progress
- Registered nurse/midwife safer staffing fill rate for combined day and night was 93% in December and 92.3% year-to-date
- 0 falls resulting in severe harm or above in December, with 15 year-to-date and 1 category 3 pressure ulcer reported on StEIS
- HSMR was 97.7 year-to-date (April – September)
- 62 day and 31-day targets were achieved in December, although the 2-week target was not achieved due to the increase in referrals. However, the 75% target for the planned 28-day faster diagnosis standard was met. Assurance was provided that where the 2-week target is not met that patients are seen in a timely manner, unless the patient cancels
- Continued challenges in meeting emergency care access targets, however 98% of patients were seen and treated within 4 hours at the Urgent Treatment Centre
- Average daily number of super stranded patients (patients with length of stay over 21 days) increased to 132 in January from 109 in December 2021, with a significant number of delayed discharges which is negatively impacting on patient flow. This has been escalated to system partners and NHS England and Improvement and it was agreed that further discussion with Executive and Board is required
- 18-week referral to treatment and 6-week diagnostic targets were not achieved
- Slight increase in District Nursing referrals, but decrease in Community Matron caseloads

Update on Trust objectives aligned to the Quality Committee
Report provided on progress in delivering 2021-22 quality objectives, noting that a number were being rolled over to 2022-23, including reducing falls and maintaining safety within the ED. The inpatient survey results demonstrated that improvements had been made in increasing levels of satisfaction with information provided to patients.

Patient Experience Council report
The report summarised December 2021 meeting which included reports from the Patient Experience Team, Healthwatch Knowsley, Complaints, Corporate Matron, Dementia and Delirium Steering Group, each Care Group, Estates and Facilities and Safeguarding Team. The following were highlighted in particular:

- Decreased response rates for first stage complaints, with improvement actions in place;
- Relaunch of revised Quality Care Assurance Tool (QCAT) planned for February;
- Patient Participation Group relaunched in January 2022;
- Work to be undertaken to ensure patients on waiting lists are kept up-to-date.

Patient Safety Council report
The report summarised December 2021 meeting, including reports related to incidents, falls, safety alerts, safeguarding, claims and inquests, medical devices, VTE assessments, medicines reconciliation and each Care Group. The following were highlighted:

- Actions taken as a result of StEIS reported incidents;
- 1.89% decrease in quarter 3 in the total number of patient falls per 1000 bed days, compared to previous quarter;
- One new safety alert received, relating to preventing transfusion delays, which is being actioned;
- Work is to be undertaken prior to the implementation of new NICE guidance for prevention of venous thromboembolism, including education and training with medical staff;
- Pilot being undertaken to prepare for new serious incident framework, with establishment of weekly serious incident meeting to examine 72-hour reviews from previous week and ensure early dissemination/implementation of required actions;

- Work ongoing to ensure VTE risk assessments are documented.

Safeguarding Quarter 3 report
The report highlighted the ongoing work of the Safeguarding Team, providing assurance that the number of Deprivation of Liberty Safeguard (DoLS) applications has continued to increase and that patients with a learning disability or autism are well supported by the specialist nurse.

The Team continue to provide input into several internal and external meetings, ensuring that safeguarding is embedded across the Trust, including mortality reviews. Work is ongoing to prepare for the introduction of Liberty Protection Safeguards, however, there is no confirmed implementation date nor release of the Code of Practice for consultation.

Continued focus is being given to improving training compliance with both safeguarding and PREVENT.

Incidents, Never Events and Serious Incidents Thematic Review Quarter 3
The report noted there were no new never events, with the top themes for incidents remaining consistent with previous reports. Pressure ulcers and falls remain the highest categories, which include pressure ulcers acquired outside of the Trust. The Trust has a lower than national average for moderate harm and above incidents. The report outlined the lessons learned and actions taken/required for the StEIS reported incidents.

Feedback from Perfect Week
The presentation outlined the aims of the two initiatives, with the initial week in December focussing on discharge and the second period in December/January looking at internal flow. The initiatives saw a reduction in the number of patients waiting in ED for longer than 12 hours, increased number of patients using the Transfer Lounge and being discharged overall. Directly streaming patients to speciality areas, including frailty, released time in ED. Key elements will be continued to ensure sustained improvement, including individual managers aligned to wards as buddies and the Site Manager Support Officer role supporting discharge tracking and flow.

Infection Prevention and Control Board Assurance Framework (IPCBAF)
The report noted that the IPCBAF has been updated with a self-assessment completed, with full compliance with 122/126 indicators and partial compliance with 4. Actions are in place to address the 4 indicators, including review of cleaning frequencies due to changes in the functional risk categories, establishment of Ventilation Safety Group and reporting of fit testing records to the Board via the quarterly Infection Prevention report.

Safer Staffing November 2021
The overall registered nurse/midwife fill rate for November was 96.5% and 109.84% for HCAs, increases of 3.66% and 2.94% respectively compared to October. There was a reduction in the number of wards with less than 90% and 85% nurse/midwife fill rates compared to the previous month.

The report reviewed any incidents that had occurred on the wards with less than 85% fill rate, noting staffing levels compared to funded establishment and where additional staff were requested to provide supplementary care, including 1-1 care for patients at risk of falling.

Update following Safety Climate Questionnaire in Theatre
The report highlighted the results of the Safety Culture Survey undertaken in 2021, noting there was a 39% response rate, with generally positive findings relating to good communication, team working and organisational learning, as well as quality of care delivered. Actions are being taken to further enhance engagement between managers and clinicians,

with monthly focus groups. The appointment of two new Assistant Directors of Clinical Safety will further support the drive for clinically-led improvement.

Clinical Effectiveness Council report
The report provided a summary of the meeting and the presentations/reports received relating to Cardiology, Neurophysiology, Medical Emergency Team, Integrated Performance Report, NICE, mortality, national emergency laparotomy audit (NELA) and Pharmacy Aseptic Unit. The following were highlighted:

- Approval of standard operating procedures and policies;
- Review of metric to report Caesarean Sections within Maternity;
- 98% compliance with NICE guidance in 2020-21, with work ongoing to confirm compliance with 2021-22 by year-end.

Assurance Provided:

- Fully compliant with 97% of Infection Prevention Board Assurance Framework indicators with actions identified for the 4 areas of partial compliance, following self-assessment against updated framework
- Fully compliant with safety alerts (CAS) at quarter 3
- 96.7% patients at risk of venous thromboembolism were prescribed appropriate prophylaxis in quarters 2 and 3
- Sustained increase in DoLS applications

Decisions Taken: No formal approvals were required.

Risks identified and action taken: The Committee requested the following actions be taken:

- Continued focus on maintaining safety within Maternity Services;
- Committee requested a detailed review of a sample of 62 week wait breaches to be reviewed.

Matters for escalation: Ongoing challenges within meeting emergency care access targets.

Recommendation(s): That the Board note the report, the assurances provided, and the actions being taken to address areas of concern.

Committee Chair: Rani Thind, Non-Executive Director

Date of Meeting: 23rd February 2022

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(22)009
Title of paper: Committee Report – Finance & Performance
Purpose: To report to the Trust Board on the Finance & Performance Committee, 17th Feb

Summary

Meeting attended by:

J Kozer – NED & Chair
I Clayton – NED
P Growney – NED
A Sharples – Board Advisor
R Cooper – Director of Operations & Performance
A Bassi – Divisional Medical Director
J McCabe - Divisional Medical Director
G Lawrence – Deputy Director of Finance & Information

As a result of quoracy all decision would need to be deferred to the Board.

Agenda Items

For Assurance

A) Integrated Performance Report

- 62-day performance was slightly above the 85% target in December, at 85.02%.
- Target 31-day performance was met in December, at 98.2% against a target of 96.0%.
- Target 2 week wait cancer performance was not achieved in December, at 78.5% delivery against a target of 93.0%.
- Urgent care attendances remain high, with Accident & Emergency Type 1 performance at 55.7% in January and 57.1% year to date. All type mapped STHK Trust footprint performance was 78.1% in January and is 77.9% year to date. The Trust saw average daily attendances of 298, which is a decrease compared to November at 300. Total attendances for January 2022 were 9,248.
- The ambulance turnaround time target was not achieved in January, at 53 minutes on average. The Trust was the second busiest in C&M and fourth busiest across the North West.
- In January, overall sickness had increased to 9.6%, from 8.5% in December.

B) Finance Report Month 10

- At Month 10, the Trust is reporting a breakeven position year to date and a breakeven forecast outturn.
- The £5m forecast deficit reported at Month 9 has been mitigated through the confirmed ERF income allocation for H2 (£1.1m) and additional system support.
- The 21/22 HCP CIP target of £10m has been met. We continue to work towards the internal Trust CIP target of £15m (3%).
- The Trust's full capital allocation is expected to be utilised by the end of the 21/22 financial year.
- At Month 10, the Trust has a cash balance of £66m and is achieving

C) CIP Programme Update (CIP)

- The committee received the report on the Trust's CIP programme.
- The committee was assured of progress and that the £10m required CIP will be met in 21/22 and recurrently.
- The committee noted that schemes are now being identified for next financial year.

D) Benchmarking/GIRFT Update Month 10

- The committee noted the report, and the Trust was progressing through the benchmarks and the results were being utilised at team level to support understanding and efficiency/productivity.

