The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

Board of Directors (Public) 06.04.2022

MEETING
6 April 2022 09:30

PUBLISHED
5 April 2022

Agenda

Location	*Date*	*Owner*	*Time*
Teams	6/04/22		09:30

1. Part One - Public Meeting		09:30
1.1. Declarations of Interest	Chair	
1.2. Minutes of the Previous Meeting (Jan. 2022)	Chair	
1.3. Matters Arising	Chair	
2. HDU CQC Presentation	Chief Nurse and Patient Safety Officer	09:35
3. Patient Story	Chief Nurse and Patient Safety Officer	09:50
4. Chief Executive Update	Chief Executive	10:00

Continued on the next page...

Agenda

Location	*Date*	*Owner*	*Time*
Teams	6/04/22		09:30
5. Quality & Safety			10:10
5.1. Chair Report: Quality and Safety Committee		Non Executive Director	
5.2. Infection Control Q3 Report		Chief Nurse and Patient Safety Officer	
5.3. Chair Report: Extra Ordinary QS Committee		Non Executive Director	
5.3.1. Terms Of Reference and Committee Workplan		Chief Nurse and Patient Safety Officer	
5.4. Infection, Prevention and Control Improvement Plan			
5.5. Infection, Prevention and Control BAF		Chief Nurse and Patient Safety Officer	
5.6. IPC Hygiene Code Gap Analysis		Chief Nurse and Patient Safety Officer	
BREAK			10:50
6. People			11:05
6.1. Chair Report: People Committee		Non Executive Director	
6.2. Staff Survey		Chief People Officer	

Continued on the next page...

Agenda

Location	*Date*	*Owner*	*Time*
Teams	6/04/22		09:30
7. Performance and Governance			11:25
7.1. Chair Report: Finance, Planning and Digital Committee		Non Executive Director	
7.2. Performance Report		Chief Finance and Planning Officer	
7.3. Performance Management and Accountability Framework		Chief Finance and Planning Officer	
8. Questions from the Governors		Trust Secretary	11:50
9. Questions from the Public			11:55
10. Any Other Business		All	12:00
10.1. Next meeting: 4 May 2022 (Public)			

Contents

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust
Frank Collins ☎ 4358
Chairman

BOARD OF DIRECTOR – PUBLIC MEETING
29 JANUARY 2022
MINUTES OF MEETING

Present:		
Frank Collins	Chairman	FC
Harry Turner	Non-Executive Director	HT
Alison Tumilty	Non-Executive Director	AT
Chris Beacock	Non-Executive Director	CB
Paul Kingston	Non-Executive Director	PK
Rachel Hopwood	Non-Executive Director	RH
Stacey Keegan	Interim Chief Executive Officer	SK
Craig Macbeth	Chief Finance and Planning Officer	CM
Sara Ellis Anderson	Interim Chief Nurse and Patient Safety Officer	SEA
Kerry Robinson	Chief Performance, Improvement and OD Officer	KR
Ruth Longfellow	Chief Medical Officer	RL
In Attendance:		
Sarfraz Nawaz	Associate Non-Executive Director	SN
Hilary Pepler	Trust Board Advisor	HP
Dawn Forrest	Manging Director for Specialist Unit	DF
Sarah Sheppard	Chief People Officer	SS
Shelley Ramtuhul	Trust Secretary/Director of Governance	SR
Governors:		
Colette Gribble	Trust Governor	CG
Victoria Sugden	Trust Governor	VS
Simon Jones	Trust Governor	SJ
Kate Betts	Trust Governor	KB

FC welcomed all to the meeting and in particular the guest presenters at today's meeting.

MINUTE NO	TITLE
29/01/1.0	**DECLARATION OF INTERESTS** CB shared with the Board that he has been supporting the Vaccination Centre within the Trust as a medial prescriber and confirmed the employer is Shropshire Community Trust. CB also added, he has been completing some clinical work for MSCI with the employer being SaTH. KR shared with the Board that she has two external appointments which have no conflicts with the Trust – first is an associate for cloud scope, health and care and the second is for lecturing with Liverpool John Moores University.
29/01/1.1	**MINUTES FROM THE PREVIOUS MEETING – NOVEMBER 2021** The minutes from the previous meeting were accepted as an accurate reflection of the meeting and therefore approved by the Board.
29/01/1.2	**MATTERS ARISING** None to note.
	CHIEF EXECUTIVE UPDATE
29/01/2.0	**CEO Update** SK started the update by highlighting the challenging time for the Trust at the moment in responding to the Omicron variant of the Coronavirus. Despite significant pressures, both in urgent and emergency care across the NHS are unprecedented staff absence rates. SK reminded the Board that the national guidance changes soon but noted the importance of

	following guidelines within the Trust which is different to the community. The Board commended the Vaccination Centre for reaching 100,000 Covid-19 vaccinations on site at the end of November. In relation to the working from home national guidance, FC queried the Trusts current position. SK confirmed the Trust are supporting a hybrid approach whilst the reviews are being completed on a hot desking procedure. Staff are encouraged to come on to site but also work from home when they can. **League of Friends** – The Trust thanked the charity for supporting by funding the Allen Advanced Table which is to be utilised in Theatre. The equipment will position patients comfortably and safely which will allow surgeons to benefit from simple patient movement to maximize some of the spinal procedures. **London Marathon Runners** – A total of £30,000 was raised by 16 runners. The money will form part of the Charitable Funds which is used to fund projects across the hospital to support patient care and improve services. **Recruitment** – the Trust congratulated Mr Birender Balain who has recently been appointed the Clinical Chair for Clinical Services Unit. The Trust welcomed Simon Whitehouse who has been appointed the ICS Chief Executive. The Trust also welcomed the second cohort of international nurses. **Health Hero Award** – December winner was play specialist, Polly Brown. SK informed the Board she received a letter from one of the patients' parents who described Polly has been brilliant from the outset while supporting their son undergoing treatment. January winner is Caroline Steven, advanced pharmacists. Caroline was hailed by colleagues for her dedication, efficiency and accuracy when providing medication for patients, ensuring their wellness as a priority. Congratulations to Polly and Caroline. **Frank Collins** – SK noted the last meeting for FC as Chairman of the Trust and thanked FC for his support and guidance over the past 7 years.
	QUALITY AND SAFETY
29/01/3.0	**CHAIR REPORT QUALITY AND SAFETY COMMITTEE** CB presented the assurance report to the Board, highlighting the following: ▪ Well attended and great contributions from all ▪ There were no issues identified to escalate to the Board ▪ Significant discussion was held regarding the serious incidents and never events, and the emphasis required on the actions plans. Further progress is to be made to ensure timely reporting ▪ The Trust were commended for the work completed in relation to the Harms Review presentation where assurance has been obtained following the improved clarity on the process ▪ The Committee welcomed the update on the Trusts quality priorities The Board noted the Chairs report.
29/01/2.1	**LEARNING FROM DEATHS REPORT – Q2** RL presented the paper which outlines the data between September to December 2021 and thanked Dr James Neil for preparing the information. It was noted that there have been 3 deaths within this reporting period, a structure judgement review of 2 of the cases have been completed. The Trust continue to share learning within the System with one of the Trusts leads attending the Mortality Steering Group in SaTH and the Shropshire learning form deaths group within Midlands. The Board noted the Learning from Deaths Report.
	PEOPLE UPDATE
23/09/2.0	**CHAIR REPORT PEOPLE COMMITTEE**

	PK presented the assurance report to the Board, highlighting the following: ▪ The meeting was quorate and well attended ▪ The areas which received partial assurance include: ○ Consultant recruitment and annual leave will be presented monthly to the Committee to gain further oversight and assurance. ○ The Trust continue to inform the Board of the Covid vaccinations and those staff who haven't received ○ A 3 year rolling system for DBS checking to be implemented – proposal to be shared ○ Protected time for training – costings to be reviewed FC thanked PK for the update and agreed with the proposal relating to the DBS checks highlighting the long service of some staff members. PK also highlighted a concern raised regarding the lack of guidance in relations to Non-Executive Directors and the guidance regarding vaccination requirements and deployment. SS confirmed that any individual who is accessing the site and has contact with patients will be expected to have the vaccination – this includes volunteers and Non-Executive Directors. HT highlighted the importance of Non-Executive Directors visiting patient facing areas and encouraged the Trust to consider the options quickly due to the short timeframe. SR added there is an assessment framework that all roles are going through and suggested the Trust follows the process from a governance perspective in order to gain clear recommendations, including rationale if those decisions are going to be made. FC thanked SR for the good guidance. Following the discussion, CB queried the return of face-to-face meetings for Board and the assurance Committees, welcoming the view from the Trust. Some members of the Board shared their personal view of the current situation and it was agreed further discussion were to be held at the Private meeting. The Board noted the Chairs report.
	PERFORMANCE AND GOVERNANCE
29/01/4.0	**CHAIR REPORT FINANCE, PLANNING AN DIGITAL COMMITTEE** AT presented the Chairs report as the Chair of the meeting this month: ▪ Assurance was obtained on the processes in place to manage the performance whilst noting the deterioration in the recovery - due to Omicron ▪ The Trust are benchmarking fairly well with other Midlands's providers especially in priority two patients. There were further discussions in relation to outpatient benchmarking which the team are investigating ▪ In relation to clinical prioritisation the Committee were assured that urgent cases are dealt with as a priority and that does mean sometimes that the 104+ and 52-week waits are longer. ▪ The financial position for 21/22 and Robert Jones are expected to deliver ahead of plan, and it was noted that the system is in line with the plan that has been agreed. ▪ There is an underspend on capital, which is due to delays ▪ Planning for 2022/23 is at its early stages ait was recognised that e there's going to be challenge on financial delivery fitting both for the system and the Trust ▪ Assurance was received on the current EPR process and the Trust are awaiting approval from the system and region FC thanked AT for the updated and highlighted the challenges the NHS is to face with suppliers and materials with the increase on costs of living. FC queried the EPR waiting for approval from the System and if there was anything the Board could do to support. CM explained the Trust have received a letter of support from the ICS and a positive session was held regarding the vision and direction of the case. The Trust is now waiting final approval from NHS improvement. There is funding allocated for the system but formalities are outstanding. The Board noted the Chairs assurance report.

29/01/4.1	**PERFORMANCE REPORT (MONTH 8)** KR outlined the performance reporting explained it is presented to note the assurances provided against the overall performance but also recognising the impacts due to Covis-19. KR highlighted that not all targets are being met, but the exception report presented provide actions being taken. *Caring for Staff - Sickness Absence:* ▪ Metric showing special cause variation of a concerning nature; above control range in December ▪ Short term sickness showing special cause variation of concern and been above target for five consecutive months ▪ Long term sickness above target for seven consecutive months FC queried the consequences for the Trust in relation to the sickness levels. SEA explained there has been an increase in patient cancellation due to the Trust being unable to staff the wards safely therefore there has been an operational impact noted. *Caring for Patients* ▪ RJAH Acquired C.Difficile - low number of incidents have taken place ▪ RJAH Acquired E. Coli Bacteraemia - low number of incidents have taken place ▪ Unexpected Deaths - low number of incidents have taken place ▪ Cancer Plan 62 Days Standard - failure to meet standard in November (reported in arrears) ▪ 18 Weeks RTT Open Pathways o Metric is showing special cause variation of concerning nature and continues to fail the 92% target. As expected from covid impact, this will continue for a significant time. o Whilst this metric remains affected from the covid impact, and will not be met, NHSEI H2 planning guidance has set out the expectation that Trusts should stabilise waiting list numbers at the level seen at the end of September 2021 as the assurance around process rather than target. ▪ Patients Waiting Over 52 Weeks o Presentation includes combined number of patients, together with breakdown of English, Welsh & BCU Transfers. o Both English and Welsh showing special cause variation with increases reported this month. o BCU Transfers shows sustained improvement o NHSEI H2 planning guidance documents that as a Trust we should hold or where possible reduce the number of patients waiting over 52 weeks. For month 9 our English patients waiting over 52 weeks is 192 patients below our planned trajectory and Welsh patients 112 below our planned trajectory. ▪ 6 and 8 Week Wait for Diagnostics o Both metrics remain behind target and show as special cause variation of a concerning nature HT suggested that in order to demonstrate the focus on the 104weeks the information should be reported to the Board and not only the Finance, Planning and Digital Committee to which the Board agreed. CB highlighted that over half of the patients on the 52weeks are outstanding which has been a noted issue for the NHS and asked for further clarification on how to support. KR explained some of the actions taken by the Trust include, returning of retired consultants, employing locums, mutual aid with Stanmore as well as exploring the local independent sector. Awareness has been noted by the regional team as this is a national issue. KR reminded the Board that the Trust provides a Welsh service for spinal disorders and that is causing some of the disconnect in terms of our clinical priorities. Further information, including priority tools is to be reported to the FPD Committee. FC suggested the information should be flagged through to the system to which KR explained the Trust continue to meet with the system and region frequently. *Caring for Finance* ▪ Total Elective Activity o 93.70% of plan achieved in December o 79.30% of 19/20 baseline

	▪ Total Outpatient Activity o 93.25% of plan achieved in December o 84.19% of 19/20 baseline ▪ Bed Occupancy – All Wards – 2pm o Metric shown as special cause variation of an improving nature, although consistently failing target ▪ Expenditure o Adverse in month CB highlighted the private patient income begin reported a head of plan and on behalf of the Board and the public asked for further assurance on the allocation of theatres which could potentially be used for NHS patients. CM reassured the Board that NHS patients are not displaced by private work and continued to explain the Trust have previously set a lower plan, and the second impact being the Trust has worked to fill the theatre capacity and where able to allocate lists for a variety of reasons of consultants based on patient availability. Private patients' lists are offered and confirmed on a last-minute basis to ensure the Trust utilise capacity to the full potential. CB thanked the Trust for the reassurance. AT added the information was discussed at the FPD Committee earlier in the month and assurance was obtained. The Committee noted the performance report.
23/09/2.0	**PLANNING GUIDANCE AND TIMETABLE** KR explained the planning guidance sets out the requirement for 2022/23, which outlines the priorities. There are a set of 10 priorities and the Trust have received a report of those which impact the organisation. The Trust recognised that as part of the operating within the wider system, the Trust will need to be aware of all requirements. ▪ **Workforce**: o workforce plan requirements o recruitment o retention o well-being o equality o new models of care; different roles o system bank o agency reduction o training provision o job planning – highest attainment levels o e-rostering – highest attainment levels. ▪ **Elective recovery**: o activity (110% 2022/23 to 130% 2024/25 against pre covid baseline) o diagnostics (120% 2022/23 against pre covid baseline) o waiting times standards (104 weeks, 78 weeks, 52 weeks) o cancer standards (Feb 2020 performance for 62 days, improvement in all cancer standards) o PIFU o advice and guidance o bed capacity (pre-covid minimum level) o delayed discharges (to be sustained) ▪ **Digital:** o deliver pathology and imaging digital road map (10% productivity improvement output in 2024/25) o access to the Local Care Shared Record across NHS and LA providers o technical capability required for population health management o first year's priorities for achieving a core level of digitisation by march 2022; o Costed three-year digital investment plans by June 2022 o skilling up workforce to maximise the opportunities of digital solutions o NHS e-referral service (e-RS) to become an any-to-any health sector triage, referral and booking system by 2025.

	▪ **Finance:** o 1 year revenue allocation to be issued and 3-year capital allocation. o Significant additional efficiencies expected, on top of the NHS Long Term Plan requirements, moving back to and beyond pre-pandemic levels of productivity o financial objective to deliver a financially balanced system (duty on breakeven), o written contracts between commissioners and all providers (NHS and non-NHS) will be needed to cover the whole of the 2022/23 financial year. o System allocation or specific identified funding stream expectations are noted in further detail in the paper where identified. ▪ **Additional Board level requirements:** o Trust performance packs are expected to be disaggregated by deprivation and ethnicity o board level Net Zero lead and a Green Plan and are asked to deliver carbon reductions against this throughout 2022/23. KR reminded the Board that the submission is completed as part of the System and not by individual organisations – the draft submission is due on 17th March with the final being submitted on 28th April. KR presented the planning guidance timetable for information highlighting the draft and final submission dates. The Committees will receive oversight of the draft submissions and it was noted the Trust will struggle to hit the activity levels reported without transformation. The Trust will continue to prioritise the spinal disorders patients which will have an effect on cases per session and staffing. PK asked how is the Trust communicating the requirements to staff members? FC agreed with PK comments adding there is an internal communication on this, both around workforce, availability, and expectation of awareness and encouraged the Trust to keep staff informed. SK added the Senior Leaders are already in discussions on sharing the information including an explanation of the Trusts finances. The Board noted the planning guidance and timetable and thanked the Executive Team in advance on working to report the detail at subsequent meetings.
23/09/2.0	**CHAIR REPORT – AUDIT AND RISK COMMITTEE** AT presented the assurance report to the Board, highlighting the following: ▪ Good discussion through out the meeting which was well attended ▪ Further assurance was required in the following areas: o Delays in approvals relating to risks, incidents and policy approval – assurance was obtained on areas being prioritised. o The security annual report was presented to us relating to back last April – the workplan has been amended to ensure timely reporting. o Further assurance required linking the hospitality register to the Trust policy to allow for further scrutiny o There are a number of internal audit outstanding in the final month to be reported – the Trust will continue to monitor through monthly meetings o Moderate assurances was given on the delayed discharges internal sudit due to paperwork not being completed in full. The policy has since been reviewed and in live on the document centre. o Substantial assurance was received on the main finanical systems and planned care internal audits The Committee noted the Chair assurance report.
23/09/2.0	**REVIEW OF STANDARD FINANCIAL INSTRUCTIONS AND SCHEME OF DELEGATIONS** CM presented the document which is reviewed on an annul basis. CM informed the Board there have been a couple of minor changes made to schema of delegations only.

	The information has been presented to the Audit and Risk Committee earlier in the month and were supportive of the proposed changes. The Trust ask for formal approval from the Board of Directors. The Board approved the Review od Standard Financial Instructions and Scheme of Delegation.
23/09/2.0	**ANNUAL REPORT AND ANNUAL ACCOUNTS REPORTING TIMETABLE** SR presented the usual timetable which is shared in preparation for the Annual Report and Annual Accounts. SR reminded the Board each assurance Committee will have the opportunity to consider ahead of formal approval. The Board approved the recommendation for the Audit and Risk Committee to have delegated authority to approval the accounts on behalf of the Board of Directors.
23/09/2.0	**QUESTIONS FROM THE GOVERNORS** None to note.
	ANY OTHER BUSINESS:
23/09/2.0	**QUESTIONS FROM THE PUBLIC** None to note.
23/09/2.0	**ANY OTHER BUSINESS** Farewell to Frank Collins – HT thanked FC on behalf of the Board and highlighted FC unique character and that the Trust has had the pleasure of seeing through integrity., ambition, passion and humour which many have appreciated, particularly in difficult times. HT continued to say a big thank you from the workforce and a big thank you on behalf of the all the patients that have passed through big thank you from the system for what you have done and when and lastly a big thank you on behalf of the Board for his leadership and his support over the years. In return FC reflected on his past 7years of employment with the Trust highlighting the challenges and success.
	CLOSING REMARKS: For FC thanked everyone for attending the meeting and for their contribution in the discussions.
	NEXT MEETING: PUBLIC MEETING – TO BE CONFIRMED

BOARD OF DIRECTOR – PUBLIC MEETING
29 JANUARY 2022
SUMMARY OF ACTIONS

REFERENCE/TITLE	LEAD	STATUS
Actions from the Previous Meeting – November 2021		
None outstanding.		
Actions from the Meeting – January 2022		
None to note.		

CQC HDU update 2022

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Aspiring to deliver world class patient care

CQC – Critical Care

In 2018 the CQC rated Critical Care as the following;

- Is the service safe?

  Requires Improvement

- Is the service effective

  Requires Improvement

- Is the service caring?

  Good

- Is the service responsive?

  Good

- Is the service Well-led?

  Requires Improvement

Overall Rating

Requires Improvement

Aspiring to deliver world class patient care

Is Our Service Safe?

Key areas identified for Improvement 2018:

- Mandatory training compliance, inclusive of sepsis training.
- Limited cover by Outreach team at times as a result of responding to hospital wide pressures.
- The service did not have enough medical staff with the right qualifications, skills, training and experience.
- Shift patterns, handover and ward round arrangements for duty anaesthetists were not in line with recommendations.
- Allied health professionals staffing not in line with national standards.
- Medicines Management; assurance of practices.

Is Our Service Safe?

Actions completed:

- Sepsis Training is covered within ILS, Higher level sepsis learning module is being developed with SATH.
- Critical Care Outreach service is now 24/7 and a separate hospital cover rota now exists to free them for patient care in the daytime.
- Allied health professionals now are embedded within the structure of HDU and involved in it's Well Led meetings.
- Pharmacy now has dedicated support to HDU, and is involved with their regional critical care networks.

Guidelines for the Provision of Intensive Care Services

In 2019 the Faculty of Intensive Care Medicine updated their guidelines for the provision of Intensive Care Services, with specific reference to organisations that provide only level 2 care for patients.

"A subset of remote and rural hospitals provide only Level 2 beds accompanied by a stabilisation and transfer service for Level 3 patients. Sustaining a service is difficult without Level 3 patients on site, and it may be difficult to attract consultants in Intensive Care Medicine such that care cannot be directly provided by a consultant trained in ICM. In such circumstances, alternative models of support are needed. A supportive network structure is therefore essential for staff to feel confident in dealing with a deteriorating patient. It is imperative that remote and rural Level 2 units should have immediate access to telephone or telemedicine advice from professionals in a Level 3 unit or retrieval service over secure means of communication, allowing specialist advice and support at all times. In these hospitals, maintenance of competencies is challenging and staff should have full access to training and support to enable them to fulfil their role in providing the service. In units close to other centres, it may be possible for staff to have a job plan involving two sites. In very small isolated hospitals, staffing may be further compromised in the current workforce climate and pragmatic management of limited resources may be necessary. These units should also be able to evidence adherence to recommendations and standards, even though the solutions they reach will be different to larger less remote units."

Is Our Service Safe?

- Gap analysis has been performed against GPICS standards and action plans completed. Areas of non-compliance are captured on the risk register.
- A Service Level Agreement with UHNM is in place for advice and guidance on critical care patients. The agreement also offers the opportunity for the organisation's anaesthetists to 'shadow' at UHNM.
- There is now a regional critical care transfer team (AACOTS) to assist and advise on transfers to level three care.
- Arrangements for medical staffing;
  - ✓ Duty Anaesthetist is now free from other duties when on cover for the unit.
  - ✓ There is a second cover anaesthetist in hours to assist with emergencies.
  - ✓ Handover between duty anaesthetist and theatre is documented in the HDU pathways.
  - ✓ Ward rounds now twice daily (morning and evening) and recorded to EPR to assist handover. (Audited as part of well-led process).
  - ✓ Critical Care Operational Policy clearly defines roles and responsibilities of the duty anaesthetist.

Is Our Service Effective?

Key areas identified for improvement 2018:

- Monitoring effectiveness of care and treatment outcomes were not being used to improve practice.
- Policies, Procedures and protocols were not always in date.
- Little involvement with peer review, benchmarking or accreditation schemes.
- Lack of engagement in Clinical Audit
- Limited opportunities to identify learning needs of all staff, to support and manage staff in delivering effective care and treatment.
- Some services not available seven days per week
- Mental Capacity assessments

Is Our Service Effective?

Actions completed:

- ICNARC fully implemented and results shared with Patient Safety Committee. Outcomes consistently positive compared with other units.
- Monthly audit of all unplanned admissions discussed at Well-Led meeting. Learning and education from this fed back via practice educators to wards. Summary of learning shared via Patient Safety Committee and also Hospital Quality Forum.
- Policies, Procedures and Protocols tracked, updated and reviewed at Well Led meeting.
- Tendable and other audit tools are now used for assurance audits, including IPC, documentation, Sepsis, falls, and patient experience data.
- Identified areas for learning and improvements discussed at the Well-led meeting, minutes shared with staff.

Is Our Service Effective?

Actions completed:

- Clinical Nurse Educator appointed to support the development of staff.
- Quarterly clinical development sessions led by the Clinical Lead for nursing staff on the unit.
- Training needs analysis completed for staff on the unit.
  - Critical Care specific qualification.
  - Competency framework document, completion of parts 1 and 2.
  - Transfer Training (for anaesthetic staff also) completed for all on-call staff.
- Patients have a CAM score completed 12 hourly. If CAM positive there is a flow chart for staff to follow, ensuring correct process is followed.

Is Our Service Well-led?

Key areas identified for improvement 2018:

- Challenges to quality and sustainability were understood but it was not clear whether actions were being taken to address them.
- There was no systematic approach to continually improving the quality of services and safeguarding high standards care.
- There were no specific governance arrangements for the high dependency unit
- The trust had a system for identifying risks, planning to eliminate or reduce them but there was a lack of assurance all risks associated had been recorded and mitigated.
- There were service performance measures which were reported but it was unclear whether they were being effectively monitored or used to improve practice.

Is Our Service Well-led?

Actions completed:

- HDU Well-led meeting occurs on a monthly basis and consists of Clinical Lead, Matron, Unit Manager, ICNARC Clerk, Outreach, HDU Clinical Practice Educator, Resuscitation officer, Acute Pain team, Physiotherapy and Pharmacy. The agenda comprises;
  - Risk Register and monitoring progress on actions to mitigate risks.
  - Datix Incidents, complaints and compliments.
  - KPI Monitoring.
  - Quality Improvement Initiatives (Deteriorating patient and transfer reviews).
  - ICNARC Data.
  - Service planning and development, including review of policy updates.
  - Speciality updates from the other teams.
  - Monthly team award.
- A report containing Learning, risks or concerns is raised monthly to Patient Safety Committee and MSK governance committee (with upward reporting to Q+S).

Moving Forward

- Hospital at Night once 24/7 outreach embedded.
- Nursing education (Critical care course).
- Medical education (HDU Shadowing at SATH or UHNM).

Questions

Acronyms

- HDU High Dependency Unit
- CQC Care Quality Commission
- ILS Immediate Life Support
- GPICS Guideline for Provision of Intensive Care Standards
- UHNM University Hospital North Midlands
- AACOTS Adult Critical Care Transfer Services
- EPR Electric Patient Record
- ICNARC Intensive Care Nation Audit and Research Centre
- SaTH Shrewsbury and Telford Hospital
- IPC Infection, Prevention and Control
- CAM Confusion Assessment Method
- Q&S Quality and Safety

0. Reference Information

Author:	Stacey Keegan, Interim Chief Executive Officer	Paper date:	6 April 2022
Senior Leader Sponsor:	Stacey Keegan, Interim Chief Executive Officer	Paper written on:	1 April 2022
Paper Reviewed by:	N/A	Paper Type:	Update
Forum submitted to:	Board of Directors - Public Session	Paper FOIA Status:	Full

1. Purpose of Paper

1.1. Why is this paper going to Trust Board and what input is required?

This paper provides and update to Board members on key local activities not covered within the main agenda.