For Approval

E) 2022/23 Draft Financial Plan

- The committee reviewed the high-level planning assumptions.
- The committee noted that Elective Recovery Guidance and system income allocations have yet to be released/confirmed.
- The committee noted that the draft activity plans exceed the requirement set out in the planning guidance, but these plans are underpinned by changes in Infection, Prevention and Control.
- The committee reviewed the proposed draft expenditure that included:
  - A net increase of costs of £10m (1.9%)
  - Cost Improvement Programme savings of £10.4m (2%)
  - Inflation pressures relating to PFI because of RPI increases.

For Information

N/A

Risks noted/items to be raised at Board

- Risks associated with 22/23 draft financial plan and how income may flow within the newly formed ICS
- The challenging timeframes around the plan submission and that delegated authority for the draft plan should be passed to the Executive Committee.

Corporate objectives met or risks addressed: Finance and Performance duties
Financial implications: None as a direct consequence of this paper
Stakeholders: Trust Board Members
Recommendation(s): Members are asked to note the contents of the report
Presenting officer: Jeff Kozer, Non-Executive Director
Date of meeting: 17th February 2022

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(22)010
Reporting from: Audit Committee
Date of Committee/Council Meeting: 9 February 2022
Reporting to: Trust Board
Attendance: Ian Clayton (Chair), Jeff Kozer, Gill Brown.
Matters discussed • **Losses and Special Payments** – report was discussed and accepted. • **Year-end Update** – the Finance Team outlined progress made towards financial close and headlines from the central timetable, with accounts approval in June 2022.
Assurance provided External audit • **Audit Progress Report and Sector Update –** Grant Thornton UK LLP (GT) verbally updated the Committee on issues relating to the sector and to the 2021/22 audit. Internal audit • **Progress Report** – MIAA outlined delivery to date of the 2021/22 internal audit plan, including one finalised report – *Mandatory Training* [moderate assurance]. Anti-fraud • **Anti-fraud Progress Report** – the Trust's Anti-Fraud Specialist presented an update, which was discussed and accepted. There are no substantial concerns around planned delivery in 2021-22. Standing items • **Audit Log –** the Trust's internal summary of progress in implementing MIAA recommendations was discussed and accepted. • **Aged Debt –** the Trust's M9 'over 90 day' debt balance is £7.4m, which is significantly lower than in previous years. Recent progress with the individually largest invoices was noted. • **Tender and Quotation Waivers** – the Head of Procurement's assurance paper was noted.
Decisions taken: The *Anti-Fraud, Bribery and Corruption Policy* was accepted for recommendation to the Board.
Risks identified and action taken: None.
Matters for escalation: None.
Recommendation: The *Anti-Fraud, Bribery and Corruption Policy* is recommended to the Board for approval.
Committee Chair: Ian Clayton, Non-Executive Director
Date of Meeting: 23rd February 2022

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(22)011
Title of paper: Committee Report – Charitable Funds Committee
Purpose: To brief the Board on the main issues discussed and decisions made at the Committee meeting on 17th February 2022
Summary: **Meeting attended by:** P Growney – NED & Chair L Knight – NED G Lawrence – Deputy Director of Finance K Hughes – Assistant Director of Communications D Pye – Financial Accountant C Simmo – Charity Fundraiser (Apologies Received from N Khashu) **Agenda Items:** 1) Investment Portfolio Update – The committee reviewed the funds within the portfolio which had appreciated during the year. 2) Income & Expenditure Position – The committee reviewed the position and noted and were thankful for the donations that had been received since the last meeting. 3) Approval of Expenditure – The committee approved the requests submitted 4) Fundraising Update – The committee had a long discussion over the future fundraising opportunities. Options are to be drawn up over the coming months on how the charity can develop over the coming years. There were no issues to escalate to the Board.
Corporate objective met or risk addressed: Contributes to the Trust's objectives regarding Finance, Performance, Efficiency and Productivity.
Financial implications: None directly from this report.
Stakeholders: The Trust, its staff, and all stakeholders.
Recommendation(s): The Board is asked to note the contents of the report.
Presenting officer: Paul Growney, Chair, Charitable Funds Committee
Date of meeting: 17th February 2022

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(22)012
Title of paper: Freedom to Speak Up Annual Self-Assessment 2022
Purpose: Board members are asked to review and approve the annual Freedom to Speak Up Self-Assessment for 2022
Summary: The Trust's 'Freedom to Speak Up' and 'Raise a Concern' vision is to promote an open and transparent culture across the organisation to ensure that all members of staff feel safe, supported, and confident to speak out. The vision and supporting strategy are aligned to the Trust's objective of delivering 5 Star patient care. New requirements from NHSE/I stipulate that Trust Boards must have oversight of their 'Freedom to Speak Up' arrangements and undertake a comprehensive annual self-assessment. The Trust consistently scores high on the staff survey, on ability of staff members to raise concerns, with the latest published in 2021. The Trust scored highest in the North West region with 74.9% positive score on staff perception of feeling safe to speak up about anything that concerns them in the organisation, and higher than national mean positive scores of 65.6%. Trust recorded a mean Freedom to Speak up Index score of 82.3% for 2020-21, an increase from 81.9% for 2019, and 81% in 2018. The Trust score is significantly higher than the national mean score for all acute Trust of 79%. This provides assurance of Trust commitment to creating an open and honest culture.
Corporate objectives met or risks addressed: Care, safety, pathways, communication, system
Financial implications: None directly from this report
Stakeholders: Patients, the public, staff, regulators and commissioners
Recommendation(s): That the Board review and approve the self-assessment
Presenting officer: Anne-Marie Stretch, Director of Human Resources & Executive Lead for Freedom to Speak Up
Date of meeting: 23rd February 2022

Freedom to Speak Up review tool for NHS trusts and foundation trusts

2022

NHS England and NHS Improvement

Summary of the expectation	Evidence to support a 'full' rating		Principal actions needed in relation to a 'not' or 'partial' rating
	Compliance		
Individual executive and non-executive directors can evidence that they behave in a way that encourages workers to speak up. Evidence should demonstrate that they: • understand the impact their behaviour can have on a trust's culture • know what behaviours encourage and inhibit workers from speaking up • test their beliefs about their behaviours using a wide range of feedback • reflect on the feedback and make changes as necessary • constructively and compassionately challenge each other when appropriate behaviour is not displayed	Fully	• Chairman - Non-executive and Chief Executive - Executive are nominated FTSU Guardians • Trust value 2021-22, emphasises the commitment to attract and develop, caring, highly skilled staff. • Trust Objective 2021-22: 'developing organisational culture and supporting workforce', encourages staff to speak up • Engagement events in place to encourage staff to showcase achievements and offers opportunities for staff to raise concerns to senior leaders directly. • High visibility of Board members through service visits and communication channels with Executive and Non-Executive team members. • Formal and informal discussions with all staff groups and receive feedback. • Regular communication to appreciate work of staff members – Thank you emails, Chief Executive Communications, Team Brief and Board meeting reports highlighting appreciation. • Positive staff survey results published in 2021. Changes made to improve areas based on feedback from survey. • CQC inspection published 2019 - Outstanding rating • Improvement in Speak up index for 2020 compared with 2018 and 2019 (published 2021) • Lead by example with ACE behavioural standards.	
The board can evidence their commitment to creating an open and honest culture by demonstrating: • there are a named executive and non-executive leads responsible for speaking up • speaking up and other cultural issues are included in the board development programme • they welcome workers to speak about their experiences in person at board meetings • the trust has a sustained and ongoing focus on the reduction of bullying, harassment, and incivility • there is a plan to monitor possible detriment to those who have spoken up and a robust process to review claims of detriment if they are made • the trust continually invests in leadership development • the trust regularly evaluates how effective its FTSU Guardian and champion model is • the trust invests in a sustained, creative, and engaging communication strategy to tell positive stories about speaking up.	Fully	• Chairman and Chief Executive are nominated FTSU Guardians. • Chief Executive (FTSU) and Deputy Chief Executive (Executive lead for FTSU) review of FTSU concerns and actions • Strong culture and promoting openness and honesty at Board sessions. • FTSU report presented to Quality Committee every 6 months. • Continuous evaluation of FTSU model and raising concerns options. • Continued communication with staff members of methods for 'Raising Concerns' • Development of Staff App with FTSU/ Raising concerns information • Development programme for various staff groups in place. • FTSU and HR collaboration in reviewing any cases with detriment / bullying allegations. • Communication to support changes made because of speaking up. • Trust achieved high assurance on MIAA audit conducted in 2020 reviewing the raising concerns process and actions taken in addressing issues/ sharing lessons learnt.	

Summary of the expectation	Evidence to support a 'full' rating		Principal actions needed in relation to a 'not' or 'partial' rating
	Compliance		
The board can evidence it has a comprehensive and up-to-date strategy to improve its FTSU culture. Evidence should demonstrate: • as a minimum – the draft strategy was shared with key stakeholders • the strategy has been discussed and agreed by the board • the strategy is linked to or embedded within other relevant strategies • the board is regularly updated by the executive lead on the progress against the strategy as a whole • the executive lead oversees the regular evaluation of what the strategy has achieved using a range of qualitative and quantitative measures.	**Fully**	• Clear and consistent Trust vision, encompassing speaking up and embedded throughout the Trust. • Speaking up integrated into Trust values and objectives, supported in delivery by the nominated executive lead. • Clinical and Quality Strategy links speaking up and being open process in ensuing patient and staff safety. • Board members updated with progress made regarding FTSU through scheduled regular reports. • Provision of several channels for staff to raise concerns including internal and external routes, this includes Guardians, speak in confidence system, Ask Ann system. • Further improvement in 2020 Freedom to Speak up Index (published in 2021) from 2019. • ACE behavioural standards existent and well-advertised.	
The executive team can evidence they actively support their FTSU Guardian. Evidence should demonstrate: • they have carefully evaluated whether their Guardian/champions have enough ringfenced time to carry out all aspects of their role effectively • the Guardian has been given time and resource to complete training and development • there is support available to enable the Guardian to reflect on the emotional aspects of their role • there are regular meetings between the Guardian and key executives as well as the non-executive lead. • individual executives have enabled the Guardian to escalate patient safety matters and to ensure that speaking up cases are progressed in a timely manner • they have enabled the Guardian to have access to anonymised patient safety and employee relations data for triangulation purposes • the Guardian is enabled to develop external relationships and attend National Guardian related events	**Fully**	• The Guardians are supported by the Executive Lead for FTSU to complete any necessary training required for the role. • The Guardians are supported with time for FTSU activities, in negotiation with line managers. . • Regular meetings and updates between Guardians and key executives and non-executive lead. • The Guardians are active participants of the North West FTSU Group and the National FTSU Group. • Guardians have developed external relationships with local networks. • Internal collaboration with HR, Patient Safety Teams and Guardian for Safe Working.	
Evidence that you have a speaking up policy that reflects the minimum standards set out by NHS Improvement. Evidence should demonstrate: • that the policy is up to date and has been reviewed at least every two years • reviews have been informed by feedback from workers who have spoken up, audits, quality assurance findings and gap analysis against recommendations from the National Guardian.	**Fully**	• Raising Concerns & Speaking Out Safely – Policy and Procedure in place • Quarterly update on speaking up/ speak in confidence usage provided to Trust workforce Council. • Trust achieved high assurance on MIAA audit conducted in 2020 reviewing the raising concerns process and actions taken in addressing issues/ sharing lessons learnt.	

Summary of the expectation	Evidence to support a 'full' rating		Principal actions needed in relation to a 'not' or 'partial' rating
	Compliance		
Evidence that you receive assurance to demonstrate that the speaking up culture is healthy and effective. Evidence should demonstrate: • you receive a variety of assurance • assurance in relation to FTSU is appropriately triangulated with assurance in relation to patient experience/safety and worker experience. • you map and assess your assurance to ensure there are no gaps and you flex the amount of assurance you require to suit your current circumstances • you have gathered further assurance during times of change or when there has been a negative outcome of an investigation or inspection • you evaluate gaps in assurance and manage any risks identified, adding them to the trust's risk register where appropriate.	**Fully**	• Assurance of consistent reporting of concerns using various methods • Contact with individuals, teams, HR and relevant to ensure that changes made has a positive impact. • Risks identified are reported to risk register appropriately. • Feedback from individuals on their experience and support from FTSU/ Raising concerns procedures. • Feedback from FTSU events and training on the processes used by the Trust.	
The board can evidence the Guardian attends board meetings, at least every six months, and presents a comprehensive report.	**Partial**	• The Guardian presents paper to the Quality Committee every 6 months, with Executive and Non-Executive members represented. The Trust Board receives update from Quality Committee.	• The FTSU report is presented to Quality Committee - a sub-committee of the board, with Executive and Non-Executive members represented. Effectiveness to be reviewed annually.
The board can evidence the FTSU Guardian role has been implemented using a fair recruitment process in accordance with the example job description (JD) and other guidance published by the National Guardian.	**Partial**	• Current Guardians appointed with Freedom to speak up role integrated to existing substantive clinical/ non-clinical role. • Functional role and responsibilities matched against national job description and guidance.	• Use of NGO advised recruitment process for any future FTSU champion or guardian role recruitment
The board can evidence they receive gap analysis in relation to guidance and reports from the National Guardian.	**Fully**	• Case review findings discussed at the guardians meeting and Executive lead meetings	
The trust can evidence how it has been open and transparent in relation to concerns raised by its workers. Evidence should demonstrate: • discussion with relevant oversight organisation • discussion within relevant peer networks • content in the trust's annual report • content on the trust's website • discussion at the public board • welcoming engagement with the National Guardian and her staff	**Fully**	• Freedom to speak up and Raising Concerns reports shared with Trust Quality committee and Workforce Council. • Trust achieved high assurance on MIAA audit conducted in 2020 reviewing the raising concerns process. • Consistent high scores of NHS Staff surveys on ability to raise concerns. • Information and contact details of Guardians on the Trust intranet and Staff App • Active membership and participation in the North West FTSU network. • Freedom to speak up information as content in annual quality accounts	
The chair, chief executive, executive lead for FTSU, Non-executive lead for FTSU, HR/OD director, medical director and director of nursing should evidence that they have considered how they meet the various responsibilities associated with their role as part of their appraisal.	**Fully**	• As members of a unitary board, the Executive and Non-Executive members are committed to the Trust values and objectives, supporting speak up • Appraisals to include how the Executive and Non-Executive members have supported speaking up.	

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(22)013

Title of paper: Infection Prevention and Control Board Assurance Framework

Purpose: The aim of this report is to provide the Trust Board with an overview of the Trust review of the revised infection prevention and control board assurance framework

Summary:

As the evidence related to COVID-19 has developed, PHE and related guidance on the required infection prevention and control measures has been published, updated, and refined to reflect the learning. NHSE have further revised the IPC board assurance framework (BAF), to help providers assess themselves against the guidance. This framework is a source of internal assurance that quality standards are being maintained. It will also help Trusts to identify any areas of risk and show the corrective actions taken in response.

The framework is structured around the existing 10 criteria set out in the Code of Practice on the prevention and control of infection which links directly to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Robust risk assessment processes are central to protecting the health, safety and welfare of patients, service users and staff under both pieces of legislation. Where it is not possible to eliminate risk, organisations must assess and mitigate risk and provide safe systems of work. Local risk assessments should be based on the measures as prioritised in the hierarchy of 4 controls.

In the context of COVID-19, there is an inherent level of risk for NHS staff who are treating and caring for patients and service users and for the patients and service users themselves in a healthcare setting. All organisations must therefore ensure that risks are identified, managed and mitigated effectively.

The revised IPC BAF has been reviewed and a self-assessment undertaken by the DIPC, Director/ Deputy Director of Estates and facilities, Infection control consultant/ IPC Lead Nurse and Deputy Director of Governance.

The framework has 10 criteria and 126 Indicators, the self-assessment has indicated that the trust is fully compliant with 122/126 and partially compliant with 4 indicators (appendix1)

The indicators of partial compliance relate to:

- **Criteria 2: Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections**

Indicator 22.4: ‘Frequently touched’ surfaces e.g., door/toilet handles, patient call bells, over bed tables and bed rails are cleaned twice daily. This is in place on escalation area but not all wards.

Indicator 22.5: where there may be higher environmental contamination rates, including toilets/ commodes particularly if patients have diarrhoea. Enhanced cleaning is in place for higher risk areas.

Action

- Additional cleaning has been introduced in escalation areas
- As part of the national standards of cleanliness review areas that require changes in cleaning frequencies due to the changes in the functional risk category are being identified, risk assessed with costs identified for approval
- Indicator 26: ventilation systems, particularly in patient care areas (natural or mechanical) meet national recommendations for minimum air changes refer to country specific guidance.
- The Deputy Director of Estates is obtaining additional assurance relating to the ventilation system at he one of in-patient bedded facilities and further monitoring of ventilation in progress inside rooms
- Action Ventilation Safety Group to be established. Remit of this group to include assessment of Trust premises against the updated ventilation HTM 04-01 (2021).

- **Criterion 10: The Trust has a system in place to manage the occupational health needs and obligations of staff in relation to infection**

Indicator 122: Boards have a system in place that demonstrates how, regarding fit testing, the organisation maintains staff safety and provides safe care across all care settings. This system should include a centrally held record of results which is regularly reviewed by the board. The Trust has record of compliance in place however is not regularly reported to Board.

Action

- This will be included into the quarterly IPC report.

The actions will be monitored via the Hospital Infection Group (HIPG) to ensure compliance is achieved.

Corporate objectives met or risks addressed: Contributes towards the achievement of Patient Safety

Financial implications: Financial Implications to be determined when national standards of cleanliness are implemented.

Stakeholders: Trust Board members, Trust staff, patients, commissioners, regulators.

Recommendation(s): It is recommended that the Committee note this report and associated data.