2. Executive Summary

2.1. Context

This paper provides an update regarding some of the most noteworthy events and updates since the last Board from the Interim Chief Executive's position.

2.2. Conclusion

The Board is asked to note and discuss the contents of the report.

3. The Main Report

The Robert Jones and Agnes Hunt Hospital (RJAH) Update

3.1. Executive Director Recruitment

In March 2022, we commenced our recruitment process for our Chief Operating and Chief People Officers, both posts will be voting members of the Board. Shortlisting has taken place and interviews scheduled for the 7th of April 2022.

3.2. Quality Data Provider by National Joint Register

RJAH was named as a National Joint Registry Quality Data Provider for the second year running after meeting a series of targets during an audit period. It means RJAH meets the blueprint for high-quality data relating to patient safety.

3.3. Saplings planted to mark milestones

100 saplings were planted around the Path of Positivity at RJAH as part of the Queen's Green Canopy along with commemorating the 100-year anniversary of RJAH moving to its current site in Gobowen.

The Queen's Green Canopy is a tree planting initiative to mark 70 years since The Queen's ascension to the throne where people are invited to plant a tree for the jubilee.

Thank you to the RJAH Charity and Access Tree Services for the donation of saplings.

3.4. Occupational Therapy equipment

A £225,000 investment of rehabilitation equipment has been received at RJAH thanks to funding from NHS Commissioners for Spinal Injuries and NHS England and Improvement. The state-of-the-art collection of upper limb rehabilitation equipment will be used to support spinal cord injury patients with their rehabilitation.

3.5. Surgeon takes gold in Registry Award

Mr Nilesh Makwana was awarded the Registry Gold Award by the British Orthopaedic Foot and Ankle Society for entering the most patient data out of all foot and ankle surgeons in the country for the second year running. The registry is used to collect patient outcomes to ensure patient care and experience are improved.

3.6. Electric Vehicle charging points installed

We are further reducing our impact on the environment and protecting environmental resources with the installation of eight electric vehicle charging points on the hospital site.

They form part of the new Headley Court Veterans' Orthopaedic Centre – the bespoke £6million facility being built at RJAH.

3.7. Overseas NHS Workers Day

In March, we marked Overseas NHS Workers Day by celebrating some of our fantastic overseas staff at RJAH and the impact they have on the organisation. Thank you to all our overseas workers

3.8. Second cohort of Trainee Nurse Associates

At the end of March, we welcomed our second cohort of Trainee Nurse Associates to the Trust. They are working in a range of clinical areas, including inpatient wards, Main Outpatients and Pre-op Assessment, at RJAH as well as studying at Staffordshire University. The two-year foundation degree will train Nurse Associates to bridge the gap in skills between healthcare assistants and registered nurses.

3.9. Heath Hero Awards

Our February winner was Finance Business Partner Andrew Williams who was nominated for stepping up to cover sickness absence within the team. Andrew was hailed for going above and beyond to ensure the needs of the Clinical Services Unit were met.

Well done, Andrew!

Our March winner was Telephonist Tracy Knight who works as part of our Switchboard team.

Tracy was hailed for taking on added responsibilities within the team, and also giving up her weekends and days off to support the Covid Vaccination Service by picking up shifts within the Vaccination Centre.

Well done, Tracy!

Shropshire, Telford and Wrekin (STW) Integrated Care System (ICS) Update

3.10. Executive and Non-Executive Appointments

Four new appointments to the STW Integrated Care Board (ICB) have been confirmed.

- Chief Finance Officer – Claire Skidmore
- Chief Medical Officer – Mr Nick White
- Director of Delivery and Transformation – Gareth Robinson
- Director of Strategy and Integration – Nicola Dymond

It is expected that the appointment of the Chief Nursing Officer will be announced in April 2022. At that point the recruitment process for the STW ICB will be complete.

Regarding Non-Executive Director appointments, the Regional Director has supported the appointments of the following candidates.

- Chair of the Digital Committee – Dr Niti Pall
- Chair of the Audit Committee – Roger Dunshea
- Chair of the Remuneration Committee – Professor Trevor McMillan.

3.11. Elective Hub

Targeted Investment Funding (TIF) of up to £24 million has been provisionally reserved for STW for phase 1&2 of an elective hub at Princess Royal Hospital (Telford), a further bid by RJAH has been put on a reserved list. PWC have been commissioned to support the system in completing a business case in line with regional/national timelines. The hub will provide much needed ring-fenced elective capacity to support elective recovery.

3.12. Getting it right first time (GIRFT) National Visits

Getting It Right First Time (GIRFT) is a national programme designed to improve the treatment and care of patients through in-depth review of services, benchmarking and presenting a data driven evidence base to support change.

Professor Tim Briggs and the national team made their virtual visit to STW on the 11th of March 2022. The feedback for the system was very encouraging, most areas/services were doing very well against the GIRFT standard and in a few metrics the system is the best in the country. The GIRFT team are keen for the good practices to be shared with other systems.

Orthopaedics are in the upper decile for hip and knee patient PROMS (Patient Recorded Outcome Measures), with improvement required in length of stay.

3.13. LGBTQ+ History Month

At the end of February, for LGBTQ+ History month, I gave a radio interview reflecting on my personal experiences and how STW ICS are supporting the LGBTQ+ community with our system LGBTQ+ network and resources.

3.14. Conclusion

The Board is asked to note and discuss the contents of the report.

Chair's Assurance Report
Quality and Safety Committee 17 March 2022

0. Reference Information

Author:	Mary Bardsley, Assistant Trust Secretary	**Paper date:**	6 April 2022
Executive Sponsor:	Chris Beacock, Quality and Safety Committee Chair	**Paper written on:**	30 March 2022
Paper Reviewed by:	N/A	**Paper Category:**	Governance and Assurance
Forum submitted to:	Board of Directors	**Paper FOIA Status:**	Full

1. Purpose of Paper

1.1. Why is this paper going to the Trust Board and what input is required?

This paper presents a summary of the Quality and Safety Committee meeting held on 17 March 2022 for assurance purposes. The Trust Board is asked to consider the assurances provided and whether any additional assurances are required.

2. Executive Summary

2.1 Context

The Board of Directors has delegated responsibility for the oversight of patient safety and quality to the Quality and Safety Committee. This Committee is responsible for seeking assurance on the quality and safety of the services it delivers in order that it may provide appropriate assurance to the Board.

2.2 Summary

- The Committee were quorate
- The Committee received the standard agenda items which included the SI and Never Events paper, a Unit quality report, the Harms presentation and the performance report.
- The Committee received a presentation regarding the Operational Plan for 2022/23
- The Committee approved the NICE Policy, VTE policy and Duty of Candour Policy – subject to minor amendments
- It was noted through the Committee workplan that all IPC agenda items would be discussed at the Extra Ordinary Quality and Safety Committee later in the month
- Areas to highlight to the Board include:
    - The Committee is to receive an assurance report on clinical prioritisation at the next meeting
    - The governance arrangements for the Health and Safety Committee is to be discussed within the Trust as concerns raised regarding the appropriateness of the Chair. Along with confirmation regarding the inspections completed with Horatio's Garden

2.3. Conclusion

The Trust Board is asked to note the Chair's Report for assurance purposes and consider any additional assurances required.

Chair's Assurance Report
Quality and Safety Committee 17 March 2022

3. Main Report

3.1 Introduction

This report has been prepared to provide assurance to the Trust Board from the Quality and Safety Committee which met on 17 March 2022. The meeting was quorate with 1 Non-Executive Directors and 2 Executive Directors in attendance. A full list of the attendance is outlined below:

Chair/Attendance:	
Membership:	
Chris Beacock	Non-Executive Director (Chair)
Sara Ellis Anderson	Interim Chief Nurse and Patient Safety Officer
Ruth Longfellow	Chief Medical Officer
In Attendance:	
Shelley Ramtuhul	Trust Secretary/Director of Clinical Governance
Hilary Pepler	Trust Board Advisor
Dawn Forrest	Managing Director for Specialist Unit
Alyson Jordan	Managing Director for Clinical Services and Support Services Unit
Mark Salisbury	Operational Director of Finance
Nia Jones	Head of Planning
Phil Davies	Head of Estates and Facilities
Tracey Slater	CCG Representative (observing)
Hayley Cavenagh	CCG Representative (observing)
Lorraine Fearne	Minute Secretary
Apologies:	
Apologies were received from Paul Kingston and Stacey Keegan	

3.2 Actions from the Previous Meeting

The Committee discussed the action plan in detail and an update was provided for each action. There were 4 actions noted as outstanding a forwarded on to the next meeting.

3.3 Key Agenda

The Committee received all items required on the work plan (except IPC agenda items) with an outline provided below for each:

Agenda Item / Discussion	Assured (Y/N)	Assurance Sought
1. Declaration of Interest		
There was no declaration of interest shared	N/A	
2. SI and Never Event Report		
Due to the time in which the paper is written a verbal update will be presented on those actions which are overdue to ensure the Committee can gain assurance.	Yes	

Chair's Assurance Report
Quality and Safety Committee 17 March 2022

The Committee were assured of the process in place regarding the SI and Never Events.		
3. DATIX update		
The Trust informed the Committee that a new DATIX field will be added to the system. Currently the unit reports the incident is then logged against the unit, this is not necessarily where the incident happened, and this was causing some conflict. The Committee agreed to the change in reporting.	Yes	
4. PROMS Update		
The Committee received an overview of the PROMs Performance Overview relating to English patients only. For primary knee replacements, the average pre-op score is worse than other providers, which indicates that RJAH patients are starting off with more severe disease which may be due to the demographic of the patients and reported this is the same for Primary hip replacements. Post-op scores are very good and the health gain RJAH patients received was better than any other provider. RJAH report outside the boundaries of the funnel plots which shows a positive health gain for patients greater than other providers.	Yes	Assurance sought on the PROMS data presented however information on Welsh patients is to be incorporated for the next report.
5. Harms Presentation		
The Committee were informed that: • In phase one the updated number outstanding now stands at 33. 28 of these were query moderate harms and 13 were moved to lower harm, 8 have clinical appointments booked, 6 are awaiting clinical appointments and 1 is being investigated as a potential severe harm and Duty of Candour process is being followed • Phase two, as of 10th March there were 549 harms reviews completed and there are currently 703 patients in the long wait category • Cohort one patient review is now completed. The Committee commended the Trust on the work completed to date and it was noted that the CCG have arranged a system meeting to ensure the system are aware of the improvements seen.	Yes	
6. Clinical Prioritisation		
In line with the new planning guidelines the Committee were advised the Trust will replicate the harms review model for Clinical Prioritisation. The following options were presented to the Committee for consideration: 1. Replicate harms review process across all specialities, this would involve creating a new team to take on workload which would take some time as there are currently 700 patients to review and increasing.	Partial	Verbal update was obtained at the meeting. Further information on the Clinical Prioritisation to be reported at the next meeting. The Committee agreed for the subject to become a standard

Chair's Assurance Report
Quality and Safety Committee 17 March 2022

2. To make use of the My recovery app which is an option for some but not all patients 3. To create a new admin team and identify clinical people who can report and take forward to the individual specialities. The Trust agreed to share further information at the next meeting as the project commences.		agenda item and added to the work plan
7. My Planned Care App		
The Committee received an overview of the My Planned Care project for information. It was noted that NHSEI have provided 13 procedures for the Trust to work through which will each involve a template being completed with an overview of the headings included in the meeting pack adding the Trust is on target to have the templates uploaded on the 25th of March and will go live on the 31st of March. The Trust advised that there was no new information and the material provided already exists. Discissions were held in relating to health inequalities and if some patients were at a disadvantage with not having access to digital services/devices. The Trust agreed to feedback to NHSEI the concerns of the committee regarding digital inequalities.	Yes	
8. Performance Report		
The overview included: ▪ One SI – relating to a patient requiring intervention following vomiting on anaesthetic induction ▪ eight complaints didn't meet the standard 25day response time. ▪ 53 cancellations in February, which gives a cancellation rate of 6.5%. Mostly due to staff sickness, COVID and patients being medically unfit/Covid ▪ a drop in cancer target performance. Cancer, 62day standard reported at 33% in January and advised the committee this was in relation to two breaches, one was related to patient choice and the second, a deep dive is to be completed Assurance was obtained on the hospital acquired VTE and the reporting figures by assuring the CCG that the VTE committee do a comprehensive root cause analysis on all VTE cases and no themes have been found and reported.	Yes	The Committee were assured that there is a process are in place in order to manage the performance issues raised.
9. Clinical Service Unit Quality Report		
The Committee commended the unit on the completion of the spot check/investigation work undertaken and suggested this is shared across the wider organisation.	Yes	

Chair's Assurance Report
Quality and Safety Committee 17 March 2022

There was a noted delay in IPC audits due to staff sickness however, this is currently being overseen by the hygiene gap analysis. The Committee suggested an action plan is created in relation to the bare below the elbows as this is a noted difference in the data reported which has been completed through a peer review.		
10. Operational Plan Presentation		
The Committee received the draft Operation Plan in relation to the quality aspects which included bed occupancy, clinical prioritisation, cancer standards, delayed transfers of care, pathology network, population health management and addressing health inequalities and concluded with use of antibiotics. The Committee were content that the information listed in the presentation is already overseen by the Committee and noted within the workplan.	Yes	
11. NICE Policy		
The Committee approved the NICE Policy which has been overseen by the Clinical Effectiveness Committee. Going forward the Committee will receive a bi-annual report regarding the compliance levels for the Trust against NICE Guidelines.	Yes	
12. Duty of Candour Policy		
The Committee approved the Duty of Candour Policy – a minor amendment was requested; incorporate the definition of low, moderate, and severe harm which the Trust agreed too.	Yes	
13. VTE Policy		
The Committee approved the VTE Policy which was also presented to the VTE Committee and the Patient Safety Committee for consideration.	Yes	
14. Chair Report – Research Committee		
Due to the absence of the Managing Director, the Chairs Reports was deferred to the next meeting	N/A	
15. Chair Report – Health and Safety Committee		
Concerns were raised in relation to the H&S advisor chairing the Committee in the Chairs absence. Discussions were held regarding the Horatio's Garden completing their own EHO inspection and involvement from the Trust should be incorporated as landowners. There is a requirement for the Board to receive IOSHH training however this is being investigated to source the most suitable delivery of the training.	Partial	Further information on Horatio's Garden to be shared at the next meeting. Discussion to be taken place regarding the terms of reference for the H&S committee
16. Chair Report – Patient Safety Committee		
The Trust reported a decrease in incident reporting and advised this was being monitored and understands this may be down to improved staffing levels on MCSI. The Committee were advised that the Patient Safety Committee wished to escalate the delay in implementation of the 'My Recovery' app as a risk.	Yes	

Chair's Assurance Report
Quality and Safety Committee 17 March 2022

17. Chair Report – Trust Performance and Improvement Board		
The Committee noted the Chairs report which is shared for information only.	N/A	
18. Chair Report – ICS Quality Committee		
The Committee noted the Chairs report which is shared for information only.	N/A	
19. Review of the Work Plan		
The Committee noted the workplan for 2022/23 and will continue to reflect upon the document throughout the year.	N/A	
20. Attendance Matrix		
The Committee noted the attendance matrix which is shared for information.	N/A	

3.4 Approvals

Approval Sought	Outcome
NICE Policy	Approved
Duty of Candour Policy	Approved
VTE Policy	Approved

3.5 Risks to be Escalated

In the course of its business the Committee confirmed there are no risks to be escalated to the Board along there are areas which the Committee has requested further assurance on.

4. Conclusion

The Board of Directors is asked to note the meeting that took place and the assurances obtained.

Infection Prevention & Control & Cleanliness Quarter 3 Report 2021/22

0.0 Reference Information

Author(s):	Infection Control Team	Paper date:	6 April 2022
Executive Sponsor:	Sara Ellis-Anderson	Paper Category:	Governance and Quality
Paper Reviewed by:	Quality and Safety Committee 17/02/2022	Paper Ref:	N/A
Forum submitted to:	Board of Directors	Paper FOIA Status:	Full

1.0 Purpose of Paper

1.1. Why is this paper going to Trust Board and what input is required?

The Board is asked to note the progress report against the annual plan for Infection Prevention and Control and Cleanliness Report. The report has previously been presented to the Infection Control Committee and the Quality and Safety Committee in February 2022.

2.0 Executive Summary

2.1. Context

Through the monthly Board performance report, the Board are briefed on the mandatory HCAI surveillance and any key issues emerging from those results. Over and above the mandatory reporting, the Board receive a report at least four times per year from the Director of Infection Prevention and Control (DIPC) (Chief Nurse).

2.2. Summary

	MRSA Bacteraemia	MSSA Bacteraemia	E.coli/Pseudomonas/Klebsiella Bacteraemia	C.*difficile*
Month	**No. of Cases**	**No. of Cases**	**No. of Cases**	**No. of**
Oct	0	0	0	0
Nov	0	0	0	0
Dec	0	0	1	1
Quarter	**0**	**0**	**1**	**1**

- 1 E-coli bacteremia in Dec 21. To date there have been 2 cases of E.coli blood stream infections against a target of 7 cases
- 7 IPC Quality assurance audits conducted
- Not all wards/departments have QR codes and access to Tendable relying on paper audits continuing.
- Overall 98.6% compliance in Hand Hygiene and 99.4% compliance in Bare Below the Elbow was achieved for this quarter with three areas falling below target for both, Kenyon, Ludlow and Pre-op assessment unit
- Individual RCAs and thematic analysis completed for Surgical Site Infections. One Together audit completed Dec 21.
- Four Covid-19 outbreaks – two of which reported as Serious Incidents due to disruption to service and escalation of care.

2.3. Conclusion

The Board of Directors are asked to note the IPC quarterly report. The summary in the main report shows current performance in cleanliness and infection control against the work plan.

3 The Main Report

3.1.1. Introduction

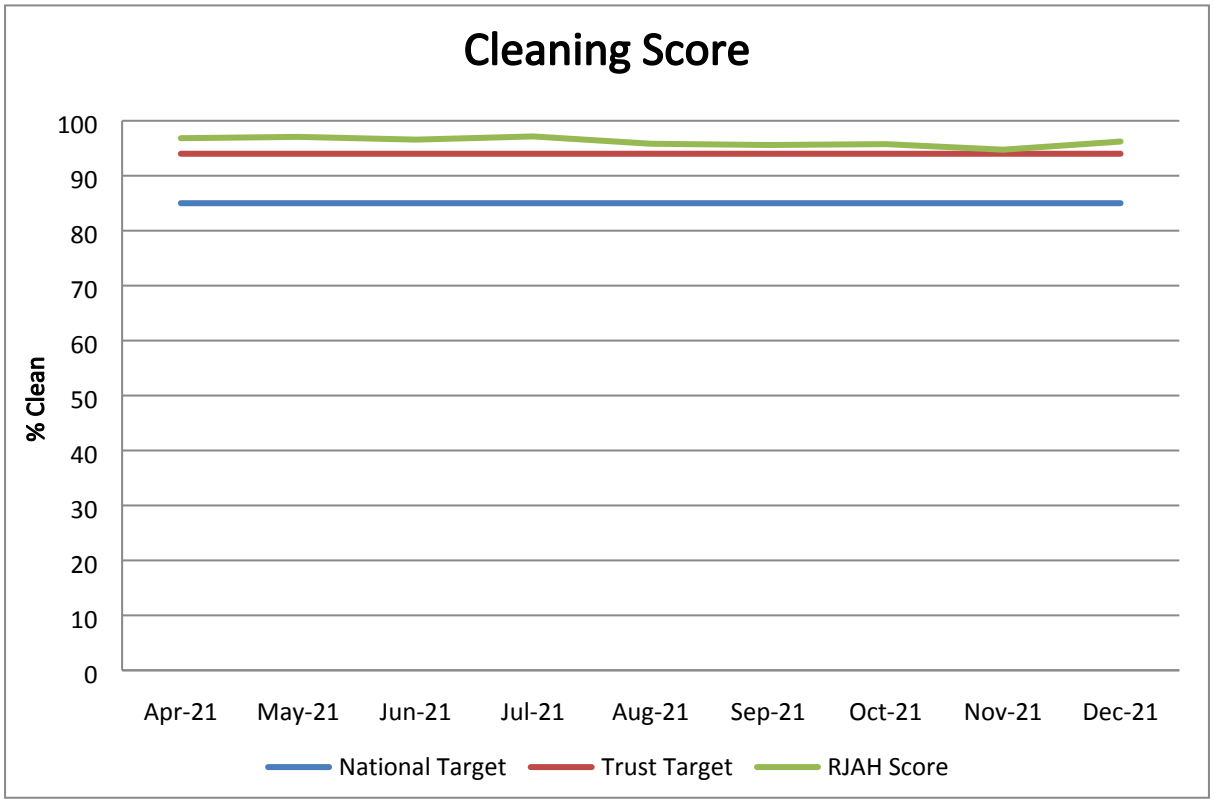
This report provides an update on progress made within Quarter 3, 2021/22 to the Board of Directors, to ensure that the Board are briefed at a high-level on any trends or issues that identify best practice or any gaps in assurance from which further work or actions are required.

3.1.2. Infection Prevention & Control Committee (IPCC)

The IPC Programme of Work (POW) 2021-2022 which is based on the 10 criterions set out in the Health & Social Care Act 2008 has been developed by the IPC team and was presented at IPCC in July 2021. The IPC POW has been added to the Quality Management System and will continue to be reviewed at IPC Committee.

3.2. Cleanliness

Measured cleanliness has been maintained above the National calculated target (85.0%) and Trust target (94.0%) over the most recent quarter, achieving an overall average for the quarter of 95.57% which is lower than recent reporting periods, this report will further detail reasons for this.



3.2.1. Cleanliness – Detail

7 functional areas did not meet their National Specification for Cleanliness target audit across the quarter – as demonstrated against their risk based target below.

Area Name	Target Score	Score
HDU	98%	97.51%
Menzies	98%	96.23%
Theatres	98%	95.77%
TSSU A	98%	92.97%
TSSU B	98%	96.43%
Wrekin	95%	92.43%
Occupational Therapy	85%	66.89%

Whilst some areas marginally missed their target (would have achieved 4* under the new standards), a focus on TSSU A has noted that the majority of fails came from wall damage. Estates are working to clag the walls with plastic to resolve the issue and address the long-term preventative approach. Occupational therapy scored a particularly low score on the back of poor standards in the heavy workshop. In association with other concerns, the facility has been closed pending a decision on the long term use of the space.

Over the quarter there were 22 instances reported where an individual area didn't meet its risk-based target for the month. Of these, 14 were in Very High-Risk Areas. Actions identified through this process continue to be raised via action sheets to the relevant team, which includes meeting with ward/department managers to discuss potential strategies to avoid repeated fails.

29% of the fails reported this quarter relate to damage/items requiring repair – highlighting the importance of collaborative working across the multi-disciplinary team to not only ensure adequate access can be gained to complete works, but also consider strategies to prevent further damage. Wall cladding, edge protections and effective use of storage can all reduce the likelihood of ongoing damage.

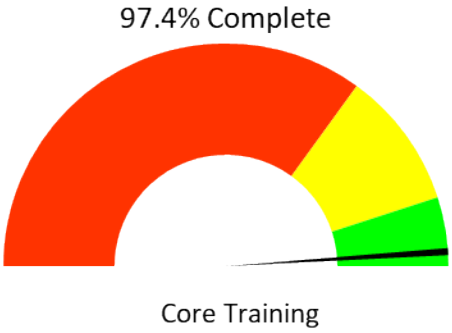
Over the quarter, the Trust has utilised external contractors to support a continued programme of deep cleaning of equipment – targeting wheeled items in particular to bring all items up to the required standard. This external team also worked in conjunction with the Trust team to complete ward deep cleans where closures were in place over the Christmas period – taking advantage of increased levels of access.

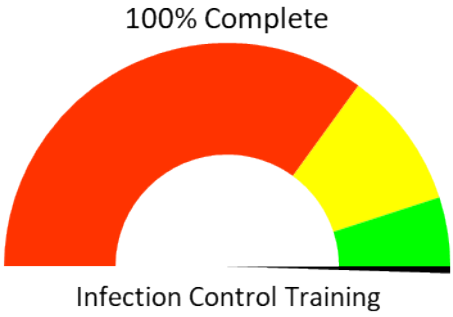
Going forward, consideration is being taken to understand a sustainable option to maintain standards. Any service changes will be discussed and reported through the infection control committee governance structure.

3.2.2. Cleanliness – Staff Competency

Training has a very high compliance for the rolling 12-month period, demonstrating our commitment to the highest level of staff competency. The rolling year position at end of December 2021 is shown.

Infection Prevention & Control & Cleanliness Quarter 3 Report 2021/22



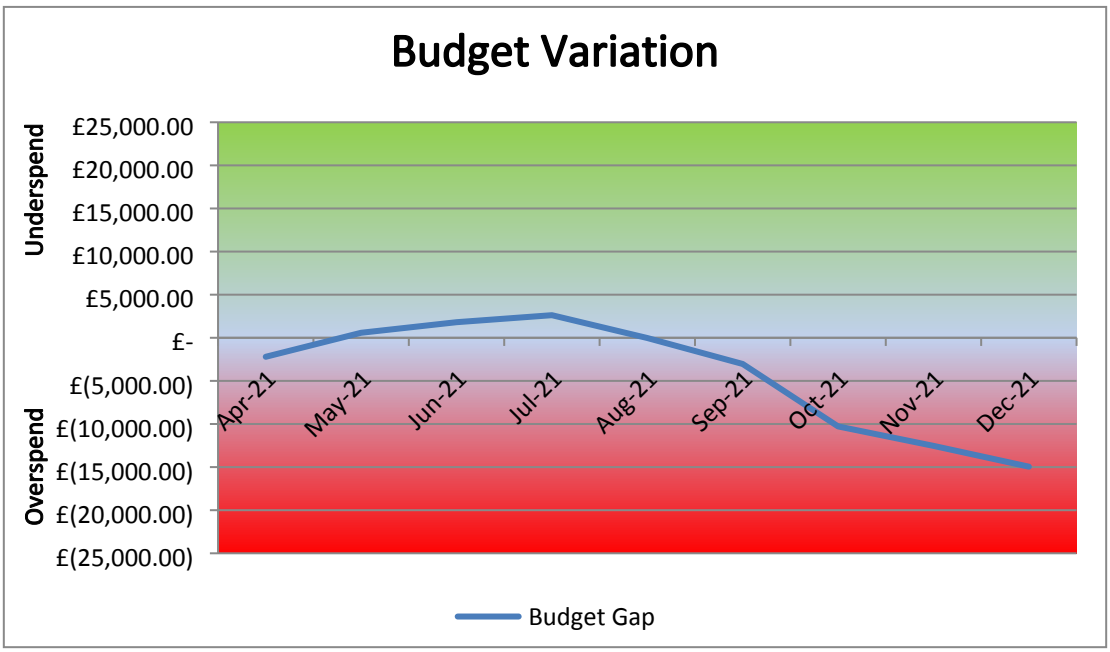


Staff across the Trust have also been required to complete NHS Midlands 'Cleaning for Confidence' programme, which reinforces the basic processes of cleaning and good cleanliness practice for staff in both clinical and non-clinical roles. Compliance at end of December 2021 is demonstrated below (rated against 92% target).

	Completed "in date" Cleaning for Confidence		
	Once Only		
Unit	**Number to complete**	**No's completed**	**% Complete**
Assurance & Standards Team	55	48	87.3%
Clinical Services Unit	308	284	92.2%
MSK Delivery Unit	424	388	91.5%
Office of the CEO	11	8	72.7%
Specialist Delivery Unit	293	279	95.2%
Support Services Unit	348	309	88.8%
Covid-19 Vaccination Centre	1	0	0.0%
TRUST WIDE TOTAL (Including Medical Staff)	**1440**	**1316**	**91.4%**
Bank Staff	154	120	77.9%
TRUST WIDE TOTAL (including Medical and Bank Staff)	**1594**	**1436**	**90.1%**

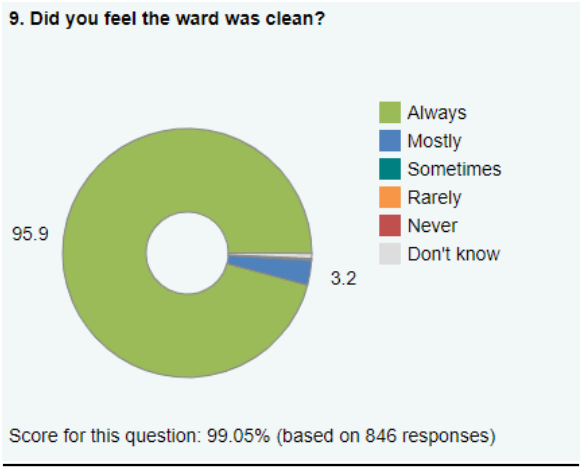
3.2.3. Cleanliness – Spend on Cleanliness

The below chart demonstrates the financial position at end of December. Increased spending on cleaning materials has taken the Trust from an underspend to overspend position. This reflects reduced PUSH stock provision and an increased number of enhanced cleans applied throughout the Trust.



3.2.4. Cleanliness – Patient Satisfaction

As part of feedback questionnaires, patients are routinely asked if their ward or department felt clean. Comments are regularly fed back to operational teams.



There were no comments, or detail relating to this specific question recorded, however feedback from the patient experience module included:

- From arrival to going home I was treated with so much care and respect. Everyone was so kind and professional. The cleanliness and quality of care was amazing. *(Baschurch, November 2021)*

- Hospital was nice & clean, good covid measures, friendly professional staff & excellent Doctor. *(Pre-Op, October 2021)*
- I was impressed and reassured by the Covid screening on entering the hospital and the cleaning taking place in the waiting area. I was very pleased with the thorough consultation itself and the fact that blood tests and x-ray were done while I was there and that there is a plan in place for follow up action. Although there was a 45-minute delay in seeing the doctor I was kept informed. The staff were very friendly and helpful. *(Main Outpatients, October 2021)*

3.2.5. Specific Cleaning & Cleanliness Improvements

HPV Decontamination:

The facilities team continues to provide HPV fogging decontamination in response to the Trusts needs via Dewpoint solutions. A summary of usage over the quarter is shown below. Following the update of the infection control isolation policy, room cleaning requirements are designated as:

- Green – Standard daily clean using detergent
- Amber – Terminal clean using 1000 ppm Chlorine Based Agent
- Red – Terminal clean using 1000 ppm Chlorine Based Agent followed by HPV fogging

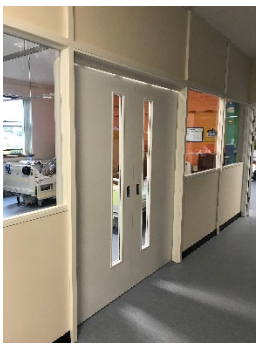
This protocol has ensured that there are no delays in the provision of enhanced cleaning whilst clinical sign off is sought.

All requests for HPV fogging this quarter were undertaken. HPV fogging undertaken on site this quarter is summarised below:

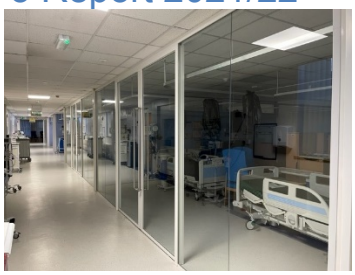
Date	Ward/Department	Area	Rationale
16/11/2021	Wrekin Ward	Side Room 2	RED Clean
02/12/2021	Wrekin Ward	Side Room 2	RED Clean
02/12/2021	Wrekin Ward	Side Room 7	RED Clean
02/12/2021	Gladstone Ward	Side Room 1	RED Clean
24/12/2021	Gladstone Ward	Side Room 1	RED Clean

Collaborative Working:

Through the IPC working group, the Estates & Facilities team continue to advocate a multi-disciplinary approach to environmental improvements across the Trust.



Installation of doors to bays on Sheldon ward.



Installation of doors to bays on Kenyon ward.

3.2.6. Compliance Update - Facilities

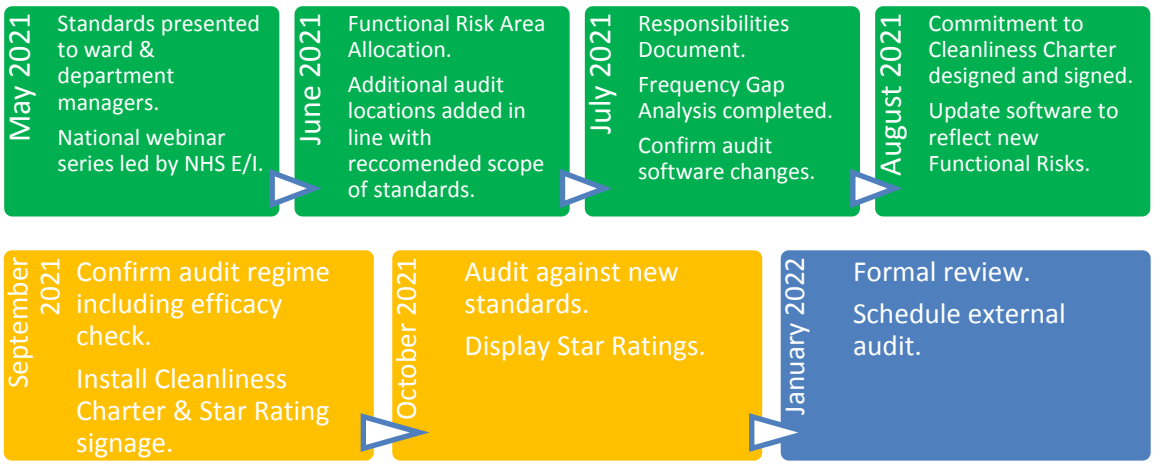
National Standards of Healthcare Cleanliness:

The National Standards of Healthcare Cleanliness were published in May 2021. Developed in collaboration with an expert multi-disciplinary team including Infection Control, Health and Safety, Nursing, Clinical and Microbiology leads and healthcare cleaning professionals, the standards seek to drive improvement whilst allowing maximum flexibility to suit the needs of all healthcare organisations.

The standards are mandatory, with acute Trusts given implementation guidance and a deadline for completion of May 2022.

Implementation of the New Standards is being managed through the Infection Control Working Group, key milestones are detailed below. At each stage, relevant stakeholders (including the Senior Nursing Infection Control, Operational Cleaning and Ward/Department teams) are consulted. Facilities colleagues are linking in with counterparts across SaTH and Shropcom to ensure a comparable approach is taken across the system.

Through the implementation process, discussion was held regarding ownership responsibilities of cleaning elements, the multi-disciplinary group reflected on the current board approved responsibilities, and where we would ideally wish the responsibilities to lie. This falls in line with the previously noted concerns escalated through external IPC audit. The roles and responsibilities will be agreed and published in the cleaning charter with regular quarterly reviews.



Facilities are following the implementation plan set out by NHS England, to ensure the governance around the new standards meets expectations of future assessments.

The frequency gap analysis has highlighted the need for a review of cleaning service model, to ensure that cleaning input hours reflect the new functional risk rating requirements - particularly where areas previously designated as 'Significant Risk' (85% target score) now fall into 'FR 2' category (95% target score), reflecting the interventional procedures taking place in these areas.

At the Extraordinary Infection Control Committee held in September 2021, a delay to implementation of these standards was approved, with full implementation now due in Q4 so that additional cleaning resource and clear competencies can be defined prior to roll out. In the above flow chart, we have rated stages 5 and 6 as amber owing to delays in clarification of roles and responsibilities. This will not affect the delivery against the required deadline.

The standards supporting documents have also been updated to reflect the specific enhanced cleaning to be implemented as part of the pandemic response.

Linen

Whilst under current restrictions, the Trust has been unable to complete its annual site audit of the linen contractor; assurance has been gained through monthly compliance reports – in line with their ISO accreditation and BS EN 14065 (Laundry Processed Textiles Biocontamination Control System) these include:

- Swatch testing (Machine Performance)
- Swab Testing (Personnel Hands)
- Swab Testing (Environment)
- Bioburden Testing (Final Products)
- Rinse Water

In November, 3 non-conformances were reported in rinse water tests, requiring subsequent retesting. These was undertaken and all results within acceptable tolerances.

Contract review meetings continue quarterly.

PLACE

In September, the Trust received confirmation that National PLACE assessments would not take place again in 2021. As with 2020, Trusts are encouraged to undertake internal assessments, using the PLACE lite tool. The tool and associated guidance have been updated, with additional questions in the mood data collection focusing on key recommendations of the National Food Review, and Buildings and Facilities data collection including reference to the National Standards for Cleanliness, Commitment to Cleanliness Charter and visible star ratings.

A programme of audits has been developed, covering all wards and departments usually assessed by the National model, with representation from Estates, Facilities and Clinical teams undertaking the assessments. The audit programme is on plan and results reported through IPCC.

Ward/Dept Name	Audit Date	Cleanliness	Privacy	Condition, Appearance & Maintenance	Dementia	Disability	Movement from Previous Audit
Alice Ward	08/10/2021	100%	100%	100%	N/A	100%	→
Children's OPD	08/10/2021	99.21%	100%	91.67%	N/A	83.33%	↓ (1.4%)

Immediate feedback is shared with the ward/department team, present on the audit, accompanied by a copy of the full assessment report & associated comments.
Actions identified through the audit in these areas included:

- Flooring damage/wear in corridor
- Decoration required in waiting area

Actions and themes identified through this audit programme will be monitored by the Infection Control Working Group. Where areas of good practice are found, the group will look to share this across the Trust, encouraging a consistent approach which will improve overall scores once the National programme is reinstated.

COVID-19 Response

As previously reported, Estates & Facilities continues to support the wider Trusts COVID response, with the focus now on maintaining compliance with National guidance and safety measures whilst restoring services:

- Use of National Standard Operating Procedures for cleaning, including additional touch point cleaning and enhanced service, additional cleaning in staff only and office areas and documentation through additional sign off sheets has continued.
- Escalating any waste management issues to NHS England and maintaining links with professional stakeholder groups to ensure any limitations in terms of clinical waste disposal nationally are considered in a timely manner.
- PPE Management including stock control, top up delivery and liaison with regional partners and NHS England to ensure continued supply.
- Management of fit testing for FFP3 masks, with operational support for testing provided by NHS England, including ensuring staff are fitted to more than one model of mask. This quarter, this has included providing a flexible service based in clinical areas to ensure relevant staff groups have access to tests.
- Management of the Trusts COVID screening desk, based at the main entrance.
- To support restoration, services are being brought back with consideration to all infection control guidance via the Estates Plan meeting – with representation from the Senior Leadership Team and Estates & Facilities. Challenges arising here are focused on keeping staff and patients safe.
- Ongoing support for the Trust vaccination hub including management of consumables and PPE for this service.
- Ongoing capital projects supporting the IPC agenda including further installation of wall cladding/protection, replacement of handwash basins and consideration of 'Air Scrubber' units.
- Estates & Facilities colleagues, as standard form part of the multi-disciplinary outbreak control team. As well as providing key assurance metrics (Area cleanliness scores, staff competency, relevant estates work), specialist advice and guidance is given where required

3.2.7. Compliance Update – Estates

Decontamination and Ventilation Equipment Updates

Audit

Estates support the business continuity of the Trust sterile services by maintaining the on-site decontamination equipment on a scheduled periodic basis. These periodic tests challenge the processes carried out by the decontamination equipment in 'worst case scenarios' to validate the machines for safe use. All periodic testing due this quarter have been carried out; 143 weekly tests, 15 quarterly tests and 0 yearly tests. As is standard practice all out of parameter results are followed up and resolved (note that no decontamination equipment is returned to service until it passes its periodic test).

All periodic testing is audited by the Trust appointed Authorising Engineer (Decontamination).

Settle plate testing is carried out in some areas for further assurance, or as mitigation for those systems installed prior to HTM 03-01. This gives Decontamination Group a good grasp of the air-contaminate levels in these areas, providing further assurance.

For Q3, 52 settle plate tests were carried out; no concerns to raise.

Reverification of the Critical Air Plant across site is a requirement of HTM 03-01 and is completed annually for each piece of equipment. Where remedial works cannot be completed, this is escalated through Decontamination Group. All reverifications due in Q3 have been completed. It was noted in the last Quarter there was ongoing issues with the John Charnley Laboratory clean air cabinets these have since been rectified and received full reverification.

All periodic testing is audited by the Trust appointed Authorising Engineer (Ventilation).

Water Hygiene Updates
Audit

In line with HTM 04-01 and HSE Legionella Approved Code of Practice document, L8, the Trust conducts routine maintenance on the domestic water infrastructure across site on a planned and reactive basis. This quarter, the following water quality samples were taken:

Type	01/10/2021→ 31/12/2021
Legionella	84
Pseudomonas	53
Hydro Pool Water Quality	11
Z Bacteria	4

As is standard practice all out of parameter results are followed up and resolved. There were no results that breached HSE/HTM guidelines for reporting to IPC in Q3.

3.3. Infection Prevention & Control

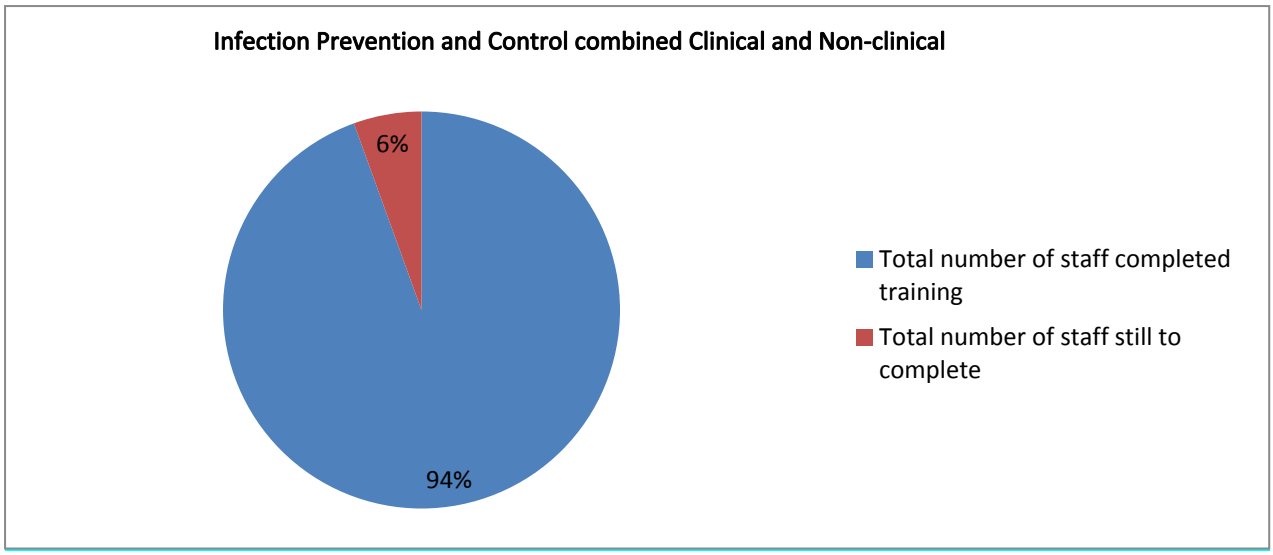
3.3.1. Training

The graphs below show a break down in the infection prevention and control training figures for clinical and non-clinical staff by unit which is accessed via e-learning. Ward/departmental managers are responsible for ensuring that staff are up to date with infection prevention and control training as part of the appraisal process. Interactive infection control training is delivered to all staff on induction including volunteers and work experience to the Trust. Practical ward training is delivered on request. The Clinical Site Managers have written to all bank staff requesting mandatory training is up to date for those indivisuals that have expired.

Infection Control Training Data as at 31 December 2021 - Unit Summary

	Completed "in date" Infection Prevention and Control (Clinical Staff)			Completed "in date" Infection Prevention and Control (Non-Clinical Staff)			Completed "in date" Infection Prevention and Control (Combined Clinical and Non-clinical)		
	Annual			3 Yearly			Annual/3 yearly depending on job role		
Unit	Number to complete	No's completed	% Complete	Number to complete	No's completed	% Complete	Number to complete	No's completed	% Complete
Assurance & Standards Team	2	2	100.0%	52	52	100.0%	54	54	100.0%
Clinical Services Unit	213	198	93.0%	101	99	98.0%	314	297	94.6%
MSK Delivery Unit	427	383	89.7%	53	52	98.1%	480	435	90.6%
Office of the CEO	0	0		11	10	90.9%	11	10	90.9%
Specialist Delivery Unit	271	257	94.8%	59	58	98.3%	330	315	95.5%
Support Services Unit	14	14	100.0%	333	329	98.8%	347	343	98.8%
Covid-19 Vaccination Centre	0	0		1	1	100.0%	1	1	100.0%
TRUST WIDE TOTAL(including Medical Staff)	**927**	**854**	**92.1%**	**610**	**601**	**98.5%**	**1537**	**1455**	**94.7%**
Bank Staff	107	86	80.4%	37	34	91.9%	144	120	83.3%
TRUST WIDE TOTAL (Including Medical and Bank Staff)	**1034**	**940**	**90.9%**	**647**	**635**	**98.1%**	**1681**	**1575**	**93.7%**

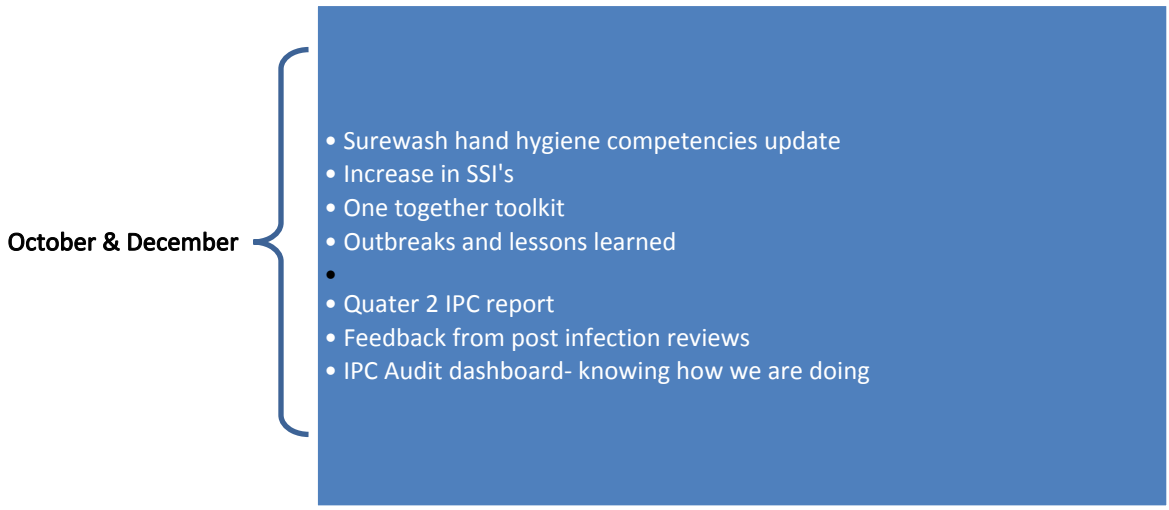
Key for Rag Rating for Training Compliance
>92%
<92%



3.3.2. Infection Control Link Meetings

Link meetings are held bi-monthly. Link staff are required to disseminate infection prevention and control updates/information to their work colleagues, as set out in the Link Staff Roles & Responsibilities document. Link Staff meeting attendance has been poor in recent months due to staff finding it difficult to access MS Teams in their work areas. This concern has been raised to ward managers at SNAHP; the IPC team are working towards to reintroduction of face-to-face link staff meetings providing mitigations are in place, to improve attendance.

IPC link staff have agreed to provide updates on action plans as a result of IPC quality assurance audits. This information will be provided at all Link Staff meetings going forward.



IPC Quality Assurance Audits

The IPC team continue to undertake regular quality assurance walks across clinical areas. During Quarter 3, 7 quality assurance audits were undertaken in the following areas:

- Cottage 101
- Gladstone Ward
- Alice Ward
- Theatres
- Powys
- Clwyd
- TSSU

Themes were identified which included:

- Not all patients wearing face masks
- Shared equipment clean but not labelled with 'I am clean' label
- Limescale on taps
- Detergent wipes not available on all obs machines

Wards/depts were provided feedback by the IPC team along with a score showing their RAG rating. Action plans are created by ward/dept and a copy is sent to the IPC team for assurance purposes. Individual actions are addressed at ward level, and progress is shared to the IPC team. Progress on actions is monitored through the QMS and a position of all action plans is provided to the monthly IPCC.

3.3.3 Ward and Departmental Audit

All clinical areas with designated QR codes submit IPC audits via the perfect Ward System. There are some areas that have not submitted audits within month and this has been discussed with individual ward/department managers.

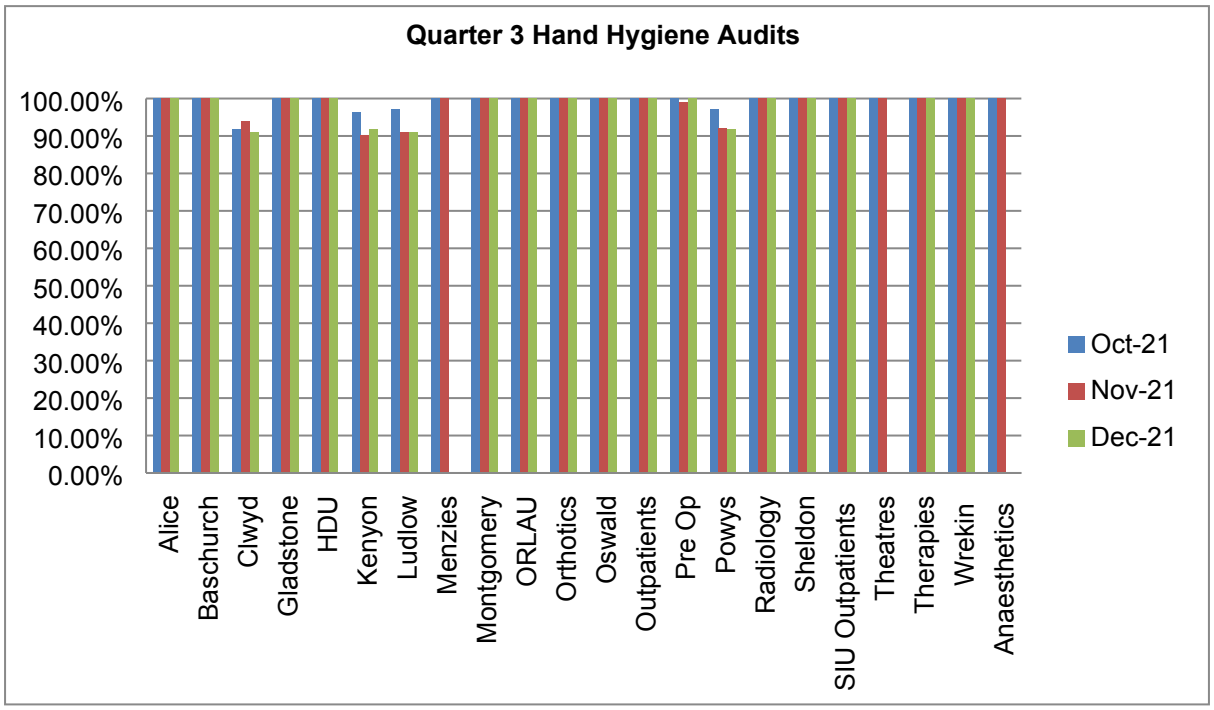
Montgomery Unit, Orthotics, ORLAU and Therapies will be added to the Perfect Ward system in the second phase of its roll out. These areas continue to complete audits via the paper system and manually analysed by the IPC Data Analyst in the interim. A dashboard is circulated monthly to ensure these areas are informed of IPC audit scores.

A QR code was issued to Recovery in November so that audits could be undertaken independently on Perfect Ward/Tenable. Theatres, Menzies and Anaesthetics continue to share one QR code and therefore these areas are grouped on analysis. The trust is looking into the costings of purchasing

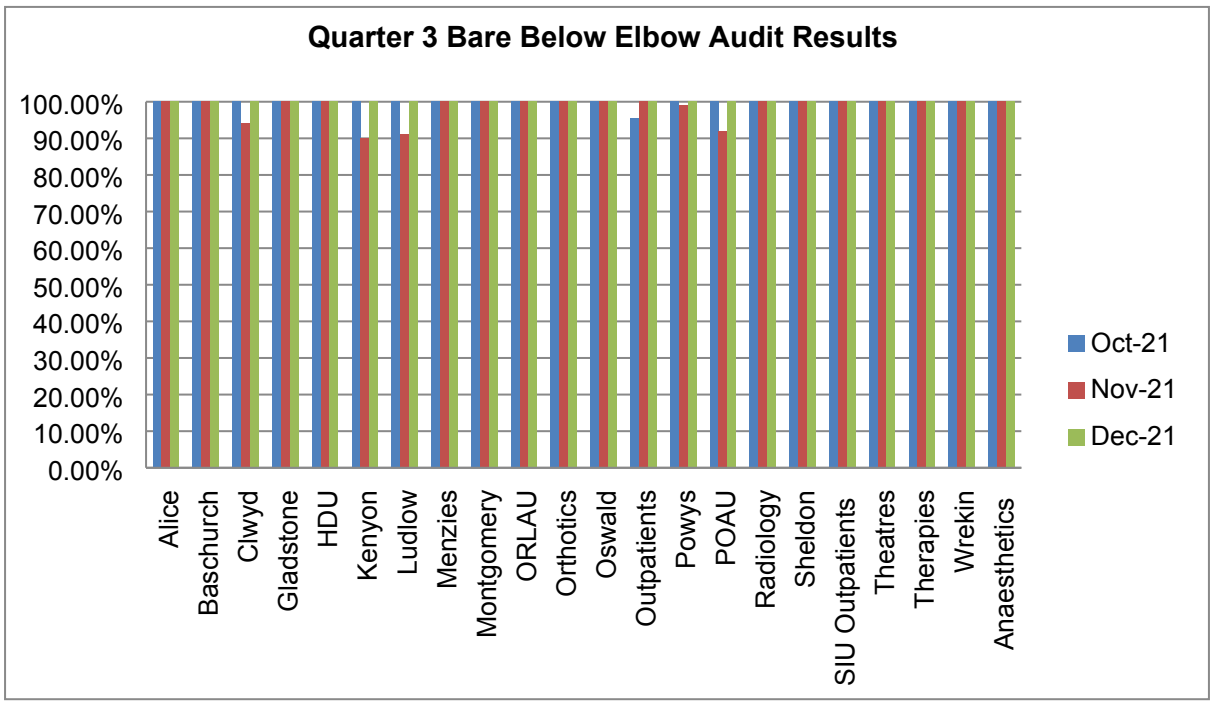
further QR codes so that these areas can be separately scored and analysed.