Presenting officer: Nicola Bunce, Director of Corporates Services on behalf of Sue Redfern, Director of Nursing, Midwifery and Governance / DIPC

Date of meeting: 15th February 2022

Appendix 1 - Infection prevention and control board assurance framework

Key Lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	Lead
1. Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks their environment and other users may pose to them					
Systems and processes are in place to ensure that:					
1.	A respiratory season/winter plan is in place:	A system wide winter plan has been agreed by AEB to ensure trusts remain responsive to system IPC/ED Lead requirements	Compliant	N/A	DIPC
1.1.	• that includes point of care testing (POCT) methods for seasonal respiratory viruses to support patient triage/placement and safe management according to local needs, prevalence, and care services	Not required as lab on site with rapid results in 90 mins	Compliant	N/A	Infection Control Consultant
1.2.	• to enable appropriate segregation of cases depending on the pathogen	Processes to support appropriate isolation of patients ensuring appropriate segregation of cases are embedded where required. IPC/ED Lead isolation and specific policies for alert organisms e.g., MRSA, CDiff and CPE	Compliant in normal circumstances		DIPC Infection Control Consultant
1.3.	• plan for and manage increasing case numbers where they occur	Use of cohort wards/patient testing	Compliant		COO/DIPC
1.4.	• a multidisciplinary team approach is adopted with hospital leadership, estates & facilities, IPC/ED Lead teams and clinical staff to assess and plan for creation of adequate isolation rooms/units as part of the Trust's winter plan	In place year-round. During periods of increased activity rapid escalation to a multidisciplinary team including estates, facilities and IPC/ED Lead teams have been established. This approach ensures adequate isolation facilities can be rapidly mobilised to support winter plans, ensuring responsiveness to assure safety.	Compliant		DIPC Infection Control Consultant
2.	Health and care settings continue to apply COVID-19 secure workplace requirements as far as practicable, and that any workplace risk(s) are mitigated for everyone	COVID-19 secure workplace standards continue to be embedded throughout all areas of the organisation to ensure effective risk mitigation. This includes continued implementation of 2m distancing between desk spaces in office environments, cleaning of equipment between usage and strict adherence to universal wearing of fluid resistant surgical face masks. This is in addition to promoting correct hand hygiene procedures, signs, COVID secure certificates displayed in each area with report, demonstrating compliance.	Compliant		DIPC Director of Estates
3.	Organisational/employer's risk assessments in the context of managing seasonal respiratory infectious agents are:				
3.1.	• based on the measures as prioritised in the hierarchy of controls, including evaluation of the ventilation in the area, operational capacity, and prevalence of infection/new variants of concern in the local area	An embedded process is in place to risk assess changes to estate including respiratory infections, with clear actions highlighted. All employees are subject to individual risk assessments to ensure allocated to appropriate areas.	Compliant		Director of Estates
3.2.	• applied in order and include elimination, substitution, engineering, administration, and PPE/ Respiratory Protective Equipment (RPE).	All Trust risk assessments are based on current national best practice guidance ensuring rapid implementation of control measures to effectively mitigate risk. Risk assessments are based on the hierarchy of controls, ensuring maximum risk	Compliant		Director of Estates Infection Control

Key Lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	Lead
		mitigation. This systematic assessment process is structured as follows: • Elimination • Substitution • Engineering controls • Administrative controls • Personal Protective Equipment. The Trust's IPC/ED Lead team support the development of local risk assessments based on regional and national guidance.			Consultant
3.3.	• Communicated to staff.	Staff risk assessments are part of induction checklist and regularly communicated to managers. HSE risk assessments held by H&S Team and local managers.	Compliant		HWWB/ H&S Ward Manager
4.	Safe systems of working, including managing the risk associated with infectious agents through the completion of risk assessments, have been approved through local governance procedures, e.g., Integrated Care Systems	The risk assessment process is also utilised to support the health and social care system to effectively control and mitigate risk when supporting patient transfers in and out of the Trust. The status of patients communicated on discharge to relevant parties, including community IPC/ED Lead, were appropriate. The patient's infection status is carefully considered in advance of any patient moves. This is incorporated in the transfer and discharge policy.	Compliant		DIPC Ward Manager
5.	If the organisation has adopted practices that differ from those recommended/stated in the national guidance, a risk assessment has been completed and approved through local governance procedures, eg Integrated Care Systems	No practices have currently been adopted that do not follow national guidance.	Compliant		DIPC ED Lead/ Infection Control Consultant/ IPC/ED Lead Nurse
6.	Risk assessments are carried out in all areas by a competent person with the skills, knowledge, and experience to be able to recognise the hazards associated with respiratory infectious agents	All risk assessments are carried out by subject experts in their field as a multidisciplinary approach, and therefore able to provide the advice and guidance, ie H&S/Infection Prevention Teams available for advice as required.	Compliant		H&S Team IPC/ED Lead Nurse
7.	If an unacceptable risk of transmission remains following the risk assessment, the extended use of RPE for patient care in specific situations should be considered.	This situation has not yet occurred, however, in the event of such a situation advice would be sought by the IPC/ED Lead team/Microbiologist who are available 24/7, IPC/ED Lead team from NHSE/I and UK Health Security Agency (PHE).	Compliant		Infection Control Consultant IPC/ED Lead Nurse
8.	Ensure that patients are not transferred unnecessarily between care areas unless, there is a change in their infectious status, clinical need, or availability of services	All patient moves are based on clinical need. During outbreak situations or at times where infections have been identified, then IPC/ED Lead advice is proactively managed.	Compliant		Ward Teams
9.	The Trust Chief Executive, the Medical Director or the Chief Nurse have oversight of daily sitrep in relation to COVID-19, other seasonal respiratory infections, and hospital onset cases	An embedded approval process in place for submitting national daily COVID-19 returns to NHSE/I regarding the collective COVID-19 status of the patients within Trust.	Compliant		Chief Executive/ DIPC MD
10.	There are check and challenge opportunities by the executive/senior leadership teams of IPC/ED Lead practice in both clinical and non-clinical areas	Clinical visits undertaken. IPC/ED Lead report discussed at Quality committee and Board. All staff are encouraged to challenge any non-compliance. Discussed at twice-weekly RCA panels. 'IPC/ED Lead is everyone's business.' Bimonthly Hospital	Compliant		DIPC Infection Control Consultant

Key Lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	Lead
		Infection Prevention Group chaired by DIPC Monthly reports to the Patient Safety Council (PSC). The groups report directly to Quality Committee and Trust Board. Monthly HCAI lessons learnt regarding mandatory reporting is circulated Trust-wide via clinical and nursing leads for care groups and departments. Joint IPC/ED Lead/Estates' visits with domestic contractors are undertaken as part of the monitoring process. Senior nurses' weekly walkabout to wards and departments. Twice weekly MDT IPC/ED Lead panels and weekly patient safety meetings in place. In the event of an outbreak, the Executive Committee and Board are kept updated by the DONM&G/ DIPC//DIPC via regular IPC/ED Lead assurance reports and IPR. In addition, the DIPC and Lead Infection Control Consultant have check and challenge opportunities for IPC/ED Lead throughout the Trust's governance framework, including the twice weekly MDT RCA review meetings and monthly meeting related to IPC/ED Lead, i.e., water safety, decontamination, Estates and Facilities and Matrons/ Ward Manager meetings. These groups report directly to the PSC and Quality committees, which include membership of Non-Executive and Executive directors. Assurance mechanisms are embedded within the Trust's governance structure including monitoring hand hygiene compliance, IPC/ED Lead training and cleaning standards.			
11.	The resources are in place to implement and measure adherence to good IPC/ED Lead practice. This must include all care areas and all staff (permanent, agency and external contractors)	The Trust has adequate resources in place to implement good IPC/ED Lead practice. Monitoring in place, with all outbreaks/NCI reviewed, with ongoing audits at local level. All Trust risk assessments are based on current national best practice guidance ensuring rapid implementation of control measures to effectively mitigate risk of all staff (permanent, agency and external contractors) patients and visitors.	Compliant		DIPC Infection Control Consultant/ H&S
12.	The application of IPC/ED Lead practices within this guidance is monitored, e.g.:				
12.1.	• hand hygiene	Compliant – monthly audits and incorporated in ward visits and RCA panel discussions.	Compliant		Ward Managers
12.2.	• PPE donning and doffing training	Training provided locally with guidance available on intranet. Continue to identify areas of non-compliance and ensure staff retraining takes place. Covered in local induction checklist. Refresher training by IPC/ED Lead link nurses. Reinforced during periods of increased cases/outbreak areas.	Compliant		IPC/ED Lead Ward / Dept managers
12.3.	• Cleaning and decontamination	The current national standards of cleanliness are compliant. The Trust has ward/department cleaning schedules in place which are monitored by Medirest and VINCI. There is an embedded RAG- rated cleaning protocol. Hydrogen peroxide fogging protocol is in place.	Compliant		Director of Estates/ IPC/ED Lead Ward Teams

Key Lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	Lead
13.	The IPC/ED Lead Board Assurance Framework is reviewed, and evidence of assessments are made available and discussed at Trust Board	IPC/ED Lead BAF reviewed and discussed at Quality Committee and Board.	Compliant		DIPC
14.	The Trust Board has oversight of ongoing outbreaks and action plans	The DIPC (Board member) is alerted to each outbreak and will alert the Board sooner if required prior to the normal reporting arrangements Compliant – reported in CEO report/DoNM&G quarterly report. Weekly NCI report to Executive teams and monthly board report via CEO HCAI data Included in IPR and team brief	Compliant		DIPC
15.	The Trust is not reliant on a particular mask type and ensure that a range of predominantly UK Make FFP3 masks are available to users as required	The Trust has a variety of FFP3 Masks the supply of which is monitored both by Procurement team ensuring that there are sufficient supplies to assure staff safety; this is reported to silver and Gold. The H&S team are the leads for face fit testing and have competed the required training. The H&S team ensure all staff that require FFT are tested with variety of masks and a central and personal record is maintained.	Compliant		Procurement Lead/H&S/H&S/H&S
2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections					
Systems and processes are in place to ensure that:					
16.	The organisation has systems and processes in place to identify and communicate changes in the functionality of areas/rooms	Discussed via Gold, daily bed meetings and included in COVID communication bulletin IPC/ED Lead and Estates undertake a risk assessment to approve any changes in the functionality of areas/rooms or estates work to be undertaken. this is reported to HIPG.	Compliant		Director of Estates/ Infection Control/ Infection Control Consultant
17.	Cleaning standards and frequencies are monitored in clinical and non- clinical areas with actions in place to resolve issues in maintaining a clean environment.	Compliant see 12.3	Compliant		Director of Estates/ Infection Control/ Infection Control Consultant
18.	Increased frequency of cleaning should be incorporated into the environmental decontamination schedules for patient isolation rooms and cohort areas.	Increased frequency of cleaning is already incorporated the environmental decontamination schedules for patient isolation rooms and cohort areas	Compliant		Director of Estates/ Infection Control/ Infection Control Infection Control Consultant