Audit scores are fed into the local IPC Quality Management System (QMS) introduced in June 21. The system was designed to centrally collect data and form a statistical relationship between all IPC data streams. The volume of IPC audits increased for this quarter in response to outbreaks detailed in the Outbreak section of the report.

3.3.3.1. Hand Hygiene



3.3.3.2. Bare Below the Elbow (BBE)



Infection Prevention & Control & Cleanliness Quarter 3 Report 2021/22

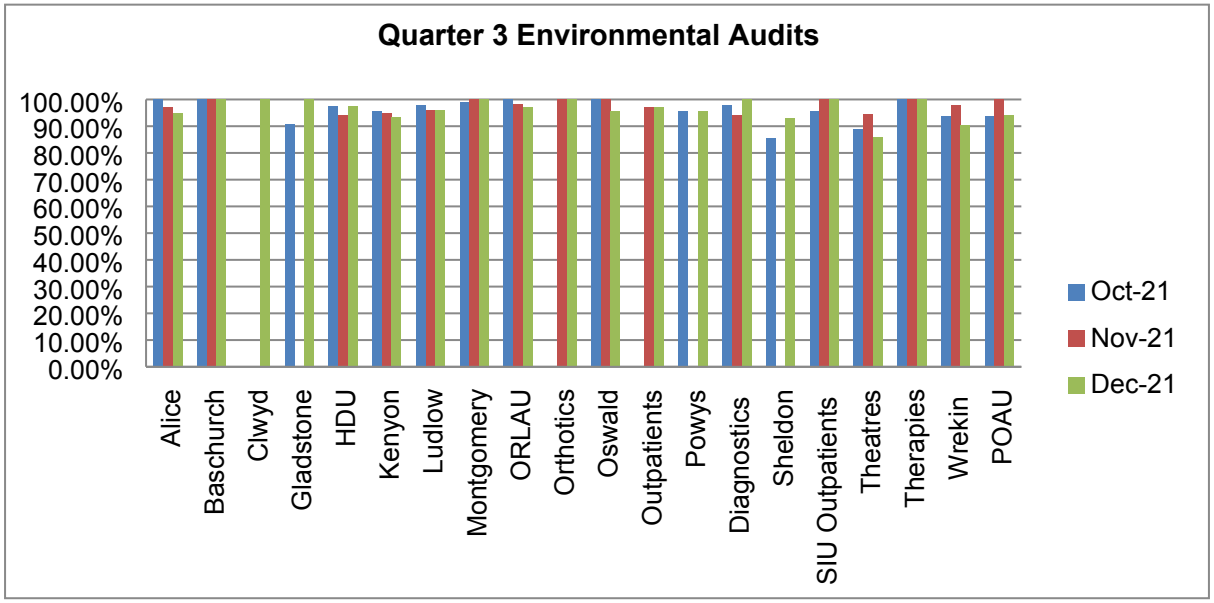
The above graphs demonstrate a 98.6% compliance in Hand Hygiene and 99.4% compliance in Bare Below the Elbow was achieved for this quarter.
The Trust continues to undertake ward & departmental IPC audits via the app based Perfect Ward/Tenable system. Audit questions are periodically reviewed to enrich data collection. Hand Hygiene audits have been refined to capture compliance to hand hygiene competencies. As a result, it was highlighted that competencies for the following areas required updating bringing them below the 95% target for this quarter:

- Clwyd Ward
- Ludlow Ward
- Kenyon Ward
- Pre Op Assessment Unit (POAU)
- Outpatients

Kenyon Ward, Ludlow Ward and POAU also demonstrated sores below 95% target for Bare Below the Below. Noncompliance for the three areas related to staff members wearing watches and jewellery. Staff are encouraged to continue to challenge non-compliance within their clinical areas.

Audit scores are summarised in the IPC Unit reports and each unit produces a report for the Infection Control & Cleanliness Committee. Data is jointly extracted from IPC Quality Management System (QMS) and Perfect Ward/Tenable to identify details of noncompliance. The reports include actions undertaken to address nonconformance.
Issues relating to combined auditing for Theatres has now been addressed, with the introduction of a separate QR code for Recovery in November. The IPC Link nurse is working with Perfect Ward/Tenable on its configuration.

3.3.3.3. Environmental Audits



Environmental audits are now captured via Perfect Ward. Results showed that the following areas outlined in the table below fell below the 95% target for the quarter.

Infection Prevention & Control & Cleanliness Quarter 3 Report 2021/22

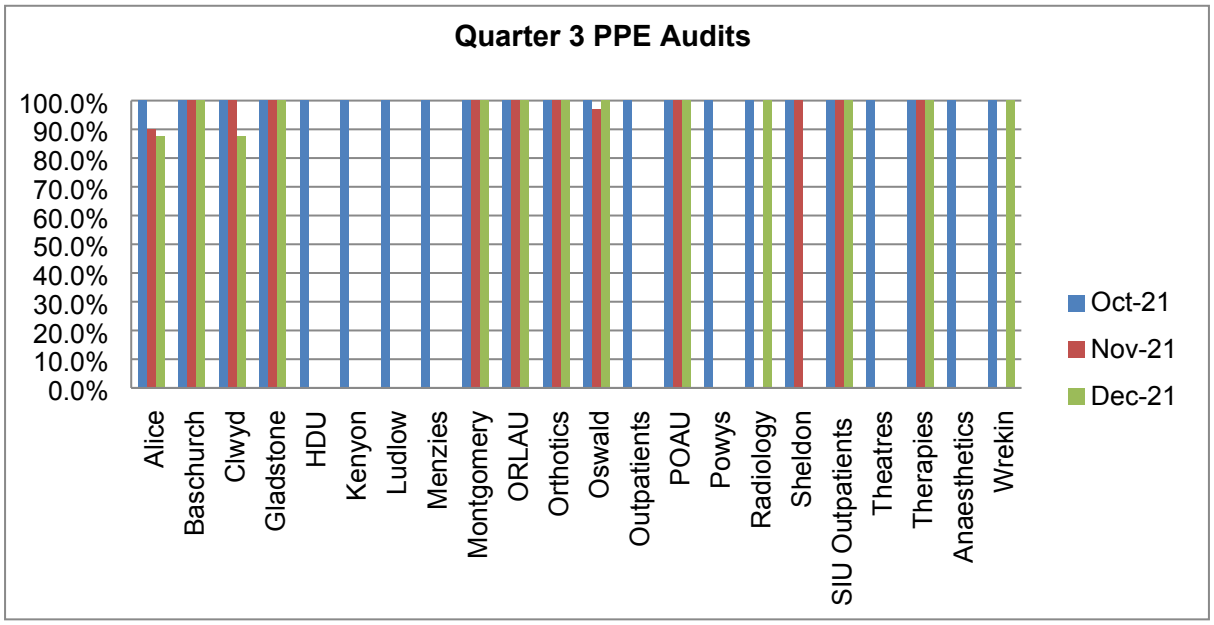
Details were summarised with actions undertaken in the quarterly IPC Unit Reports and submitted to IPCC as shown below:

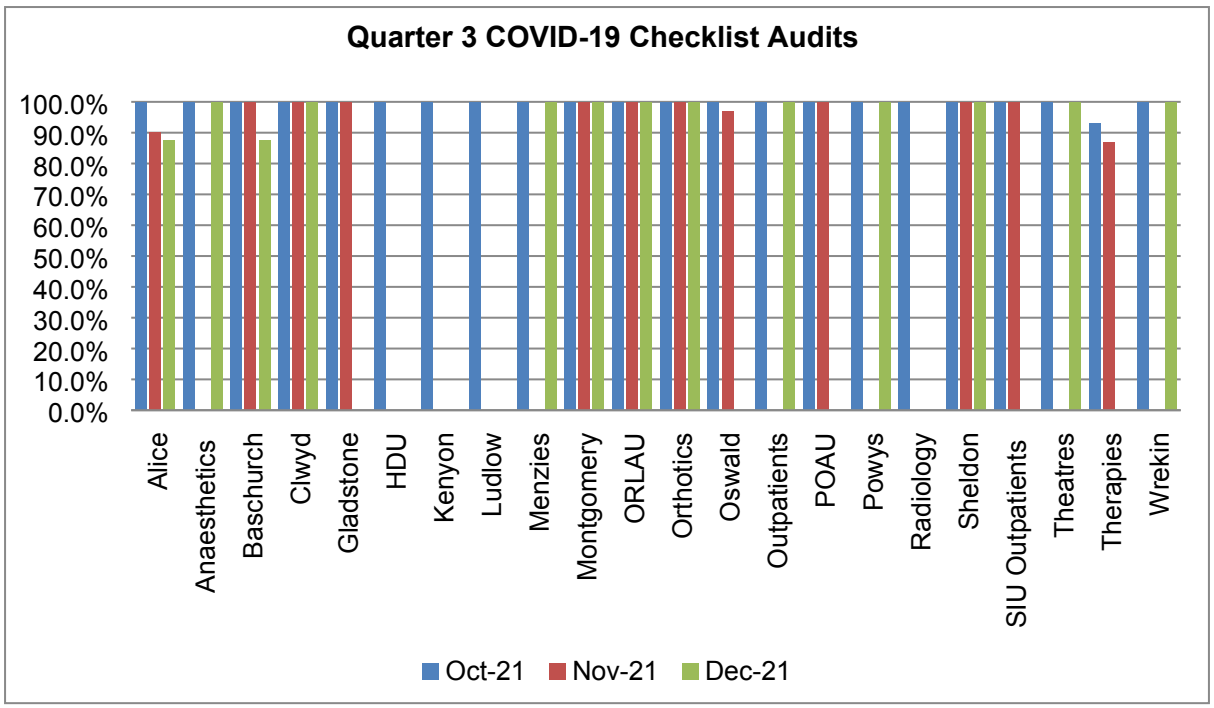
Location	Issue	Action Taken
Outpatients	Flooring in poor state of repair	Plaster room flooring and storage awaiting planned refurbishment planned for March 2022
Diagnostics	Hand Washing sink in poor state of repair	Hand washing sink reported in November and was repaired by Estates in December 21.
Theatres	• Floors by theatre 6 require repair. • Tray defenders on Floors in storeroom • Top of blanket warmer dusty. • Inappropriate items in sharps bins	• Reported to E&F remedial works to booked for January 2022 • Theatre link staff currently liaising with TSSU to establish if trays are required. • Blanket warmer cleaned and added to weekly cleaning rota • Staff informed of inappropriate items found in sharps bins and re-educated.
Preop	• Chairs not in good state of repair • Temporary closure mechanisms not in use on sharps bins	• Replacement chairs have been ordered • reminder sent out to all staff to ensure all temporary closing mechanisms are used on sharps bins and educated on the safety implications.
Kenyon	• Cleaning checklist frame requires glass. • Inappropriate items in sharps bins. • No hand cream available in main ward area	• New frame for cleaning checklist reordered requisition has been submitted to Estates. Education sent out to staff to remind of appropriate use of sharps bins • Requisition submitted to E&F to obtain hand cream
HDU	Inappropriate items in sharps bins	Reminder sent out to all staff of the appropriate usage of sharps bins
Wrekin	• Floors not clean and in poor state of repair • Sinks in bathroom in bad state of repair • Poor storage of pulp products and mattress	• Flooring due to be repaired January 2022 • Replacement sinks pending January 2022 with floor renewal. • Issues relating to storage added to the risk register – alternative area has now been identified for the storing of mattresses.
Sheldon	• BBE poster not displayed at ward entrance • Paper found in the sharps bin • Not all multi use patient equipment labelled as clean	• BBE poster obtained and will be installed on receipt of frame. • Ward manager informed staff of inappropriate items found in sharps bins. Follow up audit undertaken showed no inappropriate items found in bins. • Ward manager sent out reminder to all staff to ensure hoist is cleaned following each patient.
Oswald	• Commode did not have clean label attached. • Water located in water dispenser trays	• Commode has now been cleaned and contains a sticker to indicate. Staff reminded to use the I am clean stickers. • Daily check implemented to ensure trays to water dispensers are clean and emptied.

3.3.3.4 PPE & COVID-19 Personal Protective Equipment Checklist Observational Tool

PPE and COVID-19 checklist audits have been amalgamated to align with Perfect Ward/Tenable. However, Scores are graphically separated on the IPC QMS to show compliance to both areas.

Audits for the quarter demonstrate an overall 97.9% compliance to COVID-19 and 98% compliance to PPE precautions





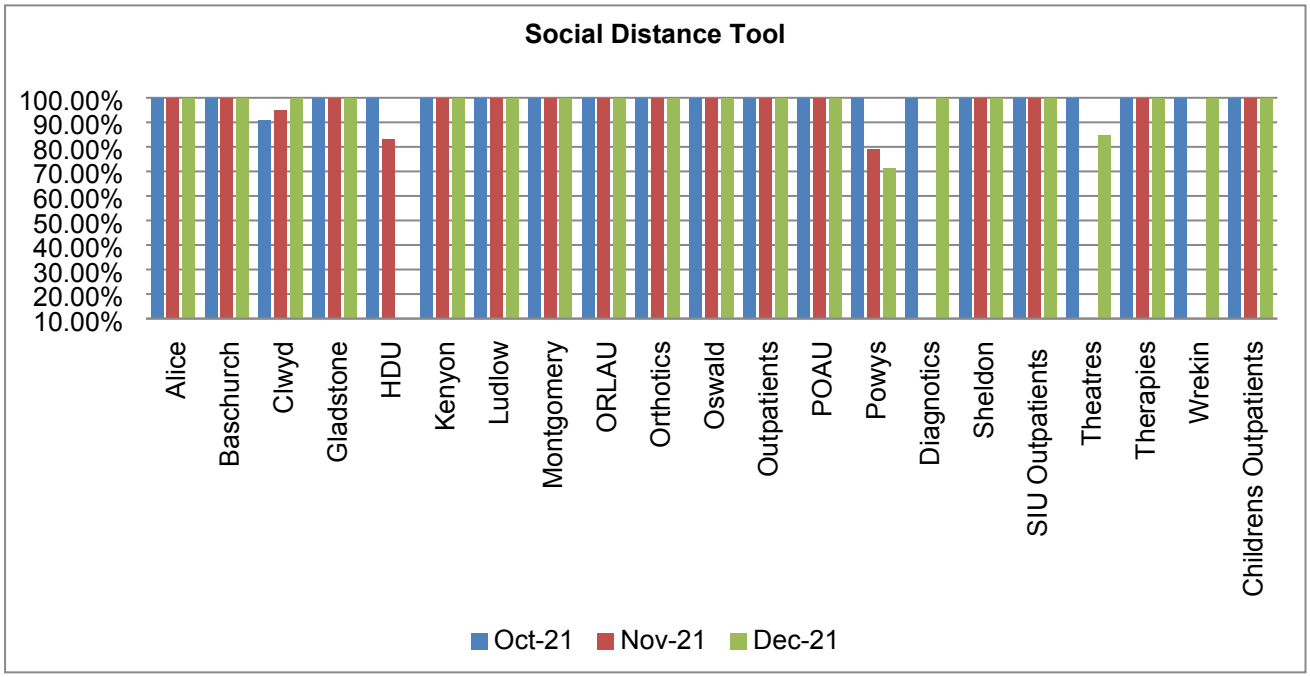
The graphs above show lack of audits undertaken in many areas for November and December. Failure to undertake audits is monitored by the Unit matron/lead via Perfect Ward/Tenable.

Perfect Ward/Tenable contains a sophisticated algorithm whereby consistence low scoring to a certain question will negatively affect monthly scores. Low scores for Alice, Baschurch, Oswald and Therapies, relate to two main themes of noncompliance being consistently reported in these areas throughout October – December 21:

Theme		Actions Undertaken
	Failure to FFP3 Mask Fit Testing	• Small number of staff have failed fit testing to current supply of FFP3 masks. Increased FFP3 fit testing provision organised against a wider supply of masks. . All PPE items are recieved system wide via the push stock model. E&F department have a system to ensure all these staff are retested when new models of masks are supplied.
	Residue in Hand Gel Dispensers	• Build up of residue located in hand gel dispensers in many areas. Daily residue expected due to frequency of use. System implemented in many areas to ensure dispensers are checked daily and cleaned.

3.3.3.5 Social Distance Checklist Observation Tool

To avoid duplication of data, the audit dashboard was ceased for all areas undertaking audits via the Perfect Ward/Tenable System. The system shows live data, and scores are reported via the app for all areas. The graphs below show lack of audits undertaken in some areas for November and December. Failure to undertake audits is monitored by the Unit matron/lead via Perfect Ward/Tenable The graph below shows an overall 97% compliance to social distancing requirements for this quarter.



Results show that the following areas failed to meet the 95% target in quarter 3:

- Theatres
- Clwyd Ward
- HDU
- Powys Ward

The following themes of noncompliance were identified:

3.3.4. Surgical Site Surveillance

Providing data to the national SSI process enables the Trust to benchmark on a national basis with other Trusts. The process uses nationally agreed criteria from which the definition of a Surgical Site Infection is formed. Understanding surgical site infection rates enables the Trust to estimate the risk of SSI in patients undergoing specific operations.

Year-round surveillance is performed for total hip, total knee and spinal surgeries which is above the national requirement for one quarter of surveillance in one category of surgery per year.

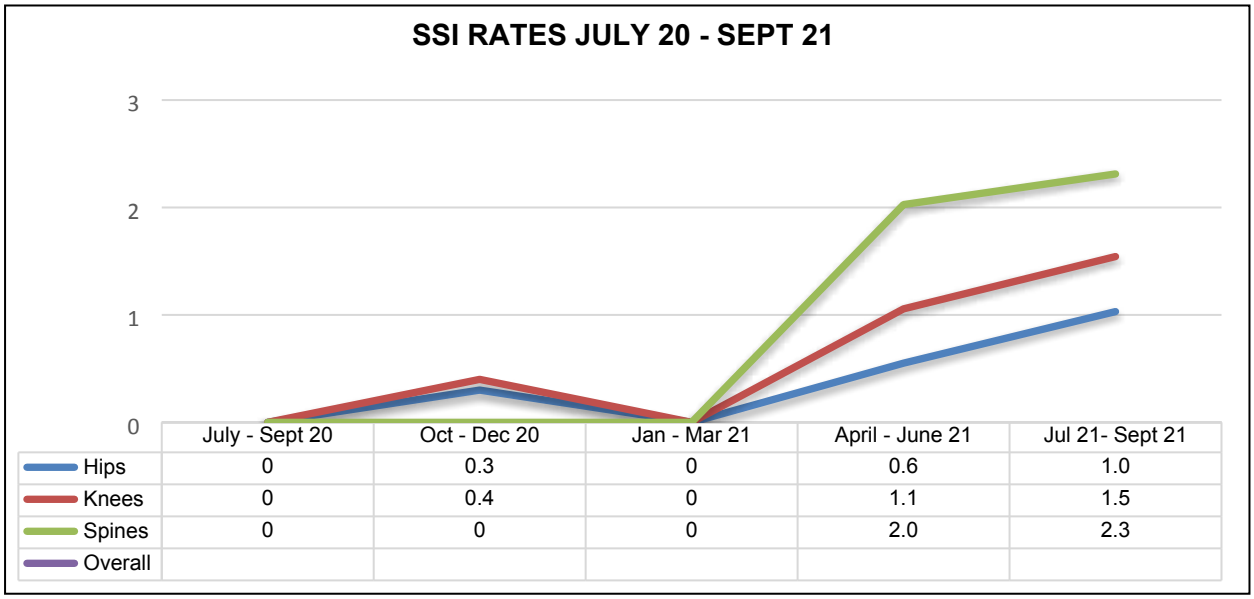
The Trust submits surgical site infection data to the SSISS database on a quarterly basis; reports are always one quarter behind to allow a window of time for any infections to present.

The data below shows the SSI rates for July to September 2021. The Trust has reported a total of 13 surgical site infections for this quarter.

Infection Prevention & Control & Cleanliness Quarter 3 Report 2021/22

TKR	5 infections from 284 procedures	1.5%	National Average 0.7%
THR	4 infections from 363 procedures	1%	National Average 0.7%
Spines	4 infections from 148 procedures	2.3%	National Average 1.2%

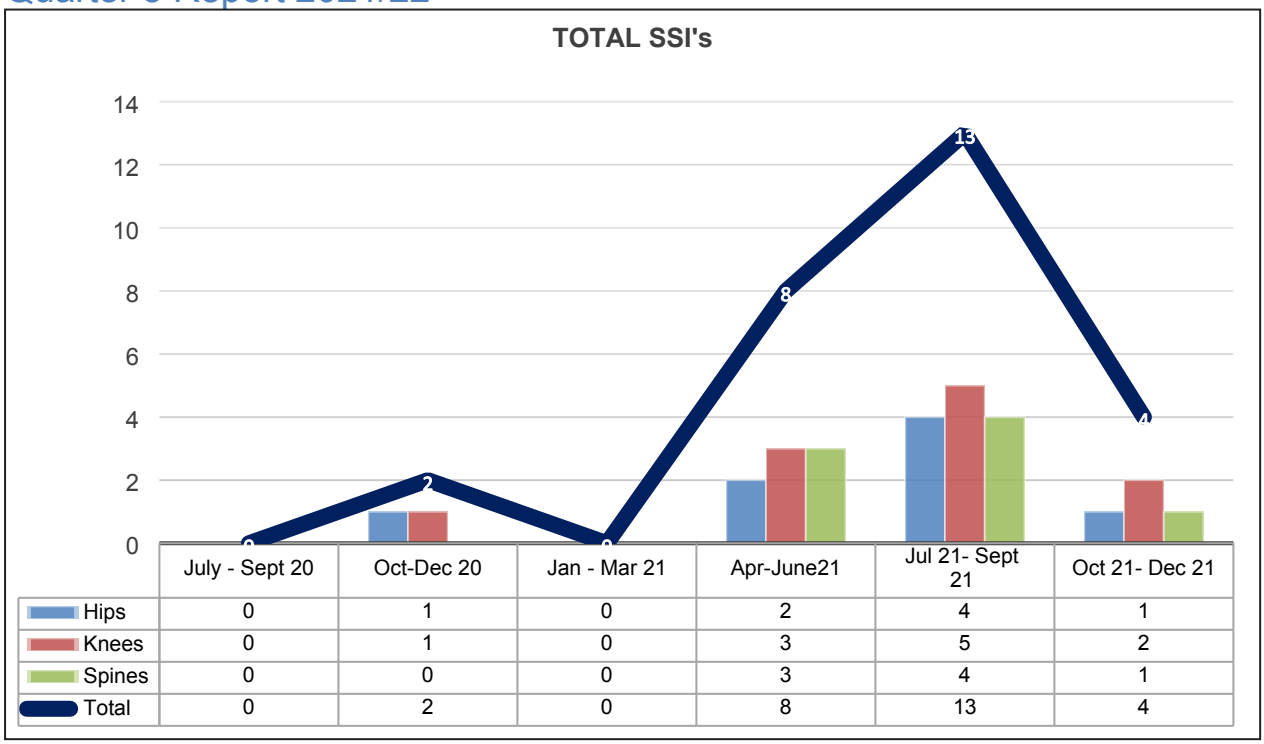
The Surgical Site Surveillance Nurse liaises with the consultants concerning wound infections. The data for July – September 2021 has been verified and the results have been submitted to UKHSA and published on their web site. All of these infections were discussed and confirmed at the Infection Multi-Disciplinary Team meeting (IMDT).



	July - Sept 20	Oct - Dec 20	Jan - Mar 21	April - June 21	Jul 21- Sept 21
Hips	0	0.3	0	0.6	1.0
Knees	0	0.4	0	1.1	1.5
Spines	0	0	0	2.0	2.3
Overall					

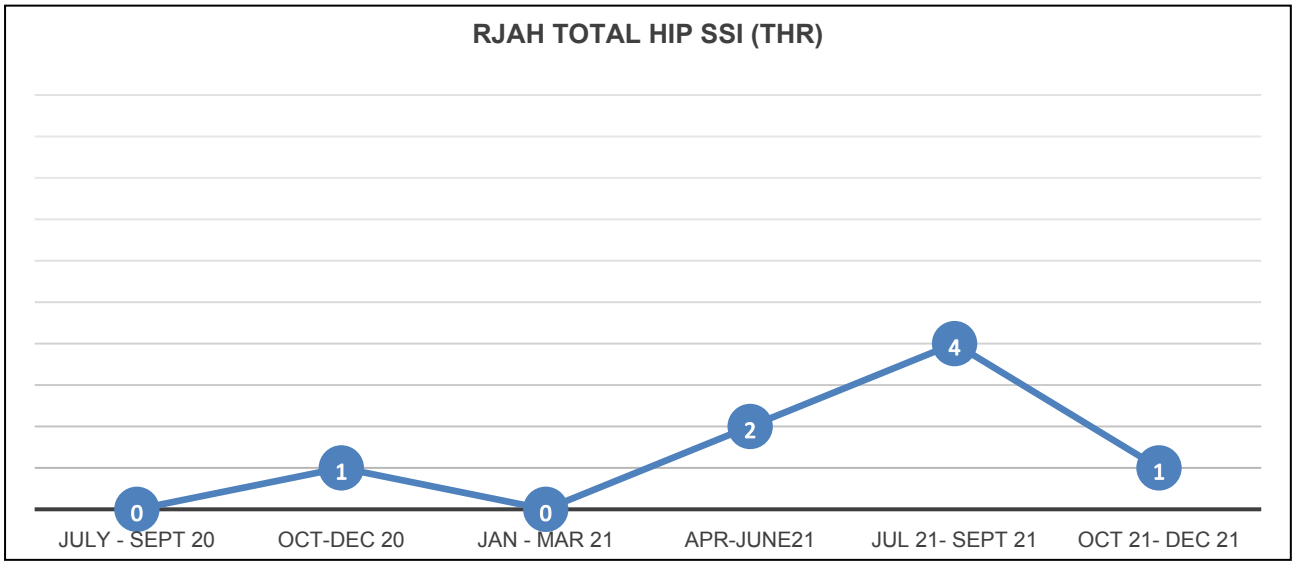
The graph above shows RJAH Infection rates for the last 12 months. Rates for Hip (THR), knee (TKR) and spinal surgery.

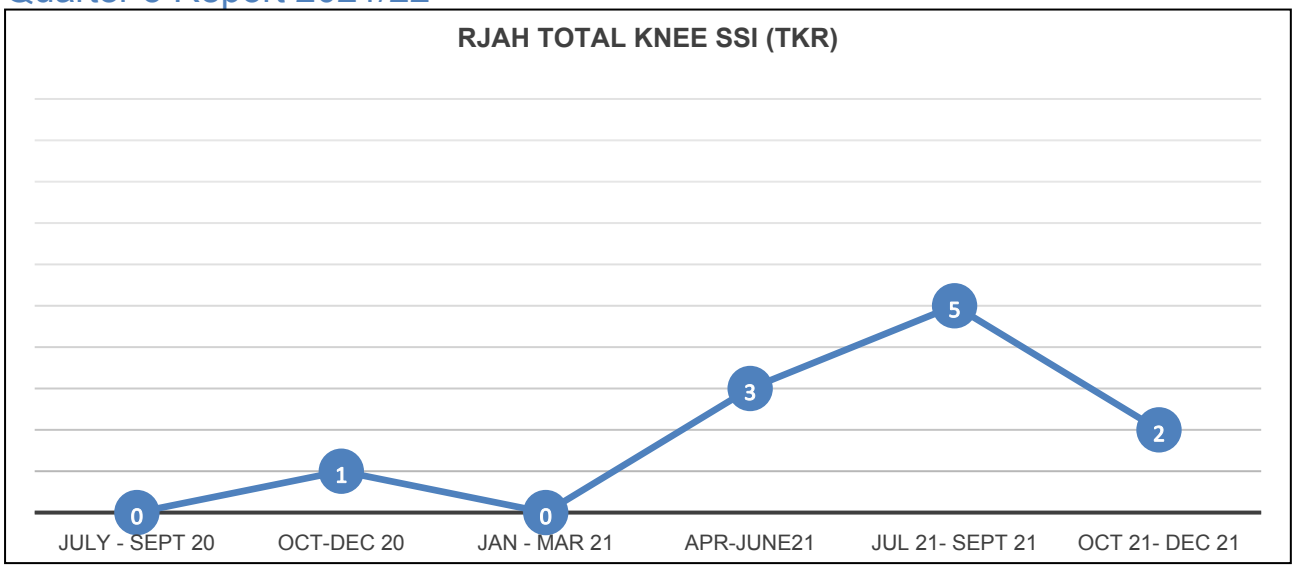
Infection Prevention & Control & Cleanliness Quarter 3 Report 2021/22

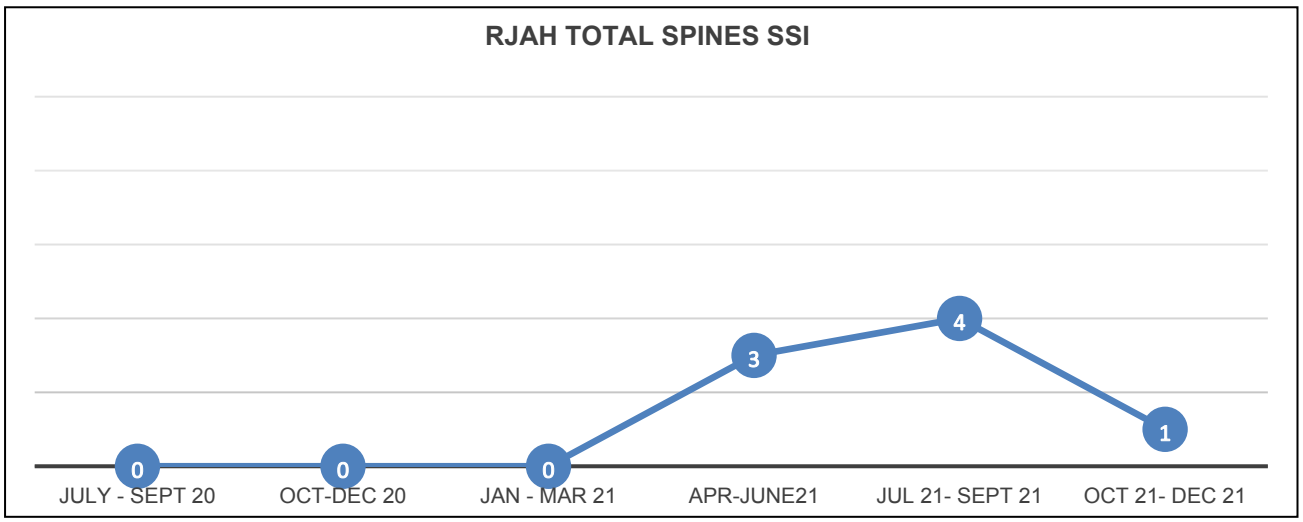


	July - Sept 20	Oct-Dec 20	Jan - Mar 21	Apr-June21	Jul 21- Sept 21	Oct 21- Dec 21
Hips	0	1	0	2	4	1
Knees	0	1	0	3	5	2
Spines	0	0	0	3	4	1
Total	0	2	0	8	13	4

The Trust reported a total of 13 SSI infections for July – September; the graphs below show the breakdown for each speciality:







SSI timeline

Month	Event
Sept 21	Rise in Surgical site infections identified (SSI) for the period April- June 21 • 8 SSIs in total • 2 SSIs in Total Hip Replacement (THR)'s out of 361 procedures = 0.6% • 3 SSIs in Total Knee Replacement (TKR)'s out of 281 procedures = 1.1% • 3 SSIs in Spinal surgeries out of 138 procedures = 2.2% Above infections agreed at the weekly Infection MDT meetings.

	In the previous quarter (Jan – Mar 21) there were no surgical site infections. out of a total 274 procedures: (69 TKR, 107 THR, 98 Spinal surgery) The complete dataset was reviewed in SPC chart format across all reportable SSIs from May 2015. This showed that 8 infections in a quarter was within our normal control limits.
	Data was shared at the Infection Control & Cleanliness Committee on 24th September 2021 IPC Team were asked to review the process for investigation and internal reporting of surgical site infections.
	The 8 SSIs for April – June 21 were formally reported to the UKHSA by the Surgical Site Infection Surveillance Scheme (SSIS) portal on 30.09.21
Oct & Nov 21	SSI process refined and documented in flowchart format and circulated to Infection MDT for input and approval.
	A further increase in Surgical site infections was identified in July –September 21: There were an additional 13 SSIs in this quarter. 4 THR's out of 388 procedures = 1.0 % 5 TKR's out of 324 procedures = 1.5% 4 Spinal surgeries out of 173 procedures = 2.3%
	April – September 21 SSI data was discussed at the Infection Control & Cleanliness Committee 2.11.21
	RCA meetings organised for all reportable SSIs and panel members identified. Data collection form developed to capture patient data as part of the RCA information gathering process
	SSI meeting with Managing Director of MSK unit on 5.11.21 to clarify the function of the Infection MDT and reporting processes/structures
	Trust KPI structure redesigned to capture confirmed cases of SSIs. SSIs will be included on the SRI reporting for board level oversite from 1st December 2021. 10 out of the 21 SSIs were due to Meticillin Sensitive Staphylococcus aureus (MSSA). 8 of these isolates had been saved and were sent for typing. This showed there was no evidence of cross infection.
	ANTT standard training/ train the trainer sourced via external provider
	One Together toolkit commenced due for completion December 2021
	Review undertaken of post-op wound care / discharge information
	TSSU were asked to review the processing of all instruments used for the 21 cases.

	IPC Assurance Walk undertaken in Theatres 12.11.21 with an 87% compliance score

Full SSI Analysis

Further analysis was undertaken by the IPC Surgical Site Surveillance Nurse for all 21 patients with findings detailed below:

Organisms Identified	10 SSIs identified from April – September 2021 were caused by Meticillin Sensitive Staphylococcus Aureus (MSSA)
Patient Washing	19 patients identified as 'clean' on preoperative checklist.
Hair Removal	Currently there is no process to record preoperative hair removal.
Skin Prep	19 patients had a 2% Chlorhexidine spirit skin prep. 2 patients had 2% Chlorhexidine spirit and Betadine.
Incise Drape	All 21 patients had incise drapes
Patient Warming	13 patients' temperatures were recorded in Theatres above 36 degrees centigrade. 8 patients had no temperature recordings documented in Theatre (3 of these patients had temperatures of less than 36 degrees on arrival in recovery).
Antibiotics	All 21 patients received appropriate antibiotics at induction.
Wound Closure	11 patients had absorbable wound closure. 9 patients had clips as wound closure. 1 patient had non absorbable sutures.
Dressings	10 patients had film and pad (e.g. Opsite) 9 patients had post op retainable dressings 1 patient had spirit blue gauze and film and pad 1 patient had a primary wound contact layer with blue gauze

Analysis was undertaken to identify correlating themes and contributory factors.

Conclusion - Key Themes & Contributary factors	Progress/Additional Information
Review to be undertaken of wound care management information provided to patients post discharge	Tissue Viability Nurse is finalising the Wound Assessment and Management Policy that will include the patient leaflet on discharge.
Assess education within the community for recommended timescales on removal of sutures	Ensure documentation relating to removal of sutures is clear on discharge.
Review information given to patients prior to surgery.	IPC Nurse Specialist is leading on the implementation of the 'One Together Programme'

	in Theatres. Process for prepping patients prior to surgery is included within this assessment.
Impact of increased activity on the TSSU service	Yale TSSU activity has been discontinued.
Investigation of post op management for patients with diabetes within the trust.	SSI nurse is investigating post op diabetes management.
Consider introduction of MSSA screening/decolonisation for all patients receiving an implant	Discussion held at Infection Control & Cleanliness Committee. To be taken forward to Infection MDT.
The risk of hypothermia is not assessed at preop.	This will be incorporated in the One Together programme.

Upon completion of the RCAs, an overarching an action plan will be developed using lessons learned to drive continuous improvement.

To date there have been 4 surgical site infections confirmed during October – December 2021 and a further infection currently under review.

OneTogether

OneTogether is a partnership between leading professional organisations with an interest in the prevention of surgical site infection (SSI). The partnership has been initiated as a quality improvement collaborative with the aim of promoting and supporting the adoption of best practice to prevent SSI throughout the patient's surgical pathway.

The OneTogether assessment tool has been designed to demonstrate compliance across the surgical pathway and is set out in 7 standards:

1. Skin preparation
2. Prophylactic antibiotics
3. Patient warming
4. Maintaining asepsis
5. Surgical environment
6. Wound management
7. Surveillance of surgical site infection

During Quarter 3, the IPC team and Theatres staff collaborated in performing the assessment. The assessment provided the opportunity to review the current standards operating procedures within each standard, and to assess the compliance of the standards in practice. A presentation of the findings will be provided in Quarter 4.

3.3.5. MRSA Swabbing and New Isolates

MRSA swabbing for all admissions (pre-operative assessment and emergency) continues and is monitored internally to ensure that the Trust remains compliant to the national requirements.

	Oct 21	Nov 21	Dec 21
Eligible patients	878	963	711
Screened for MRSA	875	961	710

	99.66%	99.79%	99.86%
	100%	100%	100%

MRSA screening compliance remains high and above the target set by the commissioners. MRSA swabs that have not been undertaken are reported to the relevant line managers for investigation.

During quarter 3 a total of 3928 MRSA screening samples were received by the lab from RJAH.
2816 of these samples were collected from the Pre-Operative Assessment Unit (POAU)
17 (0.6%) of the samples tested positive for MRSA from a total of 8 patients.
The patients underwent a course of decolonisation treatment and tested negative on subsequent swabs prior to their admission date.

There have been no new inpatient MRSA acquisitions during this quarter.

MRSA and decolonisation

Data shows that 3928 MRSA swabs were taken from 2722 patients within this quarter.

15 MRSA positive patients were identified.

The table below shows the breakdown of patients tested.

Further analysis showed that 14 of these patients were given decolonisation treatment.

1 patient did not receive decolonisation treatment due to being discharged prior to the result being available.

Location	Total Number of swabs	Number of patients	Number of positive MRSA (SAUR)
Pre-admission swabs	2816	2518	8
Other	1112	204	7
Totals	**3928**	**2722**	**15**

3.3.6. Alert Organisms

3.3.6.1. Clostridioides *difficile*

There has been 1 case of C.*difficile* infection during December. The patient had been diagnosed with C.*difficile* on the 19/11/21 during a short admission to Royal Shrewsbury Hospital from RJAH due to cholecystitis.

On the 22/12/21 the patient developed further diarrhoea symptoms; a sample obtained identified a relapse in C.*difficile* infection. The patient was reviewed by the Consultant Microbiologist and was treated with Fidaxomicin.

A post infection review was undertaken

Lessons learned:

- All appropriate processes followed, and antibiotics prescribed in line with antibiotic guidelines.
- Bristol stool chart followed at all times
- Guidance provided by IPC to ward staff regarding screening other patients on the ward.
- C.*difficile* policy was followed by the ward staff

- A-Z of infections is located on the intranet for staff to follow for the management of infections.

To date we have had 2 cases of C.*difficle* against a target set of 1 for 2021/22.

3.3.6.2. MSSA bacteraemia

There were no RJAH acquired MSSA bloodstream infections reported during Quarter 3, however there was one case of a non-RJAH acquired case in which a surgical site infection was identified as the source.

3.3.6.3. E.*coli*/Klebsiella/Pseudomonas bacteraemia

There has been one case of E.coli blood stream infection during December. The patient also grew E.coli in a urinary catheter specimen (CAUTI) which was the most likely source of the blood stream infection. The patient had a previous bacteraemia episode at RSH during October.

The patient responded to intravenous antibiotics as recommended by the Consultant Microbiologist. A post-infection review will be undertaken, and lessons learned will be shared at SNAHP, ward meetings, IPCC, Unit governance meetings and ward teaching sessions.

To date there have been 2 cases of E.coli blood stream infections against a target of 7 cases.

3.3.6.4 COVID-19 Coronavirus

During Quarter 3 the Trust continued to react and implement changes in response to COVID-19. As the National prevalence increased during December, the Trust reported 4 Covid outbreaks. As the outbreaks are ongoing a full report will be presented in the quarter 4 report. The Trust Coronavirus policy is regularly monitored and updated in accordance with the latest national guidance.

Outbreaks

A total of 4 COVID-19 outbreaks were reported during quarter 3 and are summarised below:

Dept	Date declared	How many involved (staff and pts)	Themes identified/Contributory Factors	Actions Taken
Clwyd Ward	03/12/2021	7 patients 2 staff	Improved process required for checking patient mask wearing compliance No process for ventilation (opening windows regularly) One patient not vaccinated	Updated patient mask wearing flowchart created Review of ventilation by H&S Officer Ventilation chart created – clinical areas opening windows 10 mins per hour. Regular action item for future outbreak action logs
Pharmacy	27/12/2021	5 staff	Social gathering during Christmas period Staff working within the same area in Pharmacy	Review of social distancing in break room and signage displayed

			department Poorly ventilated break room	Review of ventilation Encourage staff to work from home where possible
Gladstone	27/12/2021	11 patients 16 staff	RCA to be completed – outbreak ongoing	Declutter of ward New lockers installed for patient belongings Donning and doffing training for staff Declared as a serious incident
Sheldon	30/12/2021	11 patients 10 staff	RCA to be completed – outbreak ongoing	Purchase of more Air Sentry devices to aid ventilation Declared as a serious incident

Regular outbreak meetings were held which included representation from NHSE/I, UKHSA and Shropshire CCG. The IPC team used an outbreak collection tool that has been shown to standardise the process for the collection of information in the event of an outbreak and to provide a consistent approach. This includes standard actions to be taken in the event of an outbreak, such as deep cleaning, IPC assurance audits and training compliance data.

Lessons learned are shared with the ward/departmental teams, as IPC is routinely discussed in team safety huddles. More widely, updates on outbreaks and lessons learned will be shared SNAHP, IPCCWG and IPCC Committee.

Upon the completion of the RCA process, lessons learned, and further actions undertaken will be reported in the next quarterly report.

3.3.6.5 CQC Assessment/ Board Assurance Framework

As the understanding of COVID-19 has developed, guidance on the required infection prevention and control measures has been published, this has now been updated and refined to reflect the learning from SARS-CoV-2 and to acknowledge the threat from other respiratory viruses.

The IPC Board Assurance Framework (BAF) has been developed and updated following updates in the guidance to help providers to assess themselves as a source of internal assurance that quality standards are being maintained. The framework offers providers a way to continually review processes and respond in an evidence-based way to maintain the safety of patients, service users and staff.

There are ten overarching key lines of enquiry which align with the Health and Social Care Act 2008, Code of Practice on the prevention and control of infection and related guidance. The Trust is compliant with the majority of these standards. An action plan has been produced to capture any areas of improvement. Monitoring of this action plan is captured through the IPC QMS and a position on the progress will be reported to IPCC.

10 Key Lines of Enquiry

- Systems are in place 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 posed by their environment and other service users
- Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.
- Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance
- 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
- 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 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
- Provide or secure adequate isolation facilities
- Secure adequate access to laboratory support as appropriate
- Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections
- Have a system in place to manage the occupational health needs and obligations of staff in relation to infection.

The revised version of the Board Assurance Framework was released on the 24th December 2021, it will be signed off at board level in March 22 once review is completed.

3.4 Serious Incidents

There have been 2 serious incidents declared for quarter 3 relating to Gladstone and Sheldon ward Covid outbreaks due for submission with the commissioners at the end of March 22.

3.5 Conclusion

The Trust reports positive outcomes against national set targets for HCAI:

All orthopaedic surgery is being monitored closely and cases of suspected/confirmed infections are discussed at the Consultant led weekly Infection MDT meetings.

The Trust continues to follow national guidance in order to prevent and control the transmission of infections.

December was a particularly challenging time for the Infection Prevention and Control team due to the exponential rise in COVID-19 cases amongst patients and staff; resulting in outbreaks that placed increased demand for support in clinical areas.

Multiple changes in national guidance have proved challenging at times, however in collaboration with the Communications team, the IPC team have been able to reach out to staff to provide them with the latest guidance around self-isolation and offer support when required.

Infection Prevention & Control & Cleanliness Quarter 3 Report 2021/22

Whilst the management of COVID-19 has become a large part of the IPC workload; as we learn to overcome and adapt to the changing prevalence, we must not lose sight of the importance of preventing and controlling other healthcare acquired infections. The importance of staff IPC training remains priority as we move into the next quarter.

Appendix 1: Acronyms

BAF	Board Assurance Framework
ANTT	Aseptic Non-Touch Indicator
C.*diff*	Clostridium *difficile*
CCG	Clinical Commissioning Group
CEO	Chief Executive Officer
CQC	Care Quality Commission
E.coli	Escherichia. Coli
FFP3	Filtering Face Piece
HCAI	Healthcare Associated Infection
HDU	High Dependency Unit
HPV	Hydrogen Peroxide Vapour
HSE	Health & Safety Executive
HTM	Health Technical Memorandum
IPC	Infection Prevention & Control
IPC(N)	Infection Prevention & Control (Nurse)
IPCC	Infection Prevention Control Committee
IPCCWG	Infection Prevention Control Cleanliness Working Group
KPI	Key Performance Indicator
MCSI	Midlands Centre for Spinal Injuries
MDT	Multidisciplinary Team
MRSA	Methicillin Resistant Staphylococcus Aureus
MSK	Musculoskeletal
MSSA	Methicillin Sensitive Staphylococcus Aureus
OPD	Outpatients Department
PHE	Public Health England
PIR	Post Infection Review
PLACE	Patient Led Assessments of the Care Environment
PPE	Personal Protective Equipment
QMS	Quality Management System
QR	Quick Response
RAG	Red, Amber, Green
RCA	Root Cause Analysis

Appendix 1: Acronyms continued

RSH	Royal Shrewsbury Hospital
SaTH	Shrewsbury and Telford Hospitals
SNAHP	Senior Nurse and Allied Health Professional
SPC	Statistical Process Control
SSI	Surgical Site Infection
SSISS	Surgical site infection surveillance service GOV.UK
THR	Total Hip Replacement
TKR	Total Knee Replacement
TSSU	Theatre Sterile Services Unit
UTI	Urinary Tract Infection

Glossary

Bacteraemia: The presence of bacteria in the blood without clinical signs or symptoms of infection

C.*Difficile*: or C.*Diff* is short for Clostridium difficile. It is a type of bacteria (germ) which less than 5% of the population carry in their gut without becoming ill. It is normally kept under control by the 'good' bacteria in the gut. However, when the good bacteria are reduced, e.g. by taking antibiotics, C. difficile can multiply and produce toxins (poisons) which can cause diarrhoea. The C. difficile bacteria form spores (germs that have a protective coating). These spores are shed in the diarrhoea of an infected person and can survive for a long time in the environment. C. difficile is highly infectious and can be spread from patient to patient unless strict hygiene measures are followed.

E coli: is an organism we all carry in our gut, and most of the time it is completely harmless. It is part of the coliform group of bacteria – often known as Gram Negative bacteria. Most strains do not cause any symptoms while being carried in the gut. Instead E coli forms part of our "friendly" colonising gut bacteria. However when it escapes the gut it can be dangerous. E coli is the commonest cause of blood stream infections (bacteraemia) in the community. The most frequent problem it causes is a urinary tract infection, but it can also cause infections in the abdomen such as gallbladder infections or following perforations of the bowel.

HCAI: Health Care Associated Infection. An infection acquired because of receiving treatment in a health care setting.

MRSA: or Methicillin Resistant Staph aureus, is a highly resistant strain of the common bacteria, Staph aureus. Bloodstream infections (bacteraemia) cases are the most serious form of infection where bacteria, in this case MRSA, escape from the local site of infection, such as an abscess or wound infection, and spread throughout the body via the bloodstream. All cases of MRSA detected in the blood are reported by the trust.

MSSA: or Meticillin Sensitive Staph aureus, is the more common sensitive strain of Staph aureus. Up to 25% of us are colonised with this organism. Mostly it causes us no problem but it is a frequent cause of skin, soft tissue and bone infections. As with its more resistant cousin, MRSA, sometimes the infection can escape into the bloodstream producing a "bacteraemia" i.e. bacteria in the blood. Unlike MRSA, the majority of the infections will be acquired in the community and are not associated with health care. However, some may arise because of health care, and like MRSA, it can arise from infected peripheral and central intravenous lines and other health care interventions. We were asked by the Department of Health in 2011 to report all MSSA bacteraemia cases, whether acquired in the community or in hospital, so that we can review the sources and identify potentially avoidable cases. So far no targets have been set. However, we can compare ourselves with other trusts and put in interventions to further reduce infections.

Chair's Assurance Report
Extra Ordinary Quality and Safety Committee 29 March 2022

0. Reference Information

Author:	Mary Bardsley, Assistant Trust Secretary	**Paper date:**	6 April 2022
Executive Sponsor:	Chris Beacock, Quality and Safety Committee Chair	**Paper written on:**	30 March 2022
Paper Reviewed by:	N/A	**Paper Category:**	Governance and Assurance
Forum submitted to:	Board of Directors	**Paper FOIA Status:**	Full

1. Purpose of Paper

1.1. Why is this paper going to the Trust Board and what input is required?

This paper presents a summary of the Extra Ordinary Quality and Safety Committee meeting held on 29 March 2022 for assurance purposes. The Trust Board is asked to consider the assurances provided and whether any additional assurances are required.

2. Executive Summary

2.1 Context

The Board of Directors has delegated responsibility for the oversight of patient safety and quality to the Quality and Safety Committee. This Committee is responsible for seeking assurance on the quality and safety of the services it delivers in order that it may provide appropriate assurance to the Board.

An Extra Ordinary Quality and Safety was scheduled to discuss Infection, Prevention and Control agenda items which usually report to the Quality and Safety Committee.

2.2 Summary

- All members of the Committee were in attendance and therefore quorate
- The Committee received the IPC Improvement Plan, IPC BAF and IPC Hygiene Code Gap analysis assurance reports
- The Committee considered the terms of reference and committee work plan for the suggested IPC Quality Assurance Committee

2.3. Conclusion

The Trust Board is asked to note the Chair's Report for assurance purposes and consider any additional assurances required.

Chair's Assurance Report
Extra Ordinary Quality and Safety Committee 29 March 2022

3. Main Report

3.1 Introduction

This report has been prepared to provide assurance to the Trust Board from the Extra Ordinary Quality and Safety Committee which met on 29 March 2022. The meeting was quorate with 2 Non-Executive Directors and 3 Executive Directors in attendance. A full list of the attendance is outlined below:

Chair/Attendance:	
Membership:	
Chris Beacock	Non-Executive Director (Chair)
Paul Kingston	Non-Executive Director
Stacey Keegan	Interim Chief Executive Officer
Sara Ellis Anderson	Interim Chief Nurse and Patient Safety Officer
Ruth Longfellow	Chief Medical Officer
In Attendance:	
Shelley Ramtuhul	Trust Secretary/Director of Clinical Governance
Kirsty Foskett	Head of Clinical Governance
Mary Bardsley	Assistant Trust Secretary (Minutes)
Apologies:	
All members of the meeting were in attendance	

3.2 Actions from the Previous Meeting

Due to the meeting being an extra ordinary meeting there were no actions for discussion.