Key Lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	Lead
19.	Where patients with respiratory infections are cared for cleaning and decontamination are carried out with neutral detergent or a combined solution followed by a chlorine-based disinfectant, in the form of a solution at a minimum strength of 1,000ppm available chlorine as per national guidance	standard cleaning throughout uses 1,000ppm	Compliant		Director of Estates/ Infection Control/ Infection Control Infection Control Consultant
20.	If an alternative disinfectant is used, the local infection prevention and control team (IPC/ED Lead) are consulted on this to ensure that this is effective against enveloped viruses.	N/A see 19	N/A		Infection Control Consultant
21.	Manufacturers' guidance and recommended product 'contact time' is followed for all cleaning/disinfectant solutions/products.	Staff trained how to use product recommended 'contact time' COSHH risk assessments in place Ward based daily monitoring of time solution	Compliant		Estates Ward Manager
22.	A minimum of twice daily cleaning of:				
22	• patient isolation rooms.	Compliant	Compliant		Medirest
22	• cohort areas.	Compliant	Compliant		Medirest
22	• Donning & doffing areas	Compliant	Compliant		Medirest
22	• 'Frequently touched' surfaces e.g., door/toilet handles, patient call bells, over bed tables and bed rails.	Additional cleaning has been introduced in escalation areas.	Partially compliant	As part of the national standards of cleanliness review areas that require changes in cleaning frequencies due to the changes in the functional risk category are being identified, risk assessed with costs identified for approval	Director of Estates/ Infection Control/ Infection Control

Key Lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	Lead
22	• where there may be higher environmental contamination rates, including toilets/ commodes particularly if patients have diarrhoea	Enhanced cleaning is in place for higher risk areas	Partially compliant	As part of the national standards of cleanliness review areas that require changes in cleaning frequencies due to the changes in the functional risk category will be identified, risk assessed with costs identified for approval	Director of Estates/ Infection Control/ Infection Control
23.	A terminal/deep clean of inpatient rooms is carried out:				
23	• Following resolutions of symptoms and removal of precautions	completed when the patient vacates bed space	Compliant		Medirest// Ward Staff
23	• when vacated following discharge or transfer (this includes removal and disposal/or laundering of all curtains and bed screens);	A terminal/deep clean of inpatient rooms is undertaken on each transfer or discharge of an patient	Compliant		Medirest
23	• following an AGP **if room vacated** (clearance of infectious particles after an AGP is dependent on the ventilation and air change within the room).	Completed following an AGP if room vacated	Compliant		Medirest
24.	Reusable non-invasive care equipment is decontaminated:				
24	• between each use**.**	Reusable non-invasive care equipment is decontaminated pre and post use	Compliant		Ward Staff
24	• after blood and/or body fluid contamination	Reusable non-invasive care equipment is decontaminated pre and post use and if soiled	Compliant		Ward Staff
24	• at regular predefined intervals as part of an equipment cleaning protocol	Compliant as per trust equipment cleaning protocol	Compliant		Ward Staff Medirest

Key Lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	Lead
24	• before inspection, servicing, or repair equipment.	Reusable non-invasive care equipment is decontaminated pre and post use and during nay servicing. equipment is tagged as “I am clean “, and a decontamination label / form completed. this includes all EBME equipment, mattresses, and beds/trolleys	Compliant		EBME
25.	Compliance with regular cleaning regimes is monitored including that of reusable patient care equipment.	regular cleaning regimes are monitored including that of reusable patient care equipment. This included in environmental audits	Compliant		EBME Ward Staff/ IPC/ED Lead
26.	As part of the Hierarchy of controls assessment: ventilation systems, particularly in patient care areas (natural or mechanical) meet national recommendations for minimum air changes refer to country specific guidance. In patient Care Health Building Note 04-01: Adult in-patient facilities.	The Director of Estates/ Infection Control/ Infection Control is obtaining additional assurance relating to the ventilation system at the one of in-patient bedded facility Further monitoring of ventilation in progress	Partially compliant	Ventilation Safety Group to be established . Remit of this group to include assessment of Trust premises against the updated ventilation HTM 04-01 (2021). Establish what is possible in terms of the building mechanical and engineering infrastructure, and finances. Put systems in place to manage/mitigate any risks identified.	Director of Estates/ Infection Control/ Infection Control Consultant
27.	The assessment is carried out in conjunction with organisational estates teams and or specialist	assessments are completed in conjunction with organisational estates teams and or specialist advice from ventilation group and or the organisations, authorised engineer	Compliant		Director of Estates/ Infection

Key Lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	Lead
	advice from ventilation group and or the organisations, authorised engineer.				Control/ Infection Control Co
28.	A systematic review of ventilation and risk assessment is undertaken to support location of patient care areas for respiratory pathways	All changes to estates are fully reviewed/ assessed	Compliant		Director of Estates/ Infection Control/ Infection Control/ Infection Control/ Infection Control Consultant
29.	Where possible air is diluted by natural ventilation by opening windows and doors where appropriate	air is diluted by natural ventilation by opening windows and doors	Compliant		
30.	Where a clinical space has very low air changes and it is not possible to increase dilution effectively, alternative technologies are considered with Estates/ventilation group.	Where a clinical space has very low air changes and it is not possible to increase dilution effectively, alternative technologies are considered with Estates/ventilation group.	Compliant		Director of Estates/ Infection Control/ Infection Control
31.	When considering screens/partitions in reception/ waiting areas, consult with estates/facilities teams, to ensure that air flow is not affected, and cleaning schedules are in place.	Any additional screens / patriations are jointly approved by IPC/ED Lead and Estates following a risk assessment to ensure that air flow is not affected, and cleaning schedules are in place.	Compliant		Director of Estates/ Infection Control/ Infection Control Infection Control Consultant
3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance					
Systems and process are in place to ensure that:					
32.	Arrangements for antimicrobial stewardship are maintained	The Trust has an established antimicrobial team incorporating pharmacy and consultant microbiologist including OPAT service. Antimicrobial ward rounds occur throughout the trust for e.g., ICU. Haematology Consultant Microbiology/ Pharmacy meet with CCG/ GPs re antimicrobial stewardship	Compliant		AM Lead/ Pharmacist/ Infection Control Consultant

Key Lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	Lead
33.	Previous antimicrobial history is considered	Covered by AM policy in place			AM Lead/ Pharmacist/ Infection Control Pharmacist Infection Control Consultant
34.	The use of antimicrobials is managed and monitored:				
34	• to reduce inappropriate prescribing.	Principles for Antimicrobial Stewardship are embedded and on Dr induction Antimicrobial stewardship and audits reports to HIPG bimonthly and reports incorporated in IPC/ED Lead reports. this includes audits of compliance in line with antimicrobial CQUIN Antimicrobial stewardship discussed at each IPC/ED Lead RCA panel EMPA in place which includes alerts for previous/ current MRSA status. This ensures monitoring of antimicrobials to reduce inappropriate prescribing and to ensure patients with infections are treated appropriately. Antimicrobial policy available on app for clinical staff	Compliant		AM Lead/ Pharmacist/ Infection Control Pharmacist Infection Control Consultant
34	• to ensure patients with infections are treated promptly with correct antibiotic.	Monthly audit completed and circulated to consultants	Compliant		AM Lead/ Pharmacist/ Infection Control Pharmacist Infection Control Consultant
35.	Mandatory reporting requirements are adhered to, and boards continue to maintain oversight.	Mandatory reporting requirements are embedded and shared	Compliant		AM Lead/ Pharmacist/ Infection Control Pharmacist Infection Control Consultant
36.	Risk assessments and mitigations are in place to avoid unintended consequences from other pathogens.	Full range of policies in place and available on intranet	Compliant		AM Lead/ Pharmacist/

Key Lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	Lead
					Infection Control Pharmacist Infection Control Consultant
4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/medical care in a timely fashion					
Systems and processes are in place to ensure that:					
37.	Visits from patient's relatives and/or carers (formal/informal) should be encouraged and supported whilst maintaining the safety and wellbeing of patients, staff, and visitors	The Trust recognises the importance of supporting in-patient visiting, proactively contributing to the wellbeing and delivery of person-centred care. The Trust follows current IPC/ED Lead and C&M guidance re visiting during covid -19 guidance. The document is aligned to current NHS visiting guidance: C1519: Visiting healthcare inpatient settings during the Covid-19 pandemic: principles 1 January 2022, Version 3, and will be reviewed as guidance is updated. Compassionate visiting is in place in line with the guidance and actions are in place for patients outside these criteria i.e., face time calls, pen pals, patient liaison staff to provide updates to families	Compliant		DONM&G/ DIPC// DIPC// DIPC/ Exec Team
38.	National guidance on visiting patients in a care setting is implemented.	The document which is aligned to current NHS visiting guidance: C1519: Visiting healthcare inpatient settings during the Covid-19 pandemic: principles 1 January 2022, Version 3, is in place and will be reviewed as guidance is updated.	Compliant		DONM&G/ DIPC/
39.	Restrictive visiting may be considered appropriate during outbreaks within inpatient areas This is an organisational decision following a risk assessment.	Restricted visiting is assessed and considered during outbreaks within inpatient areas This is a decision following a risk assessment The 'Supporting excellence in infection prevention and control behaviours' Implementation Toolkit has been fully considered with the Infection Prevention team and discussed through governance and assurance forums	Compliant		DIPC Exec Team via Gold Command Escalation
40.	There is clearly displayed, written information available to prompt patients' visitors and staff to comply with handwashing, wearing of facemask/face covering and physical distancing.	The trust has multiple systems to prompt patients' visitors and staff to ensure compliance with best practice guidance including PPE to prevent transmission of infections and to ensure patients and staff safety Posters and patients' information is readily available and visible This includes external and internal to hospitals. Information on intranet / internet policy and procedures. Laminated posters re PPE requirements for various alert organisms	Compliant		IPC/ED Lead Comms Lead