3.3 Key Agenda

The Committee received all items required on the work plan with an outline provided below for each:

Agenda Item / Discussion	Assured (Y/N)	Assurance Sought
1. Declaration of Interest		
There was no declaration of interest shared	N/A	
2. IPC Improvement Plan		
The improvement plan which has been created in response to the NHSE/I visit at the end of February. The Trust remains red rated on the NHSE/I internal matrix. The Committee discussed the position of the 6 immediate actions – one of the actions have been closed. The Committee noted the IPC Improvement plan which will continue to be a standard agenda item for the Committee.	Yes	

Chair's Assurance Report
Extra Ordinary Quality and Safety Committee 29 March 2022

3. IPC Hygiene Code Gap Analysis		
The Trust presented the analysis highlighting the 5 criterion areas that require improvement to gain full compliance. The improvement plan was presented in draft format and further work it to be completed in order to align leads to the actions and identify timescales. The Committee noted the IPC Hygiene Code Gap Analysis and agreed partial assurance to be reported to the Board – assurance was gained on the reporting process and monitoring of the actions however, further information is to be provided on the green rated areas and one overarching improvement plan is to be presented to allow for easier scrutiny of the actions and timelines.	Partial	One overarching improvement plan to be development and presented to the committee to allow for easier scrutiny of the actions. Further information to be provided regarding the green rated areas and the statements listed under each criterion.
4. IPC Board Assurance Framework		
Following discussions, it was noted that the has a good process in place to review and monitor the IPC Board Assurance Framework. The framework continues to be a live document which the IPC Committee have oversight on frequently. The risks to highlight following a review of the framework include: ▪ IPC team capacity to complete assurance walks ▪ Full training needs analysis and subsequent detailed training report required The Committee agreed to seek support from the People Committee in relation to the risks identified. It was agreed that an update is to be provided to the People Committee on IPC capacity and training requirements at the next meeting.	Partial	The Committee is to seek support from the People Committee to gain further assurance on the IPC capacity and training needs analysis risks raised.
5. IPC Governance Review		
The Committee received the IPC Governance Review which outlined the recommendations for improvement. It was highlighted that there were no areas of no assurance, and all recommendations are linked to areas of improvements. Following an explanation of the delivery and reporting process the Committee were assured the appropriate actions were in place to drive improvement. The Committee will receive an overarching improvement plan which includes the recommendations following the Governance review.	Yes	
6. Chair Report – IPC Committee		
The Committee raised the following concerns: ▪ outstanding estates jobs across the organisation amounts to approx. 800.	Partial	Outstanding estates jobs to be presented to the next Committee

▪ Storage for equipment The Non-Executive Directors challenged the appropriateness of reporting process of the outstanding estates requisitions which are currently overseen by the IPC Committee. Assurance was obtained on the storage solution, with the Trust explaining an improvement plan is in place and the management line will be overseen by Stores (within Estates) instead of by each individual ward.		along with further information on the reporting process/line to ensure assurance is gained.
7. Terms of Reference		
The Committee consider the terms of reference for the suggested IPC Quality Assurance Committee and recommends approval to the Board of Directors. The Trust Secretary explained that the membership notes 3 Non-Executive Directors when currently there are 2 Non-Executive Directors in attendance. It was noted that following the successful appointments of the 2 new Board members there will be 3 Non-Executive Directors aligned to the Committee in the future.	Yes	
8. Review of the Work Plan		
The Committee noted the workplan which will become a standard agenda item for the Committee to reflect upon after each meeting.	N/A	

3.4 Approvals

Approval Sought	Outcome
Terms of Reference for the IPC Quality Assurance Committee	Recommendation for the Board to approve.

3.6 Risks to be Escalated

In the course of its business the Committee confirmed there are no risks to be escalated to the Board.

3.7 Committee Cross Cover

In the course of its business the Committee identified the following information to be shared:

- IPC Capacity and Training Requirement to be reported to the People Committee to provide further assurance. The item has been tabled for discussion at the next People Committee – 21 April 2022

4. Conclusion

The Board of Directors is asked to note the meeting that took place and the assurances obtained.

0. Reference Information

Author:	Shelley Ramtuhul, Trust Secretary/Director of Governance	Paper date:	6 April 2022
Executive Sponsor:	Sara Ellis Anderson Chief Nurse and Patient Safety Officer	Paper Category:	Governance
Paper Reviewed by:	Extra Ordinary Quality and Safety Committee 29/04/2022	Paper Ref:	N/A
Forum submitted to:	Board of Directors	Paper FOIA Status:	Full

1. Purpose of Paper

1.1. Why is this paper going to Trust Board and what input is required?

Following consideration at the Extra Ordinary Quality and Safety Committee, the members of the meeting recommend the terms of reference for the IPC Quality Assurance Committee is approved.

A copy of the Committee work plan is attached for information.

2. Executive Summary

2.1. Context

The Trust has established an IPC Quality Assurance Committee in order to seek assurance on all aspects relating to Infection, Prevention and Control.

2.2 Summary

The paper outlines the draft terms of reference for the IPC Quality Assurance Committee.

Infection, Prevention and Control is usually aligned to the Quality and Safety Committee however, as a key priority and focus area of the Trust all IPC agenda items will be reported to the IPC Quality Assurance Committee until further notice.

The Committee will seek assurance on all IPC related reporting and will presented assurance to the Board on a monthly basis.

2.3. Conclusion

The Board is asked to consider and approve the Terms of Reference for the newly established IPC Quality Assurance Committee.

1. Constitution

The Board hereby resolves to establish a Committee of the Board to be known as the Infection, Prevention Control Quality Assurance Committee. The Committee is a Non-Executive Committee of the Board and has no executive powers other than those specifically delegated in these Terms of Reference.

2. Membership and Quorum

The Committee shall be appointed by the Board from the Non-Executive Directors and Executive Directors of the Trust and shall consist of;

- Three Non-Executive Directors
- The Board will appoint a Committee Chairman and deputy Chairman from the Non-Executive members of the Committee and appoint a Non-Executive Director to attend meetings in the absence of the chairman or deputy Chairman
- Chief Executive Officer – invited to attend as required
- Chief Medical Officer
- Chief Nurse and Patient Safety Officer

In exceptional circumstances a deputy may attend in place of an Executive Director.

The Board of Directors will appoint a Committee Chairman from the Non-Executive members of the Committee and a Non-Executive Director will be nominated to Chair meetings in the absence of the Chairman.

A quorum will be one Non-Executive member and two Executive members.

3. Attendance

The Trust Secretary/Director of Governance and Head of Clinical Governance will be expected to attend each meeting.

The Chair of the Board has open invitation to attend.

The Chief Nurse and Patient Safety Officer shall agree the agenda with the Chair of the Committee and other attendees. The Assistant Trust Secretary will organise the collation and distribution of the papers and keep a record of matters arising and issues to be carried forward.

4. Frequency of meetings

The Committee will meet at least once a month for the next 6 months. The Committee will then complete a review of effectiveness. The Chairman of the Committee may call additional meetings.

5. Authority

The Committee is authorised by the Board to investigate any activity and is expected to make recommendations to the full board, within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee. The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of others from outside the Trust with relevant experience and expertise if it considers this necessary.

6. Reporting

The Chair of the Committee will report to the Board in as soon as practically possible following the Committee meeting; this will be no later than the Board meeting in the following month. A summary of the main issues of the discussion, drawing attention to any issues that require full Board or Executive action, will be presented via a Chairs Assurance Report.

The Committee will undertake an self-assessment, which will be presented to the Trust Board after 6 months to review the effectiveness of the Committee.

7. Key responsibilities

- Promote excellence in patient care in all aspects of Infection, Prevention and Control and monitor and review the "Quality Improvement Strategy".

- The purpose of the IPC Quality Assurance Committee is to assist the Board obtaining assurance that high standards of care are provided and any risks to quality identified and robustly addressed at an early stage. The Committee will work with the Audit Committee and Risk Management Committee to ensure that there are adequate and appropriate quality governance structures, processes and controls in place throughout the Trust in relation to Infection, Prevention and Control in order to:
    - Promote safety and excellence in patient care
    - Identify, prioritise and manage risk arising from clinical care
    - Ensure efficient and effective use of resources through evidence based clinical practice

- To ensure the Trust is meeting core standards and is compliant with national guidelines and regulatory requirements in relation to prevention and control of infection.

- To oversee the delivery of the infection prevention and control improvement plan and provide appropriate assurances to the Board and escalate any areas of concern.

- To ensure that the Committee has adequate information on which to advise and assure the Board on standards of care provision in relation to Infection, Prevention and Control.

- To receive Chairs Assurance Reports from the following the Infection Control Committee

- The Committee shall approve such policies as the Board has not reserved to itself and as required by the Trust's Policy Control Policy

IPC Quality Assurance Committee

Work Plan 2022/23

	29-Mar 2:30pm - 4pm	APRIL tbc	MAY tbc	JUNE tbc	JULY tbc	AUG tbc	SEPT tbc
Committee Management							
Terms of Reference	✓						
Review of the Work Plan	✓	✓	✓	✓	✓	✓	✓
Attendance Matrix	✓	✓	✓	✓	✓	✓	✓
Governance / Performance							
Chair Report from Infection Control Committee	✓	✓	✓	✓	✓	✓	✓
IPC Board Assurance Framework	✓	✓	✓	✓	✓	✓	✓
IPC Improvement Plan	✓	✓	✓	✓	✓	✓	✓
IPC Quality Report		✓	✓	✓	✓	✓	✓
Caring for Patients							
Infection Control Quarterly Report			✓		✓		
IPC Governance Review	✓						
Infection Control Assurance Report	✓	✓	✓	✓	✓	✓	✓
Annual Reports							
Infection Control Annual Report				✓			
Policy/Strategy Oversight							
As required	✓	✓	✓	✓	✓	✓	✓
Internal Audit/External Inspections							
As required	✓	✓	✓	✓	✓	✓	✓

IPC Improvement Plan

0. Reference Information

Author:	Sara Ellis-Anderson, Interim Chief Nurse and Patient Safety Officer	Paper date:	6 April 2022
Executive Sponsor:	Sara Ellis-Anderson, Interim Chief Nurse and Patient Safety Officer	Paper Category:	Quality and Governance
Paper Reviewed by:	Extra Ordinary Quality and Safety Committee	Paper Ref:	N/A
Forum submitted to:	Trust Board	Paper FOIA Status:	Partial

1. Purpose of Summary

1.1. Summary

The Trust declared an MRSA outbreak on the Midlands Centre for Spinal Cord Injury (MCSI) on the 20th of July 2021. The NHSE/I IPC team completed an assurance visit on 2nd of August 2021 highlighting areas for improvement. Subsequently RJAH was escalated to Red on the NHSE/I IPC Matrix and a subsequent improvement plan with external support was developed and progressed.

NHSE/I have continued to provide support to RJAH and the IPC team and alongside colleagues from partner organisations have visited the site regularly. Following the last visit on the 11th of February 2022 there were heightened areas of concern identified with IPC practice and governance. The Trust therefore remains red on the NHSE/I IPC matrix with immediate remedial action and improvement required.

The Board is asked to note the immediate actions taken and the progress against the trust wide improvement plan.

2. Executive Summary

2.1. Context

RJAH was escalated to Red on the NHSE/I IPC Matrix in August 2021. NHSE/I have continued to provide support to RJAH and the IPC team and alongside colleagues from partner organisations have visited the site regularly. Following the last visit on the 11th of February 2022 there were heightened areas of concern identified with IPC practice and governance. The Trust therefore remains red on the NHSE/I IPC matrix with immediate remedial action required.

The areas inspected on the 11th of February included Ludlow ward, Main Outpatient department, Gladstone ward and Sheldon ward.

2.2. Overview

The Chief Nurse received a letter on the 17th of February 2022 highlighting ongoing concerns around IPC and governance in line with the Code of Practice on the prevention and control of infections (Hygiene Code). There was concern raised that there had been a lack of progress against the previously agreed actions and a lack of evidence that the areas for improvement identified have been extrapolated across the Trust to reduce the risk of possible harm to others. A number of immediate actions were identified and outlined within the NHSE/I letter:

IPC Improvement Plan

Recommended immediate actions outlined in NHSE/I letter:

	Recommended Action	Progress update
1	Review of assurance and sign off processes for actions plans and a review of all actions plans that are currently marked as completed	This has been completed and all outstanding actions transferred to Tendable.
2	Complete the GAP analysis and action plan against the Code of Practice for the prevention of infection and related guidance (Hygeine Code) and ensure this has been presented to Trust Board within the next month.	GAP analysis completed in November 2021 with actions identified. Presented at IPCC and Q&S in March 22 and Trust Board April 22.
3	IPC BAF needs to be updated and presented to the Trust Board within the next month.	Revised IPC BAF received Dec 2021. IPC and E&F team have been providing evidence of compliance during January and February. Presented at IPCC and Q&S in March 22 and Trust Board April 22.
4	Development of recommendations of the One Together audit, presented to the Trust IPC Committee.	One Together Audit completed and circulated to key stakeholders in Dec 21. Presented at IPCC. Working group set up to progress actions with upward reporting to IPCC and subsequently Q&S via Chairs report.
5	Medical leadership intervention with medical colleagues compliance with IPC including hand hygiene, bare below the elbows and the use of theatre hats/caps.	Medical Director has written to all medical colleagues outlining expectations. Mandatory IPC Training and Cleaning for Confidence compliance per discipline is being monitored at IPCC. Further detailed quarterly training report for hand hygiene, donning and doffing and ANTT per discipline in development following transfer of local training records on to ESR and due to be presented at IPCC April 22.
6	Review of the IPC team structure and the team capacity and priorities	Review and benchmarking undertaken in Dec 21. CCG supporting with review of IPC lead job plan. Case of need outlining re-structure and strengthening of the IPC team approved at SLG 22/03/2022.

There were immediate remedial actions required within ward and department areas identified. Subsequently a live operational action plan for estates/facilities and ward/departmental actions has been developed and progress is monitored weekly with DIPC oversight with clear timescales for completion.

It should be noted many of the estates actions require external contractors and ward closures to facilitate the improvement works required. In view of continued Covid-19 impact on activity a decision was taken to close Ludlow ward until mid-April for remedial works to be completed. A review of Trust wide outstanding estates work is being undertaken with support from the IPC team to agree priorities of work on a risk-based approach.

IPC Improvement Plan

Situation reported at 17:00 1st of April:

Ward & Dept Actions:

RAG Status	Number
Amber – in progress	12
Green – completed	68
Red – behind plan	1
Grand Total	**81**

Estates and Facilities Actions:

RAG Status	Number
Amber – in progress	27
Green	44
Grand Total	**71**

The 27 estates and facilities actions are on Ludlow ward with an estimated date of completion being 15th of April 2022. The in-progress actions across the wards and departments mainly consist of equipment replacement and orders have been placed. The one action that are behind plan consist of a delay in the hoist being replaced on Ludlow ward.

Trust Wide Improvement Plan:

A Trust wide IPC improvement plan has been developed led by the Chief Nurse and supported by the Director of Performance, Improvement & OD. Recommendations from the IPC governance review have also been included. Actions to improve and sustain will include but are not limited to:

- Clear roles and responsibilities defined for teams in relation to IPC and roll out of National Standards for Cleanliness from April 2022
- Productive ward series to be re-launched
- Re-structure and strengthening of IPC team
- IPC week focussing on IPC skills stations promoting education and development on all elements of IPC for staff
- Application of 6S improvement tool to improve ward and department storage
- Review of facilities team provision
- Additional levels of IPC observation within clinical areas
- Review and update of IPC governance structure
- Re-launch of IPC strategy

NHSE/I have allocated an Improvement Director to work with the Trust to support his work going forwards.

Conclusion

The Trust will remain RED on the NHSE/I Midlands Infection Prevention and Control internal escalation matrix. A follow up visit will be scheduled with NHSE/I for three months' time in June.

The action and improvement plan will be monitored through internal IPCC, IPC Assurance Committee with system oversight at the STW System Quality Group.

The Board is asked to ***note*** the actions taken and proposed improvement plan and seek additional assurance if required.

Acronyms

ANTT	Aseptic Non Touch Technique
BAF	Board Assurance Framework
CCG	Clinical Commissioning Group
DIPC	Director of Infection Prevention and Control
E&F	Estates and Facilities
ESR	Electronic Staff Record
IPC	Infection Prevention and Control
IPCC	Infection Prevention and Control Committee
MCSI	Midlands Centre for Spinal Cord Injury
MRSA	Methicillin-resistant Staphylococcus aureus
NHSE/I	NHS England and Improvement
RJAH	Robert Jones and Agnes Hunt Orthopaedic Hospital
STW	Shropshire Telford and Wrekin

0. Reference Information

Author:	Sue Sayles, Lead IPC Nurse, Hayley Gingell, IPC Assurance Lead	Paper date:	6 April 2022
Executive Sponsor:	Sara Ellis-Anderson, Interim Chief Nurse and Patient Safety Officer	Paper Category:	Governance and Quality
Paper Reviewed by:	Extra Ordinary Quality & Safety Committee 29/03/2022	Paper Ref:	N/A
Forum submitted to:	Board of Directors	Paper FOIA Status:	Full

1. Purpose of Paper

1.1. The purpose of the Infection Prevention and Control (IPC) Board Assurance Framework (BAF) is to provide assurance to the Board of Directors that the Trust has fully assessed compliance against the updated version of the IPC BAF version 1.8, released on 24 December 2021.

1.2. An electronic file storage system has been created to store all evidence in support of each key line of enquiry. Evidence has been headlined in the evidence library column and each KLOE number is hyperlinked to the file where it is stored. The storage system is attached to a local server and therefore only persons with permissions to this folder will be able to view evidence. A request can be made to IPC Assurance Lead if required.

2. Executive Summary

2.1. Summary

- New version 1.8 IPC Board Assurance Framework (BAF) released 24th December 2021
- Governance review tracker added to monitor progress of the IPC BAF to Board.
- New version 1.8 presented at IPC&C Committee following initial release 27th January 2021
- Trust position to all KLOEs reviewed at IPC&C 1st March 2022. Out of 113 KLOEs 87 rated as green and 26 Amber with further actions required.
- Amber and Red RAG rated KLOES will form the basis of an action plan. Progress against actions monitored via the Infection Control & Cleanliness Working Group and presented at IPC&C for oversite and approval.
- Risks to escalate:
  - IPC team capacity to complete IPC assurance walks
  - Full training needs analysis and subsequent detailed training report required
- Progress:
  - IPC team structure has been reviewed and case of need approved with recruitment underway
  - Local training records for annual hand hygiene competencies being entered on ESR for full oversight and local induction for medical staff extended

IPC Board Assurance Framework Governance Tracker

IPC Board Assurance Framework is reviewed at Infection Control & Cleanliness Committee who will:

- Identify and assign appropriate leads/departments to key pieces of information where necessary.
- Offer assurance in terms of compliance with the Health & Social Care Act 2008 -Code of Practice on the prevention and control of infections to which the IPC Board Assurance Framework is linked.
- Monitor overall position to the compliance of all key lines of enquiry (KLOEs)
- Provide assurance of compliance, and escalate areas of concern, to the Quality & Safety Committee.

	Date Review at Infection Control & Cleanliness Committee	Date Presented at Quality & Safety Committee	Date Presented at Trust Board
1.0	27th May 2020	May 2020	28th May 2020
1.0	14th July 2020	July 2020	30th July 2020
1.5	27th October 2020	January 2021	28th January 2021
1.5	26th January 2021		
1.7	22nd April 2021	May 2021	27th May 2021
1.7	22nd July 2021	September 2021	IPC annual report Nov 2021
1.8	27th January 2022		
1.8	1st of March 2022	March 2022	April 2022

Version Control

Date	Version
May 2020	First release Version 1
Oct 2020	1.5 – Officially published
Feb 2021	1.6
Mar 2021	1.7
Dec 2021	1.8

Infection Prevention and Control Board Assurance Framework for COVID-19

	1. Systems are in place 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 posed by their environment and other service users					
Key lines of enquiry		**Evidence**	**Document Library**	**Gaps In Assurance**	**Actions**	**RAG**
1.1	A respiratory season/winter plan is in place: • 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 • to enable appropriate segregation of cases depending on the pathogen. • plan for and manage increasing case numbers where they occur. • a multidisciplinary team approach is adopted with hospital leadership, estates & facilities, IPC Teams and clinical staff to assess and plan for creation of adequate isolation rooms/units as part of the Trusts winter plan.	Abbott ID machine introduced for the rapid testing of patients in the absence of a PCR result. For patients who test positive for COVID-19 they are treated on a red pathway. Amber pathway provides a backup process for patients with an unknown status. The Trust has purchased 8 air scrubbers and are now being used on site. Estates & Facilities team continue to advocate a multi-disciplinary approach to environmental improvements across the Trust with installation of new doors on Sheldon and Kenyon Ward.	Abbotts I.D SOP Amber & Red Pathway SOP Purchase orders for Air scrubbers IPC Quarter 3 Report *(Section 3.2.5 Specific Cleaning & Cleanliness)* Air Sentry SOP Coronavirus Policy	Not all policies within date	Pandemic influenza plan 22/23 is currently being updated by end of March 22.	
1.2	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 secure risk assessments are completed by managers in all areas. Social distancing audits are undertaken on a monthly basis in all clinical areas via the Tenable/Perfect Ward Auditing software. And iPad haves been provided to facilitate this in all areas.	COVID-19 Risk Assessments Tendable/Perfect Ward IPC Assurance Walks	IPC assurance walks programmed in are behind schedule due to capacity of IPC team.	Review of IPC team capacity and structure by end of March 22. CCG requested to complete quality assurance visits as part of programme to	

		IPC team undertake a programme of Assurance Walks and action plans are developed as required to address any areas of concerns. Actions plans are forwarded to the ward/departmental manager for action. All actions are monitored individually by IPC QMS. Safe capacity limits have been implemented to all staff break areas. Quarterly reporting is monitored via IPC&C Committee	IPC Quality Management System Minutes of IPC&C Committee Quarter Reports		give further assurance and additional capacity.	
1.3	Organisational /employers risk assessments in the context of managing seasonal respiratory infectious agents are: • 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. • Applied in order and include elimination; substitution, engineering, administration and PPE/RPE. • Communicated to staff.	Overarching risk has been added to the Datix risk register following the hierarchy of controls. Safe capacity limits have been implemented to all staff break areas. Ward staff have a window opening schedule chart to provide regular ventilation. All information contained within the risk assessments are communicated out to staff via comms and RJAH social media.	Window-opening schedule Risk Register		Risk to be separated into individual risks for inpatients and outpatients in line with NHS England recommendations.	
1.4	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, for example Integrated Care Systems	The overarching risk is reviewed within the governance unit meetings initially and then reported to Risk Management Committee for oversite. Safe capacity limits have been implemented to all staff break areas.	Safe capacity limit poster Unit Governance risk registers Coronavirus Policy			

		Ward staff have a window opening schedule chart to provide regular ventilation. Monitoring Datix incident reports that are related to IPC.				
1.5	If the organisation has adopted practices that differ from those recommended/stated in the national guidance a risk assessment has been completed and it has been approved through local governance procedures, for example Integrated Care Systems.	UKHSA Covid-19 recommendations were approved by the Board with a full QIA. In response to increased COVID-19 national prevalence the Trust opted against stepdown of precautions and agreed to continue with the 2-meter distancing rule for all in-patient areas. PCR testing undertaken 72 hours prior to admission.	Infection Control & Cleanliness Committee Agendas and papers UKHSA Recommendations Weekly Task and Finish Group	Review presurgical testing in line with living with COVID-19 Guidance.	Implement proposal to move to LFT testing on day of admission for low risk non aerosol generating procedures March 22.	
1.6	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.	Overarching risk has been added to the Datix risk register following the hierarchy of controls. Risk assessments supported by H&S officer.			Risk to be separated into individual risks for inpatients and outpatients in line with NHS England recommendations.	
1.7	If an unacceptable risk of transmission remains following the risk assessment, the extended use of Respiratory Protective Equipment (RPE) for patient care in specific situations should be considered.	Staff have access to FFP3 masks.	Coronavirus Policy FFP3 Flowchart			
1.8	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.	To minimise spread of infection. Patients are not transferred unnecessarily between care areas.	Coronavirus Policy Isolation Policy			
1.9	The Trust Chief Executive, Medical Director or Chief Nurse has oversight of the daily SITREP in relation to COVID-19, other seasonal respiratory infections, and hospital-onset cases.	Chief Nurse has oversite of the daily SITREP submitted. Trust sends daily report to Mids ROC.	Mids ROC Circulate a regional report weekly.			