Key Lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	Lead
		The Trust has social distancing support staff who support patients/ visitors to comply with handwashing, wearing of facemask/face covering and physical distancing			
41.	If visitors are attending a care area with infectious patients, they should be made aware of any infection risks and offered appropriate PPE. This would routinely be an FRSM.	Systems and process have been developed across the Trust services, to effectively utilise triage to ensure risk of cross infection is minimised in accordance with national guidance Clinical triage questions have been disseminated across Trust services and are systematically implemented to ensure patients are allocated to the appropriate pathway at the earliest opportunity. These are reviewed on release of new national and regional guidance, to ensure adherence to current best practice guidance. Inpatients are required to wear face masks and always maintain 2 metre distancing. A robust swabbing process has been implemented to ensure rigorous monitoring of individual Covid -19 status in line with national guidance. Covid - 19, policies and procedures have been implemented to ensure suspected or confirmed patients are allocated single occupancy room and that all procedures are in place The Trust has implemented contact tracing.	Compliant		IPC/ED Lead/ Ward Teams
42.	Visitors with respiratory symptoms should not be permitted to enter a care area. However, if the visit is considered essential for compassionate (end of life) or other care reasons (e.g., parent/child) a risk assessment may be undertaken, and mitigations put in place to support visiting wherever possible.	A risk assessment is undertaken for each visitor who attends to ensure respiratory symptoms should not be permitted to enter a care area visits are considered essential for compassionate (end of life) or other care reasons (e.g., parent/child)	Compliant		IPC/ED Lead Ward teams
43.	Visitors are not present during AGPs on infectious patients unless they are considered essential following a risk assessment e.g., carer/parent/guardian.	The trust compliant with ensuring Visitors are not present during AGPs on infectious patients unless they are considered essential following a risk assessment e.g., carer/parent/guardian.	Compliant		IPC/ED Lead ward teams
44.	Implementation of the Supporting Excellence in Infection Prevention and Control Behaviours Implementation Toolkit has been adopted C1116-supporting-excellence-in-IPC/ED Lead-behaviours-imp-toolkit.pdf (england.nhs.uk)	The trust has reviewed and has implemented the Supporting Excellence in Infection Prevention and Control Behaviours Implementation Toolkit, and this will be reviewed in line with nay new changes	Compliant		IPC/ED Lead team
5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people					
Systems and processes are in place to ensure that:					
45.	Signage is displayed prior to and on entry to all health and care settings instructing patients with respiratory symptoms to inform receiving reception staff, immediately on their arrival.	Signage is displayed at all points of entry to the hospital premises to inform patients visitors and staff that prior to and on entry to all health and care settings instructing patients with respiratory	Compliant		Comms Team

Key Lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	Lead
		symptoms to inform receiving reception staff, immediately on their arrival. This is also on the trust website			
46.	Infection status of the patient is communicated to the receiving organization, department or transferring services, when a possible or confirmed seasonal respiratory infection needs to be transferred.	This is incorporated in the discharge process and checklist it is included on discharge summary Patients with Infection alerts are flagged on the hospital Medway (patient information) system The trust follows the guidance for patients who are covid -19 positive on discharge to care home setting including obtaining a covid clearance swab prior to discharge The IPC/ED Lead team liaise with community IPC/ED Lead teams to ensure patient information is communicated and support available for the care home	Compliant		IPC/ED Lead team Wards
47.	Staff are aware of agreed template for screening questions to ask.	This is incorporated in triage and screening tool	Compliant		ED and Ward Teams
48.	Screening for COVID-19 is undertaken prior to attendance wherever possible to enable early recognition and to clinically assess patients prior to any patient attending a healthcare environment.	Screening is undertaken at Pre-Op/ and on admission to the trust in line with national guidance	Compliant		Pre-Op/ ED and Ward teams
49.	Front door areas have appropriate triaging arrangements in place to cohort patients with Triage in ED or Pre-OP / other respiratory infection symptoms and segregation of cases to minimise the risk of cross-infection as per national guidance.	Triage in ED or Pre-OP to ensure cohorting / isolation of patients at Triage in ED or Pre-OP as per national guidance	Compliant		Pre-Op/ ED and ward teams
50.	Triage is undertaken by clinical staff who are trained and competent in the clinical case definition and patient is allocated appropriate pathway as soon as possible.	Staff who undertake Triage are trained and competent in the clinical case definition and patient is allocated appropriate pathway as soon as possible	Compliant		Pre-Op/ ED and ward teams
51.	There is evidence of compliance with routine patient testing protocols in line with trust approved hierarchies of control risk assessment and approved.	The trust has embedded process in place to ensure patients are tested in line with national guidance. This is communicated daily if any screens are required that day Testing if available 4/7 with results when approved immediately available on the trust Medway system	Compliant		IPC/ED Lead Ward teams BI lead
52.	Patients with suspected or confirmed respiratory infection are provided with a surgical facemask (Type II or Type IIR) to be worn in multi-bedded bays and communal areas if this can be tolerated.	All Patients are provided with a surgical mask on admission and for patients with suspected or confirmed respiratory infection are provided with a surgical facemask	Compliant		IPC/ED Lead Ward and depart leads
53.	Patients with respiratory symptoms are assessed in a segregated area, ideally a single room, and away from other patients pending their test result.	Compliant – where demand allows The trust has 50% single room occupancy. all rooms in ED are single occupancy	Compliant		IPC/ED Lead Ward and depart leads
54.	Patients with excessive cough and sputum production are prioritised for placement in single rooms whilst awaiting testing.	Compliant – where demand allows The trust has 50% single room occupancy. all rooms in ED are single occupancy	Compliant		IPC/ED Lead Ward and depart leads

Key Lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	Lead
55.	Patients at risk of severe outcomes of respiratory infection receive protective IPC/ED Lead measures depending on their medical condition and treatment whilst receiving healthcare eg, priority for single room isolation and risk for their families and carers accompanying them for treatments/procedures must be considered.	Patients at risk of severe outcomes of respiratory infection receive protective IPC/ED Lead measures depending on their medical condition and treatment whilst receiving healthcare are prioritised	Compliant		IPC/ED Lead Ward and depart leads
56.	Where treatment is not urgent consider delaying this until resolution of symptoms providing this does not impact negatively on patient outcomes.	Each patient will have an individual documented risk assessment and management plan based on their clinical symptoms	Compliant		MD Clinical leads
57.	Face masks/coverings are worn by staff and patients in all health and care facilities.	Compliant – all patients are asked to wear face masks? covering unless exemptions or patients refuse. If this is the case adjustments are made to ensure safety of others Staff unable to wear masks a risk assessment if undertaken and reasonable adjustments made to relocate to another appropriate area in line with national guidance	Compliant		Wards HWWB
58.	Where infectious respiratory patients are cared for physical distancing remains at 2 metres distance.	The trust is compliant with more than 2 metres between beds, in addition to 50% single rooms	Compliant		DIPC Director of Estates
59.	Patients, visitors, and staff can maintain 1 metre or greater social & physical distancing in all patient care areas; ideally segregation should be with separate spaces, but there is potential to use screens, e.g., to protect reception staff.	As above -The trust is compliant with more than 2 metres between beds, in addition to 50% single rooms screens, e.g., to protect reception staff and in shared office spaces Al office spaces and departments have Risk assessment completed as covid secure and this is displayed	Compliant		DIPC Director of Estates
60.	Patients that test negative but display or go on to develop symptoms of COVID-19 are segregated and promptly re-tested and contacts traced promptly.	Patients who are symptomatic are segregated in single or cohort areas The trust follows national guidance re screening day zero-day 3 day 5 then every 5 days if negative. this is embedded in practice	Compliant		IPC/ED Lead ED and wards
61.	Isolation, testing and instigation of contact tracing is achieved for all patients with new-onset symptoms, until proven negative.	The IPC/ED Lead team ensure all patients who are confirmed positive that a RCA is undertaken, and contact tracing is completed.	Compliant		IPC/ED Lead ED and wards
62.	Patients that attend for routine appointments who display symptoms of COVID-19 are managed appropriately.	Patients attending for outpatients are asked the screening questions and temp recorded . LFT are required			IPC/ED Lead Outpatient lead
6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection					
Systems and processes are in place to ensure that:					
63.	Appropriate infection prevention education is provided for staff, patients, and visitors.	The trust has IPC/ED Lead consultants and link nurses The trust has IPC/ED Lead link nurse meeting and training The trust has mandatory IPC/ED Lead training programme which is reported to governance, Executive Committee, and Quality Committee re compliance	Compliant		IPC/ED Lead L&D

Key Lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	Lead
64.	Training in IPC/ED Lead measures is provided to all staff, including: the correct use of PPE including an initial face fit test/and fit check each time when wearing a filtering face piece (FFP3) respirator and the correct technique for putting on and removing (donning/doffing) PPE safely.	Training in IPC/ED Lead measures is provided to all staff, including: the correct use of PPE including an initial face fit test/and fit check each time when wearing a filtering face piece (FFP3) respirator and the correct technique for putting on and removing (donning/doffing) PPE safely.	Compliant	IPC/ED Lead nurse as subject expert devolved responsibility to wards and depts to ensure training requirements compliance is monitored monthly	IPC/ED Lead Nurse
65.	All staff providing patient care and working within the clinical environment are trained in the selection and use of PPE appropriate for the clinical situation and on how to safely put it on and remove it;	All staff providing patient care and working within the clinical environment are trained in the selection and use of PPE appropriate for the clinical situation and on how to safely put it on and remove it; this is included in local induction provided by WM or IPC/ED Lead link nurse	Compliant		IPC/ED Lead
66.	Adherence to national guidance on the use of PPE is regularly audited with actions in place to mitigate any identified risk.	Use of PPE is audited by IPC/ED Lead included in the Tenable ward audits	Compliant		IPC/ED Lead Ward managers
67.	Gloves are worn when exposure to blood and/or other body fluids, non- intact skin or mucous membranes is anticipated or in line with standard infection control precautions (SICPs) and transmission-based precautions (TBPs)	Gloves. Aprons and eye protection are used as standard precautions	Compliant		IPC/ED Lead Ward managers
68.	The use of hand air dryers should be avoided in all clinical areas. Hands should be dried with soft, absorbent, disposable paper towels from a dispenser which is located close to the sink but beyond the risk of splash contamination as per national guidance.	The trust does not have hand air dryers in clinical areas	Compliant		Director of Estates IPC/ED Lead
69.	Staff maintaining physical and social distancing of 1 metre or greater wherever possible in the workplace	Social distancing is maintained in workplace were possible and strict adherence to PPE is in place	Compliant		All staff
70.	Staff understand the requirements for uniform laundering where this is not provided for onsite.	IPC/ED Lead policy advises staff on procedure for laundering uniforms	Compliant		IPC/ED Lead nurse
71.	All staff understand the symptoms of COVID-19 and take appropriate action if they or a member of their household display any of the symptoms (even	All staff have received training and information related to COVID-19 and take appropriate action if they or a member of their household display any of the symptoms	Compliant		HWWB Comms lead

Key Lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	Lead
	if experiencing mild symptoms) in line with national guidance.	The trust established a self-isolation team and referral process to provide advice and support staff and managers. this is based with HWWB			
72.	To monitor compliance and reporting for asymptomatic staff testing	Staff have undertaken LFT and lamp testing. results are communicated to staff and line manager	Compliant		HWWB managers
73.	There is a rapid and continued response to ongoing surveillance of rates of infection transmission within the local population and for hospital/organisation onset cases (staff and patients/individuals).	The surveillance data related to rates of infection transmission within the local population and for hospital/organisation onset cases (staff and patients/individuals). Are reported weekly to Exec committee in addition to a weekly report of the trust NCI rates, benchmarking data and actions taken This is shared weekly with ADOs for discussion at care group meetings	Compliant		Director of Strategy/ DIPC
74.	Positive cases identified after admission who fit the criteria for investigation should trigger a case investigation. Two or more positive cases linked in time and place trigger an outbreak investigation and are reported.	Each confirmed case of SARs Covid -19 is reviewed and investigated by IPC/ED Lead team; this includes the criteria for investigation should trigger a case investigation. Two or more positive cases linked in time and place trigger an outbreak investigation and are reported. This is reported weekly	Compliant		IPC/ED Lead Nurse/ DIPC
7. Provide or secure adequate isolation facilities					
Systems and processes are in place to ensure:					
75.	That clear advice is provided, and monitoring is carried out of inpatients compliance with wearing face masks (particularly when moving around the ward or healthcare facility) providing it can be tolerated and is not detrimental to their (physical or mental) care needs.	Compliant – all patients are asked to wear face masks? covering unless exemptions or patients refuse. If this is the case adjustments are made to ensure safety of others Staff unable to wear masks a risk assessment if undertaken and reasonable adjustments made to relocate to another appropriate area in line with national guidance This guidance may be changed nationally as levels reduce	Compliant	It is not a legal requirement, and we cannot enforce this.	IPC/ED Lead Wards and department
76.	Separation in space and/or time is maintained between patients with and without suspected respiratory infection by appointment or clinic scheduling to reduce waiting times in reception areas and avoid mixing of infectious and non-infectious patients.	The trust has alterations to outpatient settings and appointments to maintain this. All patients are asked screening questions on attendance and are asked to wear face masks /covering. Patients were possible attend appointments on their own, exemptions are in place	Compliant		Comms Team Outpatient manager
77.	Patients who are known or suspected to be positive with a respiratory pathogen including COVID-19 where their treatment cannot be deferred, their care is provided from services able to operate in a way which minimise the risk of spread of the virus to other patients/individuals.	Patients are individually assessed based on clinical need Actions are put in place minimise the risk of spread of the virus to other patients/individuals.	Compliant		Clinician
78.	Patients are appropriately placed ie, infectious patients in isolation or cohorts.	The trust has 50% side room, all patients with infectious conditions are prioritised for single / isolation rooms IPC/ED Lead team monitor side room availability and use	Compliant		IPC/ED Lead Ward teams
79.	Ongoing regular assessments of physical distancing and bed spacing, considering potential	The trust has 2 metre distance between bed spaces ED utilise screens to ensure compliance	Compliant		Director of Estates

Key Lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	Lead
	increases in staff to patient ratios and equipment needs (dependent on clinical care requirements).				ED lead Nurse IPC/ED Lead
80.	Standard infection control precautions (SIPC/ED Lead's) are used at point of care for patients who have been screened, triaged, and tested and have a negative result	Standard infection control precautions are in place and monitored	Compliant		Ward teams IPC/ED Lead
81.	The principles of SICPs and TBPs continued to be applied when caring for the deceased	The principles of SICPs and TBPs continued are applied when caring for the deceased and supported by care of deceased patients' policy identifying any specific IPC/ED Lead requirements The Mortuary have IPC/ED Lead policy and for covid specific they follow the national IPC/ED Lead guidance / standards	Compliant		IPC/ED Lead Nurse Wards Mortuary lead
8. Secure adequate access to laboratory support as appropriate					
Systems and processes in place to ensure:					
82.	Testing is undertaken by competent and trained individuals.	Staff are trained and competent in testing	Compliant		IPC/ED Lead
83.	Patient testing for all respiratory viruses testing is undertaken promptly and in line with national guidance;	testing for all respiratory viruses testing is undertaken promptly and in line with national guidance;	Compliant		IPC/ED Lead / med micro lab
84.	Staff testing protocols are in place	Staff testing protocols are in place	Compliant		IPC/ED Lead
85.	There is regular monitoring and reporting of the testing turnaround times, with	Turnaround time is monitored Urgent testing is reported in less than 2 hours from the time the specimen is received Within 24 hours for non-urgent	Compliant		IPC/ED Lead
86.	Focus on the time taken from the patient to time result is available.	The trust has system in place for transporting specimen to the lab in timely manner	Compliant		IPC/ED Lead
87.	There is regular monitoring and reporting that identified cases have been tested and reported in line with the testing protocols (correctly recorded data).	The reports are automatically reported via the lab to SGSS; UKHSA reporting system	Compliant		IPC/ED Lead
88.	Screening for other potential infections takes place.	The lab undertake screening for other organism i.e., RSV, Influenza, or other infections	Compliant		IPC/ED Lead
89.	That all emergency patients are tested for COVID-19 and other respiratory infections as appropriate on admission.	1. all emergency patients are tested for COVID-19 and other respiratory infections as appropriate on admission.	Compliant		IPC/ED Lead
90.	That those inpatients who go on to develop symptoms of respiratory	Symptomatic patients are screened in accordance with guidance	Compliant		IPC/ED Lead
91.	Infection/COVID-19 after admission are retested at the point symptoms arise.	Patients are tested as per guidance and if any new symptoms occur	Compliant		IPC/ED Lead
92.	That all emergency admissions who test negative on admission are retested for COVID-19 on day 3 of admission, and again between 5-7 days post admission.	All admitted patients are tested on admission, day 3 and day5 and this is repeated every 5 days if negative.	Compliant		