1.10	There are check and challenge opportunities by the executive/senior leadership teams of IPC practice in both clinical and non-clinical areas.	Senior leadership colleagues will continue to check and challenge with compliance measures. Exec Buddy visits have been reintroduced.	Exec buddy visit feedback at SLG		Patient safety walks to be extended to the Non-Executive Directors starting April 22.	
1.11	Resources are in place to implement and measure adherence to good IPC practice. This must include all care areas and all staff (permanent, agency and external contractors)	All external Estates contractors receive a verbal induction upon arrival and are informed of PPE and IPC requirements whilst on site. All Estates contractors are directed to the COVID screening desk daily whilst on site and paperwork completed is kept with them whilst on site. All Estates contractors receive a yearly induction. Bank staff receive induction through the corporate induction process. Relevant, DBS, NMC, Health checks are undertaken for agency staff and a checklist is completed when they start. State of art hand hygiene training device – Surewash was procured to assist staff with undertaking hand hygiene training.	Estates Contractor Presentation COVID-19 Screening questions Checklist for Agency Staff Hand Hygiene leaflet Tendable	Checklist for agency staff does not assess staff competency of IPC practice.	Review of agency worker checklist for local induction	
1.12	The application of IPC practices within this guidance is monitored, eg: • hand hygiene. • PPE donning and doffing training. • cleaning and decontamination.	All IPC Ward and Departmental audits undertake their own audits via the Tenable/Perfect Ward App	IPC Ward & Departmental Audit Tools IPC Assurance Walk Audits Tendable	IPC mandatory training and Cleaning for confidence modules compliance reported at IPCC. Further detail	Full training needs analysis required across all disciplines. New training report under development for April 22 to review HH, ANTT, Donning and	

			The donning of Personal Protective Equipment (PPE) . The hand washing vide o External visits	required on annual HH competencies and donning and doffing training.	Doffing training trust wide.	
1.13	The IPC BAF is reviewed, and evidence of assessments are made available and discussed at Trust Board.	Minutes of Trust Board meetings & IPCC, Q&S A tracker acts as a front cover to the BAF to demonstrate good governance with dates in which the BAF was reviewed at Infection Control & Cleanliness Committee, Quality & Safety Committee and Trust Board	Infection Control & Cleanliness Committee papers Quality & Safety Committee papers			
1.14	The Trust Board has oversight of ongoing outbreaks and action plans	The Chief Nurse reports outbreak information to the senior leadership team. Outbreak data and summary of action plans are in the quarterly reports which is taken to Trust Board Sitrep report detailing COVID-19 positive patients and associated outbreaks is forwarded to the senior leadership team.	Infection Control & Cleanliness Committee papers IPC Quarterly Reports Outbreak Management Toolkit Quality & Safety Minutes	RCAs in progress	Thematic review of all outbreaks and action plans to be conducted by May 22.	
1.15	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 receives FFP3 masks via the push stock model. The Trust has a range of UK sourced masks in stock and endeavours to ensure all relevant staff are for tested to at least two different models of FFP3 masks.	Emails from national PPE Team communicating stock levels Mask Fit Data			

		The trust is not reliant on a specific mask type and fit tests to 3 different models of masks.				
2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.						
Key lines of enquiry		**Evidence**	**Document Library**	**Gaps in Assurance**	**Actions**	**RAG**
2.1	The Trust has a plan in place for the implementation of the National Standards of Healthcare Cleanliness and this plan is monitored at board level.	Implementation plan led by IPC working group, updates reported though IPC committee structure to board via quarterly IPC report	IPC Working Group papers, IPC Committee papers			
2.2	The organisation has systems and processes in place to identify and communicate changes in the functionality of areas/rooms	The organisation has systems and processes in place to identify and communicate changes in the functionality of areas/rooms	All requests considered though Estates Plan meeting - using Space Utilisation Policy located on the document centre			
2.3	Cleaning standards and frequencies are monitored in clinical and non-clinical areas with actions in place to resolve issues in maintaining a clean environment.	Cleaning standards and frequencies are monitored in clinical and non-clinical areas with actions in place to resolve issues in maintaining a clean environment.	01 High Risk Pathway Cleaning Process Cleaning Sign Off Sheets (Paper copies in housekeeping manager office)			
2.4	Increased frequency of cleaning should be incorporated into the environmental decontamination schedules for patient isolation rooms and cohort areas.		01 High Risk Pathway Cleaning Process Cleaning Sign Off Sheets (Paper copies in housekeeping manager office)			
2.5	Where patients with respiratory infections are cared for: • cleaning and decontamination are carried out with neutral detergent or a combined solution followed by a	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	Cleaning Policy – Located on the document centre			

	chlorine-based disinfectant, in the form of a solution at a minimum strength of 1,000ppm available chlorine as per national guidance.	disinfectant, in the form of a solution at a minimum strength of 1,000ppm available chlorine as per national guidance.	01 High Risk Pathway Cleaning Process			
2.6	If an alternative disinfectant is used, the local infection prevention and control team (IPCT) are consulted on this to ensure that this is effective against enveloped viruses.		N/A			
2.7	manufacturers' guidance and recommended product 'contact time' is followed for all cleaning/disinfectant solutions/products.		Standard disinfectants used as supplied through NHS supply chain, COSHH completed & contact time adhered to			
2.8	a minimum of twice daily cleaning of: • patient isolation rooms. • cohort areas. • Donning & doffing areas • 'Frequently touched' surfaces eg, door/toilet handles, patient call bells, over bed tables and bed rails. • where there may be higher environmental contamination rates, including: toilets/commodes particularly if patients have diarrhoea.		Cleaning Sign Off Sheets (Paper copies in housekeeping manager office) COVID Cleaning SOP			
2.9	A terminal/deep clean of inpatient rooms is carried out: • following resolutions of symptoms and removal of precautions. • when vacated following discharge or transfer (this includes removal and disposal/or laundering of all curtains and bed screens) • following an AGP if room vacated (clearance of infectious particles after an AGP is dependent on the		Cleaning Sign Off Sheets (Paper copies in housekeeping manager office) Trust Cleaning Policy COVID Cleaning SOP			

	ventilation and air change within the room).					
2.10	Reusable non-invasive care equipment is decontaminated: • between each use. • after blood and/or body fluid contamination • at regular predefined intervals as part of an equipment cleaning protocol • before inspection, servicing, or repair equipment.	As per Trust Cleaning Policy	Trust Cleaning Policy			
2.11	Compliance with regular cleaning regimes is monitored including that of reusable patient care equipment.	All locations audited (frequency in line with risk rating for area); actions monitored through action sheets submitted to cleanliness technicians/clinical team. Estates actions monitored through estates helpdesk. I am Clean stickers applied to all reusable patient care equipment when cleaned.	Action sheets (paper copies in housekeeping manager office)	No standardised cleaning responsibilities and frequency information held at ward level.	Implement and display Cleanliness Charter board in clinical areas by April 22	
2.12	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.	Partial - vent in some wards only, mitigated in some areas with air scrubbers if/when required. Natural vent within the remaining areas and policy of opening windows for 10min/hr in known areas of airborne transmitted viruses				
2.13	The assessment is carried out in conjunction with organisational estates teams and or specialist advice from ventilation group and or the organisations, authorised engineer	Concerns discussed at Ventilation working group, raised on risk register as required.	Decontamination & Ventilation Group papers Risk register			

2.14	A systematic review of ventilation and risk assessment is undertaken to support location of patient care areas for respiratory pathways	Re-verifications of areas required as detailed in HTM 03-01 for critical ventilation systems / premises only				
2.15	Where possible air is diluted by natural ventilation by opening windows and doors where appropriate	Clinical areas are encouraged to have a process for regularly opening windows where applicable.	Ward level documentation			
2.16	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.	Use of Air Scrubbers	Decontamination & Ventilation Group papers			
2.17	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	Issues are discussed at Estates Planning Meetings.	Estates Planning meeting Log			
	3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance					
Key lines of enquiry		**Evidence**	**Document Library**	**Gaps in Assurance**	**Actions**	**RAG**
3.1	Arrangements around antimicrobial stewardship are maintained And previous antimicrobial history is considered	Evidence-based local antimicrobial guidelines are in place and are reviewed on an annual basis. Adherence to the local guidelines is monitored using quarterly Point Prevalence studies. Weekly microbiology ward round attended by consultant microbiologist, Antimicrobial Stewardship Pharmacist & IPC nurse, covers all wards in the hospital to review all current antibiotic prescribing. Pharmacists clinically check antibiotic prescribing daily during their ward visits.	IPC Annual Report PIR Information gathering tool PIR Minutes & Action plans Post Infection Review SOP		Toolkit for ongoing antibiotic point prevalence surveys to be devised	

		Quarterly monitoring of antibiotic issue in the Trust. Ongoing programme of audit has been introduced and will be reported to the Antimicrobial Stewardship Committee Education and training for doctors at induction, nurses at link meetings and pharmacists at department meetings Weekly ward rounds with a consultant microbiologist, IPC nurse and pharmacist. Antibiotic history (previous 6 months) is recorded on the medicines reconciliation by pharmacy. Located on EPR. Antimicrobial Pharmacist attends weekly Infection MDT meetings.				
3.2	Mandatory reporting requirements are adhered to and boards continue to maintain oversight	Report the retrospective antibiotic consumption data (declared as amount 'issued' as electronic prescribing not available) highlighting the use of broad-spectrum antibiotics i.e. piperacillin-tazobactam and the carbapenems. A quarterly antimicrobial report is produced to show the usage of all antibiotics. Also it highlights the trend of restricted antibiotics such as meropenem and tazocin. Audits - vancomycin and sepsis audits are going to be completed by trainee pharmacists this year.	Minutes of Antimicrobial Meetings and reports Antimicrobial SPC data	Attendance to Antimicrobial Stewardship committee requires strengthening.	Chief Medical Officer to ensure medical representation.	.

3.3	Risk assessments and mitigations are in place to avoid unintended consequences from other pathogens	New prescription chart will help to ensure antibiotics are reviewed within 72 hours - stopped, switched or continued. PPS - a snapshot of antibiotic usage within the Trust is completed every 3 months	Monitoring of HCAI	PPS audit results not currently shared widely	Review IPC governance framework	
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						
Key lines of enquiry		**Evidence**	**Document Library**	**Gaps in Assurance**	**Actions**	**RAG**
4.1	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 has paused visiting at present in response to increase in local COVID-19 prevalence. Visitors Protocol was revised and updated in November 2021 The Trust is part of IPC System resilience Task and finish group. The Trust is now looking into a system wide approach to visiting.	Visiting protocol		Patient visiting leaflet in development	
4.2	Restrictive visiting may be considered appropriate during outbreaks within inpatient areas. This is an organisational decision following a risk assessment.	Restricted visiting is considered during outbreaks and is outlined in the Coronavirus Policy. Visiting protocol was further revised in November 2021	Coronavirus Policy Visiting protocol			
4.3	There is clearly displayed, written information available to prompt patients visitors and staff to comply with handwashing, wearing a facemask/face covering and physical distancing.	Posters are located in all areas promoting good IPC precautions to COVID-19.	Posters displayed Hand Hygiene Trust video tour https://vimeo.com/681908110		Patient visiting leaflet in development	

4.4	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.	Ward staff will ensure that visitors are informed of infection status and the wearing of appropriate PPE. Isolation posters are attached to side room doors for patients in isolation.	EOL Visiting SOP			
4.5	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 (eg, parent/child) a risk assessment may be undertaken, and mitigations put in place to support visiting wherever possible.	The Trust has paused visiting in response to high local prevalence rates to COVID-19. The visiting protocol was updated in November 2021. End of life visiting is permitted with adherence to the agreed EOL visiting SOP.	Main entrance screening questionnaire Visiting Protocol EOL Visiting SOP			
4.6	Visitors are not present during AGPs on infectious patients unless they are considered essential following a risk assessment eg, carer/parent/guardian.	The Trust continues to follow national guidance in relation to this requirement.	Visiting Protocol Coronavirus Policy			
4.7	Implementation of the supporting excellence in infection prevention and control behaviours implementation toolkit has been adopted	Trust wellbeing comms align with the toolkit	Supporting Excellent in IPC toolkit Mar 21	Limited awareness of the Supporting excellence toolkit released in March 21	Comms to lead on its full implementation and utilise the recommended resources within the toolkit for staff and patients. Communications Manager implementing with immediate effect.	

	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					
Key lines of enquiry		**Evidence**	**Document Library**	**Gaps in Assurance**	**Actions**	**RAG**
5.1	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 on windows and doors at the main entrance.	Photos of main entrance Trust video tour https://vimeo.com/681908110			
5.2	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.	Discharge/transfer checklist in place Critical care transfer form in use	Covid-19 Passport Critical Care Transfer form			
5.3	Staff are aware of agreed template for screening questions to ask	All patients and visitors enter at the main entrance. Out of hours transfers are screened by the receiving ward.	Screening questionnaire Main Entrance			
5.4	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.	Patients attending for surgery are screened for COVID-19 72 hours prior to admission. Leaflets are sent out with appointments letters informing patients of COVID-19 precautions.	Screening requirements Patient leaflet			
5.5	Front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed COVID-19/ other respiratory infection symptoms and segregation of cases to minimise the risk of cross-infection as per national guidance.	The front door screening of patients and visitors at the main entrance of the hospital is undertaken by RJAH and volunteer staff, which have received training to be able to undertake this task.	Screening questionnaire for all Outpatient attendances			

		For patients with respiratory symptoms they are taken to the breakout room where further triage is undertaken by a clinical member of staff. For elective admissions into the organisation, isolation guidance is provided by the Pre-op Service. Any urgent / emergency transfers are requested via the Clinical Site Manager, who has oversight on the correct patient placement within the Organisation.				
5.6	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.	The front door screening of patients and visitors at the main entrance of the hospital is undertaken by RJAH and volunteer staff, which have received training to be able to undertake this task. For patients with respiratory symptoms they are taken to the breakout room where further triage is undertaken by a clinical member of staff.	Screening questionnaire for all Outpatient attendances			
5.7	There is evidence of compliance with routine patient testing protocols in line with Trust approved hierarchies of control risk assessment and approved.	All patient testing is undertaken in line with national swabbing requirements. The IPC Assurance lead will continue to undertake audits to assess Trust compliance to national swabbing requirements. Audits will be undertaken twice yearly. First audit undertaken in May 2021 showed good overall compliance to the following requirements: 72 hour pre admission swab Swab on admission 13th Day Swab	Inpatient swabbing requirements Coronavirus Policy National Swabbing requirements audits			

		With improvements required for the day 3 swab and 5-7th day. Audit undertaken in December 2021 Showed that the Trust is maintaining good levels of compliance to the 72 hr pre admissions swab, swab on admission and 13th day swab, but has also significant improved its compliance to the 3 day and 5-7th day swabbing requirements. Full reports can be viewed in the library of evidence.				
5.8	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	Inpatients are encouraged by ward staff to wear face masks if tolerated. Patients in isolation is required to wear a face mask when another person enters the room as a matter of courtesy. Patient mask wearing is monitored IPC Assurance Walks Mask dispensers are located in all areas for patients to obtain.	Patient mask wearing flowchart IPC Assurance Walks	Compliance with patient mask wearing does not feature in regular IPC audits	Robust system required for documentation of non-compliance to patient mask wearing. Consider revising IPC audit questions to include patient mask wearing.	
5.9	Patients with respiratory symptoms are assessed in a segregated area, ideally a single room, and away from other patients pending their test result	The COVID-19 screening questionnaire includes the process followed when a patient presents to the desk with respiratory symptoms. The patient is taken to the screening breakout room where triaging is undertaken by a clinical member of staff.	Coronavirus Policy Screening questionnaire Main Entrance Screening breakout room Amber & SOP			
5.10	Patients with excessive cough and sputum production are prioritised for placement in single rooms whilst awaiting testing.	For patients arriving via the main entrance, the COVID-19 screening questionnaire includes the process followed when a patient presents to the desk with respiratory symptoms.	Screening questionnaire Main Entrance			

		Inpatients are taken to isolation areas and further testing is undertaken.	Actions for suspected COVID-19 patients Amber & SOP Procedure for patients that develop COVID-19 Symptoms Air Sentry SOP			
5.11	Patients at risk of severe outcomes of respiratory infection receive protective IPC 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.	Examinations are undertaken during the pre-operative assessment where any respiratory complication/symptoms are clinically identified and assessment paused. For patients with known chronic chest and underlying lung conditions, Necessary PPE precautions are used. Patients who attend with underlying known respiratory conditions, COPD etc. They would be advised 14 days isolation prior to surgery. If one to one nursing is required there after – the patient is transferred to HDU Post op. At present the Trust has stopped family members accompanying patients for pre op appointments.	Fitness for Anaesthesia Guidelines PPE requirements updated Dec 2021			
5.12	Where treatment is not urgent consider delaying this until resolution of symptoms providing this does not impact negatively on patient outcomes	Clinical prioritisation is undertaken on patients in order to identify clinical need. Clinical decision is then made to delay or schedule for treatment.				

5.13	Face masks/coverings are worn by staff and patients in all health and care facilities	Face masks are provided at the front door for both staff and patients. Mask dispensers are sited in all areas	Patient mask wearing flowchart. Comms updates Tendable			
5.14	Where infectious respiratory patients are cared for physical distancing remains at 2 metres distance.	All beds remain at 2m distance				
5.15	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, eg, to protect reception staff.	A weekly meeting takes place to discuss all new recommendations made within the new IPC COVID-19 guidance released in November 2021. In response to increased COVID-19 national prevalence the Trust opted against stepdown of precautions and agreed to continue with the 2-meter distancing rule for all in-patient areas.	UKHSA Recommendations Weekly Task and Finish Group meetings to review 1m + to be implemented in outpatient areas		Risk assessment and QIA to be completed for moving to 1m plus	
5.16	Patients that test negative but display or go on to develop symptoms of COVID-19 are segregated and promptly retested and contacts traced promptly.	Process in place outlined in policy	Isolation Policy Actions for suspected COVID-19 patients Swabbing Requirements Contact tracing form			
5.17	Isolation testing and instigation of contact tracing is achieved for all patients new onset symptoms until proven negative	Process in place outlined in policy	Isolation Policy			
5.18	Patients that attend for routine appointments who display symptoms of COVID-19 are managed appropriately	The COVID-19 screening questionnaire includes the process followed when a patient presents to the desk with respiratory symptoms.	Screening questionnaire Main Entrance Actions for suspected COVID-19 patients process			

		The patient is taken to the breakout room where triaging is undertaken by a clinical member of staff.	Procedure for patients that develop COVID-19 Symptoms			
	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					
Key lines of enquiry		**Evidence**	**Document Library**	**Gaps in Assurance**	**Actions**	**RAG**
6.1	Appropriate infection prevention education is provided for staff, patients, and visitors.	The Trust website contains an area where visitors can obtain information relating to Coronavirus. The intranet also contains a section dedicated to coronavirus for staff to access. Leaflets are included with all appointment letters containing important information regarding COVID-19 to patients prior to arriving. Posters are located in all areas detailing mandatory IPC requirements. All visitors and patients enter via the main entrance where a COVID-19 screen in undertaken. Volunteers are located at the main entrance to support patients and visitors with compliance to mask wearing and hand hygiene	RJAH Trust website Intranet site Patient Leaflet Trust video tour https://vimeo.com/681908110	Infection Control section of Trust intranet is outdated	Update IPC information on public facing website by end of April 22.	
6.2	Training in IPC 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.	FFP3 training is provided to staff when being fit tested for masks. Donning and doffing video and hand hygiene videos have been uploaded to the intranet for all staff to access.	ESR Coronavirus Training (national modules) BBE Posters Trust video tour	Local training records held for Hand Hygiene and Donning and Doffing training	Training videos to be added to ESR to monitor compliance overall rather than local records being held.	

		National Coronavirus sessions have been uploaded to learner homepage in ESR for all staff to access.	https://vimeo.com/681908110			
6.3	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;	PPE posters are displayed in all clinical areas throughout the Trust. The Intranet contains Donning and Doffing videos for staff to access. The Intranet also includes hand hygiene videos for staff to access. PPE requirements are detailed in the Coronavirus Policy Donning and doffing video and hand hygiene videos have been uploaded to the intranet for all staff to access. The current intranet includes a dedicated area for all Coronavirus information for all staff to access.	PPE Poster Trust video tour https://vimeo.com/681908110 Videos The donning of Personal Protective Equipment (PPE) . The hand washing video Intranet link to Coronavirus Information Coronavirus policy Standard Infection Control Precautions (incorporates hand hygiene) Infection Control L1 & 2 Training - received via IPC Quarter report	Deployed staff were appointed as PPE champions during the early stages of the pandemic PPE champions delivered a programme of PPE training and advice to all areas. Upon recommencement of services, PPE champions returned to their substantive post and could not be released to undertake PPE training due to low staffing levels.	Fixed term 12 months IPC support worker role for delivery of training to be recruited to.	
6.4	Adherence to national guidance on the use of PPE is regularly audited with actions in place to mitigate any identified risk.	The IPC Department implemented a Quality Management System (QMS) The system collects all IPC related data into one central location including scores for IPC audits on a monthly basis in all areas. The QMS interprets	IPC Quality Management System Tenable Infection Control Committee			

		the data into graphical format to highlight trends. The QMS feeds into IPC quarterly and annual reports as well as IPC unit reports. The live dashboard is presented at the following meetings: • Infection Control & Cleanliness Committee • Infection Control & Cleanliness Working Group • SU Governance Meeting Compliance to PPE is monitored via the PPE and COVID-19 checklist audits completed on a monthly basis within all areas. These are now completed via Perfect Ward/Tenable.	SU Governance Meetings			
6.5	Gloves are worn when exposure to blood and/or other body fluids, nonintact skin or mucous membranes is anticipated or in line with SICP's and TBP's.	IPC are in the process of delivering a refresher training for inappropriate glove use.	PPE requirements		Ward and Departmental managers to engage and support ongoing compliance to this process.	
6.6	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	Air hand dryers have been disabled throughout the Trust. Paper Towel dispensers are situated by sinks and hand washing facilities for all clinical and nonclinical areas.				
6.7	Staff understand the requirements for uniform laundering where this is not provided for onsite.	Laundry requirements are outlined in the Uniform policy located on the document centre and can be accessed by all staff.	Tenable Uniform Policy			

6.8	Staff maintaining physical and social distancing of 1 metre or greater wherever possible in the workplace	Social Distance Checklist Audits are undertaken by all areas on a monthly basis. Results of these audits are fed into the IPC QMS for effective monitoring. Unit Leads, Matrons and Ward Managers monitor scores in their areas via the Perfect Ward/Tenable 'app'	IPC Quality Management System Tenable			
6.9	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 if experiencing mild symptoms) in line with national guidance.	Two flowcharts were created and circulated in January 2022 by the comms team outlining the following: Step-by-step process of what to do if you receive a positive lateral flow test result. What staff should do if they are a close contact of someone who has tested positive for covid-19 either via PCR or lateral flow test	News Archive Jan 2022 – Comms Team Coronavirus section of the intranet .			
6.10	Monitoring of compliance and reporting for asymptomatic staff testing	Local lateral flow testing is monitored nationally. A LFT return is received monthly via the COVID-19 inbox displaying results of positive and negative testing. Report is sent to Chief Nurse A stock level lateral flow return is completed and submitted weekly to Digital data collection national database the COVID-19 inbox is managed by the Information Team.	Asymptomatic Test Results Combined Report 20220125			

6.11	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).	State of play meetings are undertaken daily to update from a national and local perspective, and the focus for the organisation. COVID-19 prevalence and ongoing local surveillance rates are shared system wide via the ICS IPC resilience Group Meetings	ICS IPC resilience Group meetings			
6.12	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.	RCA is undertaken as part of the Outbreak process Two or more cases linked in time and place trigger an outbreak. Outbreak meetings are held and investigations supported by UKHSA and NHSE/I	Outbreak Policy Outbreak Management Toolkit			
7. Provide or secure adequate isolation facilities						
Key lines of enquiry		**Evidence**	**Document Library**	**Gaps in Assurance**	**Actions**	**RAG**
7.1	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.	Compliance to patient mask wearing process is assessed in all areas upon IPC Assurance Walks and COVID-19 checklist audits. All Ward/departmental staff actively encourage patients to wear face masks if they can be tolerated to minimise the risk of COVID-19 transmission.	IPC Assurance Walks COVID-19 checklist audits – Tenable Patient mask wearing flowchart	Compliance with patient mask wearing does not feature in regular IPC audits	Documentation audit to be completed	
7.2	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.	Patient appointments are staggered to ensure social distancing is maintained between patients.				
7.3	Patients who are known or suspected to be positive with a respiratory pathogen including COVID-19 where their treatment	Patients with known or suspected respiratory pathogen including COVID-	Coronavirus Policy			

	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.	19 are isolated and treated on the amber or red pathway.	Actions for suspected COVID-19 patients Procedure for patients that develop COVID-19 Symptoms SOP for amber and red patients April 21			
7.4	Patients are appropriately placed ie, infectious patients in isolation or cohorts.	Staff have access to the isolation risk assessment tool and advice from IPC team	Isolation Policy SOP for amber and red patients April 21	IPC alert system		
7.5	Ongoing regular assessments of physical distancing and bed spacing, considering potential increases in staff to patient ratios and equipment needs (dependent on clinical care requirements).	All Matrons, CSMs and Unit leads have access to the live Tenable Auditing software. The software has recently been updated to include an organisational report showing scores per unit for all Ward/Departmental IPC audits including Social Distancing This feature is only available via the app at present but is due to go live via the desktop site towards the middle of the year. The Trust made the decision in November 21 for 2-meter bed spacing to remain due to increased prevalence of the Omicron strain.	Tenable – QIA			
7.6	Standard infection control precautions (SIPC'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 used for patients on the green pathway.	Green Pathway Poster			
7.7	The principles of SICPs and TBPs continued to be applied when caring for the deceased		Coronavirus Policy Care After Death Policy For Adults			

8. Secure adequate access to laboratory support as appropriate						
Key lines of enquiry		**Evidence**	**Document Library**	**Gaps in Assurance**	**Actions**	**RAG**
8.1	Testing is undertaken by competent and trained individuals	Testing is performed by the Microbiology lab service provided by Shrewsbury and Telford Hospitals. Lab staff are trained and competent in processes. Patient testing is undertaken and staff are familiar and competent to undertake the procedure.	How to take a swab information			
8.2	Patient testing for all respiratory viruses is undertaken promptly and in line with PHE and other *national guidance*	Swabs are sent to the microbiology lab during the hours of 8am-2:45pm via hospital transport Out of hours specimens are sent via Blood bikes/ Trust taxi. Reports are received within 24/48hrs	Internal Transport of Samples.			
8.3	Screening for other potential infections takes place	MRSA screening for all admissions. MRSA Screening data and outcomes now included in IPC quarterly report ESBL screening on admission to Spinal Injuries Unit. CPE screening for patients from high risk areas from abroad, London, Manchester & Liverpool and documented in patient pathway.	MRSA Screening data			
8.4	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.	The Trust continues to undertake a PCR test 72 hours prior to admission. Weekly task and finish group meetings have been set to discuss recommendations made in the new guidance and their implementation	Patient Swabbing requirements Weekly Task & Finish group implementation log.			