Key Lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	Lead
93.	That sites with high nosocomial rates should consider testing COVID-19 negative patients daily.	The trust has one of lowest NCI rates therefore not required	Compliant N/A		DIPC
94.	That those being discharged to a care home are tested for COVID-19, 48 hours prior to discharge (unless they have tested positive within the previous 90 days), and result is communicated to receiving organisation prior to discharge.	Patients being discharged to a care home are tested for COVID-19, 48 hours prior to discharge as per guidance	Compliant		IPC/ED Lead Discharge Co-ordinator
95.	Those patients being discharged to a care facility within their 14-day isolation period are discharged to a designated care setting, where they should complete their remaining isolation as per national guidance	Those patients being discharged to a care facility within their 14-day isolation period are discharged to a designated care setting, where they should complete their remaining isolation as per national guidance However. If challenges in discharging patients this is communicated via IPC/ED Lead and la teams	Compliant		Discharge Co-ordinator
96.	There is an assessment of the need for a negative PCR and 3 days self- isolation before certain elective procedures on selected low risk patients who are fully vaccinated, asymptomatic, and not a contact of case suspected/confirmed case of COVID-19 within the last 10 days. Instead, these patients can take a lateral flow test (LFT) on the day of the procedure as per national guidance.	Protocol in place	Compliant		
9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections					
Systems and processes are in place to ensure that					
97.	The application of IPC/ED Lead practices is monitored and that resources are in place to implement and measure adherence to good IPC/ED Lead practice. This must include all care areas and all staff (permanent, agency and external contractors).	IPC/ED Lead practices are monitored and that resources are in place to implement and measure adherence to good IPC/ED Lead practice	Compliant		IPC/ED Lead
98.	Staff are supported in adhering to all IPC/ED Lead policies, including those for other alert organisms.	Staff have training on IPC/ED Lead and access to information and support via IPC/ED Lead team and on the trust website. out of hours advice available via medical microbiologist on call	Compliant		IPC/ED Lead
99.	Safe spaces for staff break areas/changing facilities are provided.	Safe spaces for staff break areas/changing facilities are provided	Compliant		Wards
100.	Robust policies and procedures are in place for the identification of and management of outbreaks of infection. This includes the documented recording of an outbreak.	Robust policies and procedures are in place for the identification of and management of outbreaks of infection Out breaks are reported weekly to Exec committee and shared with ADO at weekly briefing for onward cascade of actions required	Compliant		IPC/ED Lead
101.	All clinical waste and linen/laundry related to confirmed or suspected COVID- 19 cases is handled, stored, and managed in accordance with current national guidance.	All clinical waste and linen/laundry are handled, stored, and managed in accordance with current national guidance. This is monitored by waste management team who provide reports to HIPG	Compliant		Estates & Facilities

Key Lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	Lead
102.	PPE stock is appropriately stored and accessible to staff who require it.	The procurement team monitor PPE supply and support clinical teams . PPE is readily available	Compliant		Procurement Lead/H&S
10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection					
Systems and processes are in place to ensure that:					
103.	Staff seek advice when required from their IPC/ED Lead/occupational health department/GP or employer as per their local policy.	The trust has an inhouse HWWB and self-isolation team and robust policies in place	Compliant		IPC/ED Lead HWWB
104.	Bank, agency, and locum staff follow the same deployment advice as permanent staff.	Bank, agency, and locum staff are provided with the same deployment advice as permanent staff.	Compliant		Staffing Solutions
105.	Staff who are fully vaccinated against COVID-19 and are a close contact of a case of COVID-19 are enabled to return to work without the need to self-isolate (see Staff isolation: approach following updated government guidance)	The trust has a robust process in place to support staff return to work if are fully vaccinated against COVID-19 and are a close contact of a case of COVID-19 A risk assessment and authorisation are completed	Compliant		Self-Isolation Team Manager
106.	Staff understand and are adequately trained in safe systems of working, including donning, and doffing of PPE.	Staff understand and are trained in safe systems of working, including donning, and doffing of PPE	Compliant		IPC/ED Lead
107.	A fit testing programme is in place for those who may need to wear respiratory protection.	A fit testing programme is in place undertaken by trained staff in H&S	Compliant		H&S Team
108.	Where there has been a breach in infection control procedures staff are reviewed by occupational health. Who will:				
10	• lead on the implementation of systems to monitor for illness and absence.	Policy in place and supported by IPC/ED Lead	Compliant		HR
10	• facilitate access of staff to antiviral treatment where necessary and implement a vaccination programme for the healthcare workforce	Trust had mass vaccination programme in place HWWB will undertake risk assessment and facilitate antiviral treatment where necessary and implement a vaccination programme for the healthcare workforce as required	Compliant		HWWB
10	• lead on the implementation of systems to monitor staff illness, absence and vaccination against seasonal influenza and COVID-19	The trust HR and HWWB have robust process in place to monitor staff illness, absence and vaccination against seasonal influenza and COVID-19 This is reported monthly in IPR	Compliant		HR/ HWWB
10	• encourage staff vaccine uptake.	Staff have ben proactively encouraged to have both flu and Covid vaccination Visible leadership and support have been provided	Compliant		HWWB/ DIPC
109.	Staff who have had and recovered from or have received vaccination for a specific respiratory pathogen continue to follow the infection control precautions, including PPE, as outlined in national guidance.	Staff follow the national guidance; this is monitored via IPC/ED Lead and HWWB	Compliant		HWWB
110.	A risk assessment is carried for health and social care staff including pregnant and specific ethnic minority groups who may be at high risk of	Individual risk assessments have been / are completed for all pregnant and specific ethnic minority groups who may be at high risk of complications from respiratory infections	Compliant		HR Manager/ HWWB

Key Lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	Lead
	complications from respiratory infections such as influenza and severe illness from COVID-19.				
11	• a discussion is had with employees who are in the at-risk groups, including those who are pregnant and specific ethnic minority groups**;**	HWWB and managers have undertaken individual risk assessment and discussions with staff in high-risk groups	Compliant		HR Manager/ HWWB
11	• that advice is available to all health and social care staff, including specific advice to those at risk from complications**.**	specific advice is readily available and provided to those at risk from complications.	Compliant		
11	• Bank, agency, and locum staff who fall into these categories should follow the same deployment advice as permanent staff**.**	Bank, agency, and locum staff who fall into these categories do have the same deployment advice as permanent staff.	Compliant		
11	• A risk assessment is required for health and social care staff at high risk of complications, including pregnant staff.	HWWB and managers have undertaken individual risk assessment and discussions with staff in high-risk groups	Compliant		
111.	Vaccination and testing policies are in place as advised by occupational health/public health.	Vaccination and testing policies are in place in line with occupational health/public health national guidance	Compliant		HWWB
112.	Staff required to wear FFP3 reusable respirators undergo training that is compliant with HSE guidance, and a record of this training is maintained and held centrally/ESR records.	Staff required to wear FFP3 reusable respirators undergo training that is compliant with HSE guidance and is provided by an opportunely qualified staff Records are kept of training and type of masks suitable for the individual and the dates of the test	Compliant		H&S Team
113.	Staff who carry out fit test training are trained and competent to do so.	The trust has designated staff who carry out fit test training and who have been trained and assessed as competent to do this .	Compliant		H&S Team
114.	All staff required to wear an FFP3 respirator have been fit tested for the model being used and this should be repeated each time a different model is used.	The trust is compliant with ensuring that all staff required to wear an FFP3 respirator have been fit tested for the model being used and this should be repeated each time a different model is used.	Compliant		H&S Team
115.	All staff required to wear an FFP3 respirator should be fit tested to use at least two different masks	The trust is compliant with ensuring that all staff required to wear an FFP3 respirator have been fit tested for the model being used and this should be repeated each time a different model is used including different makes of masks	Compliant		H&S Team
116.	A record of the fit test and result is given to and kept by the trainee and centrally within the organisation.	A record of the fit test and result is given to and kept by the trainee and centrally within the organisation on ESR.	Compliant		H&S Team
117.	Those who fail a fit test, there is a record given to and held by employee and centrally within the organisation of repeated testing on alternative respirators and hoods.	Staff who fail FFT are provided with alternative respirators, there is a record given to and held by employee and centrally within the organisation of repeated testing	Compliant		H&S Team
118.	That where fit testing fails, suitable alternative equipment is provided.	As above alternative respirators and hoods are provided	Compliant		H&S Team
119.	Reusable respirators can be used by individuals if they comply with HSE recommendations and	Reusable respirators comply with HSE reformations	Compliant		H&S Team

Key Lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	Lead
	should be decontaminated and maintained according to the manufacturer's instructions.				
120.	Members of staff who fail to be adequately fit tested a discussion should be had, regarding re deployment opportunities and options commensurate with the staff members skills and experience and in line with nationally agreed algorithm.	Members of staff who fail to be adequately fit tested a discussion should be had, regarding re deployment opportunities and options made available. This is rare	Compliant		H&S Team
121.	A documented record of this discussion should be available for the staff member and held centrally within the organisation, as part of employment record including Occupational health.	Process in place	Compliant		H&S Team
122.	Boards have a system in place that demonstrates how, regarding fit testing, the organisation maintains staff safety and provides safe care across all care settings. This system should include a centrally held record of results which is regularly reviewed by the board.	The trust has record of compliance in place however is not regularly reported to board	Partially compliant	This will be included in IPC/ED Lead report	DIPC
123.	Consistency in staff allocation should be maintained, reducing movement of staff and the crossover of care pathways between planned/elective care pathways and urgent/emergency care pathways as per national guidance.	Twice daily safer staffing meetings are in place which reviews redeployment of staff considering outbreaks and pathways	Compliant		DONM&G/ DIPC/
124.	Health and care settings are COVID-19 secure workplaces as far as practical, that is, that any workplace risk(s) are mitigated maximally for everyone.	The trust has undertaken Risk assessments to ensure covid secure areas and to identify pathways and processes to maintain patient and staff safety	Compliant		Managers
125.	Staff absence and well-being are monitored and staff who are self -isolating are supported and able to access testing.	HR monitors staff absence and staff self-isolation. Support is available via Self isolation team Data is reported on IPR	Compliant		HR
126.	Staff who test positive have adequate information and support to aid their recovery and return to work.	Self-isolation team. HR and IPC/ED Lead provide information and support to staff who have tested positive	Compliant		HWWB/IPC/ED Lead