	Instead, these patients can take a lateral flow test (LFT) on the day of the procedure as per national guidance.		SLG proposal and QIA			
8.5	Staff testing protocols are in place	Staff are directed to the intranet where details of obtaining a PCR can be found. The site also contains information on Lateral Flow Testing, Flu Vaccinations and COVID-19 Boosters. Staff are required to carry out twice-weekly lateral flow tests with results to be reported to the government national portal.	Staff PCR Testing Government LFT result portal			
8.6	Regular monitoring and reporting of the testing turnaround times with focus on the time taken from the patient to time result is available.	The Trust has a SLA with SaTH for the provision of laboratory testing including COVID-19. Turn around times are monitored by the microbiology laboratory.				
8.7	Regular monitoring and reporting that identified cases have been tested and reported in line with the testing protocols (correctly recorded data).	The laboratory has quality assurance processes in place to monitor this.				
8.8	Screening for other potential infections is undertaken.	MRSA screening data is collected by the Information Department. IPC team continue to be sighted on this data monthly.	MRSA Screening Daily Positive Samples from Microbiology Lab (OIC)			
8.9	All emergency patients are tested for COVID-19 and other respiratory infections as appropriate on admission.	The Trust continued to follow national screening requirement outlined in the UKHSA guidance. Audits are undertaken twice yearly by the IPC Assurance Lead, to assess trust compliance to all requirements.	National Swabbing Requirement Audits Swabbing Requirements			

8.10	inpatients who go on to develop symptoms of respiratory infection/COVID-19 after admission are retested at the point symptoms arise.		Swabbing Requirements National Swabbing Requirements Audits Actions for suspected COVID-19 patients Procedure for patients that develop COVID-19 Symptoms			
8.11	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.	The Trust continued to follow national screening requirement outlined in the UKHSA guidance. Audits are undertaken twice yearly by the IPC Assurance Lead, to assess trust compliance to all requirements.	National Swabbing Requirement Audits Swabbing Requirements			
8.12	Sites with high nosocomial rates should consider testing COVID-19 negative patients daily.	Local outbreaks of COVID-19 are monitored by the Infection Control Team. It has not been necessary to instigate daily testing.				
8.13	Patients 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. 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.	The Trust follows discharge criteria for care homes.	National Swabbing Requirement Audits Swabbing Requirements			

9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections						
Key lines of enquiry		**Evidence**	**Document Library**	**Gaps in Assurance**	**Actions**	**RAG**
9.1	The application of IPC practices are monitored and that resources are in place to	Monthly scores for ward & departmental IPC audits are inputted and monitored via the IPC QMS.	Quality Management System			

	implement and measure adherence to good IPC practice.	The IPC team undertake a programme of Quality Assurance walks. There is an escalation process for issues identified. Unit quarterly reports are presented to IPCC	Tenable Quality Assurance Walks QA Walks Escalation Process QA Walk Governance Wheel			
9.2	Staff are supported in adhering to all IPC policies, including those for other alert organisms.	IPC Newsletter sent out to all staff includes IPC policies recently undergone approval/review and amendment. Staff are directed to the document centre and are encouraged to familiarise themselves with the changes. IPC training is also provided upon induction There is an A-Z guide to infections available on the intranet.	IPC Newsletter IPC Staff induction presentation IPC Policies			
9.3	Safe spaces for staff break areas/changing facilities are provided.	Trust board room is being utilised as a safe space for staff to undertake breaks. Denbighs restaurant has socially distanced facilities. Safe capacity limits have been implemented to all staff break areas. Additional changing facilities have been provided for Powys and Clwyd Ward	IPC Quarter 3 Report Infection Control Committee minutes	Lack of adequate changing facilities across the Trust.		
9.4	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.	The Trust has an outbreak policy that outlines the management of outbreaks for COVID-19.	Coronavirus Policy Outbreak Policy			

	All clinical waste and linen/laundry related to confirmed or suspected COVID19 cases is handled, stored and managed in accordance with current national guidance. PPE stock is appropriately stored and accessible to staff who require it	Management of clinal waste for infected patients can be found Waste Management Procedure. Management of Linen for infected patients can be found in the Linen Procedure. Both documents can be located on the document centre. Supplies of IIR masks are kept on switchboard. Supplies of FFP3 masks and other PPE is requested via out of hours call out.	Management of Waste and Management of Linen Procedures			

10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection						
Key lines of enquiry		**Evidence**	**Document Library**	**Gaps in Assurance**	**Actions**	**RAG**
10.1	Staff seek advice when required from their IPCT/occupational health department/GP or employer as per their local policy.	Current Trust contract with Occupational Health provides staff access to a dedicated advice line for all Occupational Health queries relating to COVID-19. All advice issued follows national guidance. Infection Control Team have a dedicated inbox for IPC related queries. The email address is as follows: ipc.rjah@nhs.net Staff can contact the advice line currently in place.	Examples of IPC advice provided via the IPC Inbox Management of the IPC Inbox		Occupational Health contract in the process of being reviewed.	
10.2	Bank, agency, and locum staff follow the same deployment advice as permanent staff.	Bank staff and Locum staff receive IPC training on induction. Agency staff are provided with a checklist upon starting.		Checklist for agency staff does not assess staff competency to IPC practice.	Review of agency worker checklist for local induction	
10.3	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	Flowcharts were developed in December 2021 to provide a step by step process in the event of a positive lateral flow test result and/or a close	Covid-19 Positive Staff Flowchart for Managers			

	following updated government guidance)	contact with someone with COVID-19 positive status. Both flowcharts were uploaded to the document centre located on the intranet for staff and managers to easily access when required. Risk assessments reviewed by daily decision making panel (CNO, CMO and IPC team)	Covid-19 Close Contact Flowchart COVID-19 Return to work Risk Assessments			
10.4	Staff understand and are adequately trained in safe systems of working, including donning, and doffing of PPE.	There is a dedicated Coronavirus area on the Trust intranet for staff to access information relating to COVID-19. Videos are provided for staff to review.	The donning of Personal Protective Equipment (PPE) . The hand washing vide o	Deployed staff were appointed as PPE champions during the early stages of the pandemic PPE champions delivered a programme of PPE training and advice to all areas. Upon recommencement of services, PPE champions returned to their substantive post and could not be released to undertake PPE training due to low staffing levels.	Review of agency worker checklist for local induction	
10.5	A fit testing programme is in place for those who may need to wear respiratory protection.	Department of Health Fit testers are contracted on site until September 2022.	Email – Fit testing extending service Department of Health Fit test data			

		Fit test data is now uploaded to individual staff ESR records. Managers are responsible for uploading their staff fit test result onto ESR				
10.6	Where there has been a breach in infection control procedures staff are reviewed by occupational health. Who will: • lead on the implementation of systems to monitor for illness and absence. • facilitate access of staff to antiviral treatment where necessary and implement a vaccination programme for the healthcare workforce • lead on the implementation of systems to monitor staff illness, absence and vaccination against seasonal influenza and COVID-19 • encourage staff vaccine uptake.	Current Trust contract with Occupational Health provides staff access to a dedicated advice line for all Occupational Health queries relating to COVID-19. All advice issued follows national guidance. Staff are also referred to Occupational Health services for case management in relation PPE queries such as breaches and mask queries (allergies) All staff are given clarity on PPE requirements. (In line with national guidance) as part of the case management process. Evidence of Covid-19 vaccinations is being documented for all new starters (clinical and nonclinical) Support delivery of flu vaccine and encourage uptake				
10.7	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.	All O/H reports outline that staff member must adhere to all PPE and IPC precautions.				
10.8	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 complications from respiratory infections such as	Individual risk assessments are undertaken for all staff. Risk assessments have been shared with Peoples Services department throughout the pandemic.	staff demographic risk assessments held at ward/department level	Limited oversight of compliance with risk assessments	Oversight of individual staff risk assessments and % compliance to be presented at H&S	

	influenza and severe illness from COVID-19. • A discussion is had with employees who are in the at-risk groups, including those who are pregnant and specific ethnic minority groups; • that advice is available to all health and social care staff, including specific advice to those at risk from complications. • Bank, agency, and locum staff who fall into these categories should follow the same deployment advice as permanent staff. • A risk assessment is required for health and social care staff at high risk of complications, including pregnant staff.	Latest versions of risk assessments are kept locally within this department. All staff in high risk groups are referred to O/H for further clarity for fitness to work by managers and appropriate mitigations put in place.				
10.9	Vaccination and testing policies are in place as advised by occupational health/public health.	Staff are directed the Trust intranet where details of PCR testing is available. It also includes information in relation to Lateral Flow Testing. The Trust has a contract with Shropcom who process all staff samples and feedback all positive cases of COVID-19 to the Trust.	Staff testing intranet			
10.10	That where fit testing fails, suitable alternative equipment is provided. Reusable respirators can be used by individuals if they comply with HSE recommendations and should be decontaminated and maintained according to the manufacturer's instructions.	If a fit test is not achieved, the FFP3 Process Flowchart is followed. Powered Air Purifying Respirators (PAPR) are only available following a risk assessment of the clinical need for PAPR protection.	Fit Testing Flowchart			

10.11	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.	FFP3 process flowchart outlines this process	FFP3 Process Flowchart			
10.12	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.	An SOP has been implemented for staff who fail fit testing and outlines the options available to the individual Discussions are held with staff but on a voluntary basis. Staff member can be referred to Occupational Health who will offer further support	FFP3 Process Flowchart	No consistent process for recording redeployment opportunities	Consistent process required for logging discussions with staff and communicated out to all managers	
10.13	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.	Infection Control Committee is chaired by a member of the board. Health & Safety Advisor is now a member of the Infection Control & Cleanliness Committee and will provide an assurance report at future meetings.	Minutes of Infection Control Committee IPC Quarterly Reports			
10.14	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.	Movement of staff between the green and red pathways are restricted and monitored on a daily basis and staff have dedicated allocations Discussed and reviewed in State of Play daily meetings Areas are identified by various signage. Dedicated clinical areas / theatres for amber and green pathways				
10.15	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.	Ward/departmental Managers coordinate team breaks and encourage to stagger to reduce crowding and maintain social distancing.				

		Additional rest areas have been designated for staff in Denbighs and meeting room areas in the main conference facility.				
10.16	Staff absence and well-being are monitored and staff who are self-isolating are supported and able to access testing.	Staff absences both through self-isolation, clinically extremely vulnerable or other high risk reason are monitored daily; we have put in place an central absence reporting line to ensure that any member of staff with covid-19 (or similarly a household member) can immediately be referred to our testing service				
10.17	staff who test positive have adequate information and support to aid their recovery and return to work	Current Trust contract with Occupational Health provides staff access to a dedicated advice line for all Occupational Health queries relating to COVID-19. All advice issued follows national guidance. People business partners liaise with the line manager of any staff testing positive for covid-19 to ensure their ongoing welfare	Covid-19 return to work form			

Hygiene Code Gap Analysis

0. Reference Information

Author:	Kirsty Foskett, Head of Clinical Governance and Sara Ellis-Anderson, Interim Chief Nurse and Patient Safety Officer	Paper date:	6 April 2022
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1. Purpose of Paper

1.1. Why is this paper going to Trust Board and what input is required?

This paper presents an overview of Trust compliance against the Hygiene Code to the Trust Board for assurance purposes.

The report has been presented and discussed at the Extra Ordinary Quality and Safety Committee on 29 March 2022.

1.2. Context

The Health and Social Care Act (2008) Code of Practice on the prevention and control of infections, applies to all healthcare and social care settings in England. The Code of Practice (Hygiene Code) sets out the 10 criteria with 243 elements against which the Care Quality Commission (CQC) will judge a registered provider on how it complies with the infection prevention requirements. To ensure that consistently high levels of infection prevention (including cleanliness) are developed and maintained Trusts complete a self-assessment.

2.2. Summary

- Summary table provided in table 1 with overall compliance of **92%** with no red rated criterion
- Criterion 2 scored **89%** - this identifies resource requirements within the facilities team. The implementation of the National Cleanliness Standards from 1st of April will see improvement with compliance.
- Criterion 3 scored **83%** - antimicrobial stewardship membership and upward reporting to IPCC requires improvement
- Criterion 4 – scored at **88%** identifies improvements that can be made to public facing information on IPC
- Criterion 6 scored lowest at **78%** - full training needs analysis required and focus on training at induction
- Criterion 7 – scored at **89%** - this will be improved with the completion of bay doors being installed on Kenyon ward
- The improvement plan has been developed with clear action owners and timescales to be identified, this will be monitored through IPC working group with upward reporting to Infection Control and Cleanliness Committee.

2.3. Conclusion

The Trust Board is asked to review the Hygiene Code Gap Analysis self-assessment and note the improvement plan to increase compliance.

It should be noted there is overlap with the IPC Trust wide improvement plan. It is proposed that the summary of compliance and improvement plan is presented to the Quality and Safety committee on a regular basis and included within the Quarterly IPC report to Board.

Hygiene Code Gap Analysis

Health and Social Care Act Compliance Assessment		
Compliance requirements		RAG (% compliance)
Overall Summary of Compliance		
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 that their environment and other users may pose to them.	99
2	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.	89
3	Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.	83
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.	88
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.	100
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.	78
7	Provide or secure adequate isolation facilities.	89
8	Secure adequate access to laboratory support as appropriate.	100
9	Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections.	97
10	Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection.	98

Appendix 1: Acronyms

CQC	Care Quality Commission
IPC	Infection Prevention and Control

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Health and Social Care Act Compliance Self-Assessment Tool

Health and Social Care Act Compliance Self-Assessment Tool

Instructions for using the self-assessment tool

This self assessment tool is devised to assess compliance with the Health & Social Care Act - Code of Practice on the prevention and control of infections and related guidance (also sometimes referred to as the 'Hygiene Code').

This tool is designed to perform a self-assessment against the ten criterion contained within the code to enable an improvement plan to be developed to reduce any gaps in provision.

To enter self assessment data

You will need to use this tool in conjunction with the relevant excerpt of the code of practice which has been shared with you and accompanies this email.

Click on the relevant criterion tab below to begin the self assessment process against the criterion described.

Please enter your self-assessment score in the RAG column using the criteria for scoring as descibed below.

You can also add any evidence, observations and/or notes to the column to the right of the RAG score column.

Criteria for scoring the self assessment

3	Enter 3 for fully compliant and evidence available
2	Enter 2 for partial compliance and some evidence available
1	Enter 1 if non compliant and no evidence available

Please note you will not be able to change any other information or data on this sheet.

Don't forget to save the spreadsheet otherwise you will lose any data you have inputted.

The Summary section will update automatically and shows the Trust score by section.

Once the self-assessment has been completed, areas that require improvement actions to be implemented towards ensuring compliance is achieved will need to be developed. The final sheet of this self-assessment is a template improvement plan which will then need to be completed.

Health and Social Care Act Compliance Assessment (February 2022)			
Criterion 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 that their environment and other users may pose to them.			
	Compliance requirements	**RAG (1 / 2 / 3)**	**Evidence / observations / notes**
	Appropriate management and monitoring arrangements		
1.1	**These should ensure that:**		
	A registered provider has an agreement within the organisation that outlines its collective responsibility for keeping to a minimum the risks of infection and the general means by which it will prevent and control such risks i.e. an annual statement on infection prevention control is published	**3**	Annual Statetment of Infection Prevention and Control, within the Trust Annual Quality Account
	There is a clear governance structure and accountability that identifies a single lead for infection prevention (including cleanliness) accountable directly to the head of the registered provider	**2**	DIPC (Chief Nurse and Patient Safety Officer) in place. The organisational structure is being reviewed following an assessment of the IPC Governance/Assurance structure by the Director of Governance.
	The mechanisms are in place by which the registered provider ensures that sufficient resources are available to secure the effective prevention of infection. These should include the implementation of an infection prevention and cleanliness programme, infection prevention and cleanliness infrastructure and the ability to monitor and report infections	**3**	There is an annual Infection Control programme of works which sets out the monitoring of environmental cleanliness, policies/guidelines. This is montiored on a quarterly basis via IPC Committee and the IPC Quality Management System.
	All relevant staff, whose normal duties are directly or indirectly concerned with providing care, receive suitable and sufficient information on, and training and supervision in, the measures required to prevent the risks of infection	**2**	All staff IPC responsibilities are detailed in their job description. IPC training on induction SFH IPC e-learning module: Annually for clinical, 3yrly for non clinical, Face to face IPC training for wards, IPC training for domestic staff, IPC training for volunteers. Doctors training on induction does not currently allow sufficient time to deliver hand hygiene training.
	Assurance is in place to ensure that key policies and practices are being implemented, updated and adhered to appropriately	**3**	Monitoring of policies and procedures is done via IPC Committee, with an associated programme of audits on Tendable to monitor compliance. For clinical practice .i.e. ANTT, Venepuncture, Cannulation there are competency documents to complete.
	A decontamination lead is designated, where appropriate	**3**	Estates and Facilities. Quarterly Decontamination Group

	A water safety group and water safety plan (WSP) are in place	3	Estates and Facilities. Quarterly Water Group
Risk Assessment			
1.2	**A registered provider should ensure that it has:**		
	Made a suitable and sufficient assessment of the risks to the person receiving care with respect to prevention of infection	3	IPC Risks are logged on Datix with mitgations and monitoring outlined. Monitoring of SSI's and Post Infection Review (PIR)
	Identified the steps that need to be taken to reduce or control those risks	3	Process for monitoring recommendations and themes from PIRs through IPC Committee. Mitagations for IPC risks logged on Datix.
	Recorded its findings in relation to the first two points	3	Documented on Datix and monitored through IPC Working Group and IPC Committee
	Implemented the steps identified	3	As above
	Methods and interventions in place to monitor the risks of infection to determine whether further steps are needed to reduce or control infection	2	Post infection reviews, root cause analysis, periods of inreased incidence of infection are undertaken however there is no standarised process/ attendance list etc
Directors of Infection Prevention			
1.3	**The DIPC in NHS Provider organisations should:**		
	Provide oversight and assurance on infection prevention (including cleanliness) to the Trust board or equivalent. They should report directly to the board but are not required to be a board member	3	DIPC (Chief Nurse and Patient Safety Officer) in place.
	Be responsible for leading the organisation's infection prevention team	3	Delegated responsibilities to the Head of Clinical Governance & Quality, Lead IPC Nurse and Consultant Microbiologist
	Oversee local prevention of infection policies and their implementation	3	Delegated as above
	Be a full member of the infection prevention team and antimicrobial stewardship committee and regularly attend its infection prevention meetings	3	DIPC is Chair of both meetings
	Have the authority to challenge inappropriate practice and inappropriate antimicrobial prescribing decisions	3	
	Have the authority to set and challenge standards of cleanliness	3	
	Assess the impact of all existing and new policies on infections and make recommendations for change	3	
	Be an integral member of the organisation's clinical governance and patient safety teams and structures, water safety group	3	Delegated responsibilities to the Head of Clinical Governance & Quality, Lead IPC Nurse and Consultant Microbiologist.
	Produce an annual report and release it publicly as outlined in Winning ways: working together to reduce healthcare associated infection in England.	3	
1.4	**N/A to NHS organisations**		
Assurance Framework			

1.5	**Activities to demonstrate that infection prevention and cleanliness are an integral part of quality assurance should include:**		
	Regular presentations from the DIPC and/or the infection prevention team to the NHS board or registered provider. These should include a trend analysis for infections, antimicrobial resistance and antimicrobial prescribing and compliance with audit programmes	**3**	IPC Committee held monthly/quarterly. IPC Programme of works. IPC Quarterly report to Trust Board.
	Quarterly reporting to the NHS board or registered provider by clinical directors and matrons (including nurses who do not hold the specific title of 'matron' but who operate at a similar level of seniority and who have control over similar aspects of the patient or the patient's environment). What is reported on will vary according to the local arrangements For example it may include: - monthly cleanliness scores (unless this is done via the estates and facilities team); - annual Patient Led Assessments of the Care Environment (PLACE) scores plus monthly scores (where this is agreed practice); and - contract performance measures where provision is outsourced, which will include cleanliness measures and issues of non-compliance and subsequent rectification performance; - Information taken from the organisation's self-assessment using the NHS Premises Assurance Model (NHS PAM) - Monthly review of antimicrobial prescribing decisions - Observations taken from board level or other staff "walk rounds" - Complaints relating to infection prevention (including cleanliness)	**3**	IPC Committee minutes
	A review of mandatory and voluntary surveillance data, including antimicrobial resistance (drug-bug combinations), outbreaks and serious incidents;	**3**	
	Evidence of appropriate action taken to deal with occurrences of infection including, where applicable, root cause analysis and/or post infection review; and	**2**	Post infection reviews, root cause analysis, periods of inreased incidence of infection are undertaken however there is no standarised process/ attendance list etc
	An audit programme to ensure that policies have been implemented	**3**	IPC programme of works monitored via IPC committee.
1.6	In accordance with health and safety requirements, where suitable and sufficient assessment of risks requires action to be taken, evidence must be available on compliance with the regulations or, where appropriate, justification of a suitable better alternative. This applies to all healthcare and adult social care.	**3**	Estates and Facilities Risk Register
	Infection prevention including cleanliness programme		
1.7	**The infection prevention including cleanliness programme should:**		
	Set objectives that meet the needs of the organisation and ensure the safety of service users, health care workers and the public	**3**	The annual IPC Programme includes environmental cleanliness

	Identify priorities for action	3	
	Provide evidence that relevant policies have been implemented	3	
	Report progress against the objectives of the programme in the DIPC's annual report or the Infection Prevention Lead's annual statement	3	
Infection prevention and cleanliness infrastructure			
1.8	**An infection prevention infrastructure should encompass:**		
	In acute healthcare settings, for example, an infection prevention team consisting of an appropriate mix of both nursing and consultant medical expertise (with specialist training in infection prevention and cleanliness), other healthcare workers and appropriate administrative and analytical support, estates and facilities management and adequate information technology – the DIPC is a key member of the Infection prevention team	3	IPC lead holds a IPC qualification, with 12 years experience in IPC. The IPC has acess to specialist support and guidance from the Consultant Microbiologist and other IPC nurses in the ICS. Attendance at IPC conferences. Close working relationship with Estates and Facilities team.
	In acute settings, have a multidisciplinary antimicrobial stewardship committee to develop and implement the organisation's Antimicrobial stewardship programme drawing on Start Smart Then Focus	3	Quarterly AMS Committee
	24-hour access to a nominated qualified infection control doctor (ICD) or consultant in health protection/communicable disease control. The registered provider should know how to access this advice	3	On call microbiologist available for clinical advice 24 hrs a day. Antimicrobial pharmacist is available during the working week. Consultant Microbiologist is on site 2 days a week, for microbiology ward round and weekly infection MDT.
Movement of service users			
1.9	There should be evidence of joint working between staff involved in the provision of advice relating to the prevention of infection; those managing bed allocation; care staff and domestic staff in planning service user referrals, admissions, transfers, discharges and movements between departments; and within and between health and adult social care facilities.	3	Alerts from Pre-op or transferring hospital used to ensure correct placement of patients. Patient placement is supported by the clinical site managers. Patient passport in place for emergency transfers in to RJAH.
1.10	A registered provider must ensure that it provides suitable and sufficient information on a service user's infection status whenever it arranges for that person to be moved from the care of one organisation to another, of from a service user's home, so that any risks to the service user and others from infection may be minimised. If appropriate, providers of a service user's transport should be informed of the service user's infection status.	2	Information is documented on Discharge Summary and EPR. However there is currently no electronic flagging system within EPR or PSAG to highlight a patients infection status, the process is heavily reliant on a paper based system.
Overall Compliance (%)		**99**	

Health and Social Care Act Compliance Assessment (February 2022)			
Criterion 2: Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections			
	Compliance requirements	**RAG (1 / 2 / 3)**	**Evidence / observations / notes**
2.1	**With a view to minimising the risk of infection, a registered provider should ensure that:**		
	It designates leads for environmental cleaning and decontamination of equipment used for diagnosis and treatment (a single individual may be designated for both areas)	**3**	Cleaning responsibilities defined by cleaning operations manual. National Cleaning Standards 2021, including responbilities have now been agreed,
	In healthcare, the designated lead for cleaning involves directors of nursing, matrons and the infection prevention team or persons of similar standing in all aspects of cleaning services, from contract negotiation and service planning to delivery at ward and clinical level. In other settings, the designated lead for cleaning will need to access appropriate advice on all aspects of cleaning services	**3**	Environment Cleaning - Lead: Facilities Operational Manager (Evidence: Job Description) Clinincal equipment cleaning- Matrons Evidence: Job Description
	In healthcare, matrons or persons of a similar standing have personal responsibility and accountability for maintaining a safe and clean care environment	**3**	Detailed in Job description. The Organisations overarching IPC Policy, details roles and responsibilities.
	The nurse or other person in charge of any patient or resident area has direct responsibility for ensuring that cleanliness standards are maintained throughout that shift	**3**	Detailed in Job description. The Organisations overarching IPC Policy, details roles and responsibilities.
	All parts of the premises from which it provides care are suitable for the purpose, kept clean and maintained in good physical repair and condition	**3**	Cleaning Operations Manual
	The cleaning arrangements detail the standards of cleanliness required in each part of its premises and that a schedule of cleaning responsibility and frequency is available on request	**2**	Ensure Cleaning Operations Manual is updated on implementation of 2021 National Cleaning Standards
	There is adequate provision of suitable hand washing facilities and antimicrobial hand rubs where appropriate	**2**	Wash hand basins present, some not compliant to HBM 00-03 and HTM 01-04 E&F team rolling out upgrade to wash hand basins across the trust managed through backlog program and risk on register (1873, 1962)
	There are effective arrangements for the appropriate cleaning of equipment that is used at the point of care, for example hoists, beds and commodes – these should be incorporated within appropriate cleaning, disinfection and decontamination policies	**2**	Assurance required to ensure there are effective and standardised checklists and monitoring in place.
	The storage, supply and provision of linen and laundry are appropriate for the level and type of care	**2**	Linen contract in place and monitored by quaeterly contract reviews against HTM 01-04. 6 monthly programe of audits compelted by contractor to ensure adequate supply & provision at ward level. Risk ID 1832 references inadequate central storage for the desired volume of linen stock to be held on site. Review and monitoring through IPC working group.
2.2	**'The environment' means the totality of a service user's surroundings when in care premises or transported in a vehicle. This includes the fabric of the building, related fixtures and fittings, and services such as air and water supplies. Where care is delivered in the service user's home, the suitability of the environment for that level of care should be considered**		
Policies on the environment			
	Premises and facilities should be provided in accordance with best practice guidance and assured with NHS PAM or similar model. The development of local policies should take account of infection prevention and cleanliness advice given by relevant expert or advisory bodies or by the infection prevention team and this should include provision for liaison between the members of the service user's environment. Policies should address but not be restricted to:		

	Cleaning services	3	Cleaning Policy - endorsed and approved at Infection Control Committee, next review date July 2023
	Building and refurbishment, including air-handling systems	3	Infection control in the Built Environment policy - The purpose of this policy is to provide guidance on the prevention of cross infection to those involved and responsible for the planning, design and maintenance of new and refurbished hospital facilities and to provide a best practice approach to the delivery of construction projects. Endorsed and approved at IPC Working Group and comittee.
	Waste management	3	Waste Management Policy, endorsed by Infection Control Working Group, review date April 2024
	Laundry arrangements for the correct classification and sorting of used and infected linen	3	Linen procedure, endorsed by Infection Control Working Group, review date July 2022
	Planned preventative maintenance	2	No policy in place for PPMs, evidence of frequency and completion managed via Estates work requisitions system (QUBE)
	Pest control	3	Pest Control policy - endorsed by Health and Safety Committee, review date July 2023
	Management of drinkable and non-drinkable water supplies	3	Water Safety Plan & Legionella Operational Management and Written Schemes of Control Procedure, endorsed by Water Quality Group, review date July 2022.
	Minimising the risk of Legionella and other water supply and building related infections eg Pseudomonas aeruginosa and aspergillus by adhering to national guidance	3	Water Safety Plan & Legionella Operational Management and Written Schemes of Control Procedure, endorsed by Water Quality Group, review date July 2022.
	Food services, including food hygiene and food brought into the care setting by service users, staff and visitors	3	Food Hygiene Policy & Management System, endorsed by Nutrition & Hydration Group, review date September 2022.
	Cleaning Services		
2.4	**The arrangements for cleaning should include:**		
	Clear definition of specific roles and responsibilities for cleaning	3	Cleaning responsibilities defined by cleaning operations manual. National Cleaning Standards 2021, including responbilities have now been agreed, implementation monitored by IPC working group - launch date 1st April 2022.
	Clear, agreed and available cleaning routines	3	Cleaning frequency defined by cleaning operations manual. National Cleaning Standards 2021, including responbilities have now been agreed, implementation monitored by IPC working group - launch date 1st April 2022.
	Sufficient resources dedicated to keeping the environment clean and fit for purpose	2	Requirement for additional resource to facilitate perdiodic (deep) cleaning idenified, paper submitted & awaiting ICS approval for additional resource.
	Consultation with ICTs or equivalent local expertise on cleaning protocols when internal or external contracts are being prepared	3	IPC working group ToR IPC committee ToR IPC in built environment policy IPC & cleanliness quarterly report
	Details of how staff can request additional cleaning, both urgently and routinely	3	Housekeeping team contactable by phone/bleep in hours, out of hours facilities on call
	Decontamination		
2.5	**The decontamination lead should have responsibility for ensuring that policies exist and that they take account of best practice and national guidance. They should consider guidance under the following headings:**		

	Decontamination of the environment – including cleaning and disinfection of the fabric, fixtures and fittings of a building (walls, floors, ceilings and bathroom facilities) or vehicle	3	Cleaning Policy Cleaning Operations Manual
	Decontamination of linen – including correct classification and sorting of used linen (e.g. soiled and fouled linen, infectious linen, heat labile linen) and disinfection of linen	3	Outsourced to an external provider, contract managed process against HTM 01-04.
	Decontamination of equipment – including cleaning and disinfection of items that come into contact with the patient or service user, but are not invasive devices (eg beds, commodes, mattresses, hoists and slings, examination couches)	2	Schedules and checklists are in place for the decontamination of clinical equipment inc. couches, trolleys, work surfaces, vaccine fridges etc. Cleaning Operations Manual. Cleaning checklists including bedspace and clinic rooms. Cleaning for confidence training. National Cleaning specifications and responbilities in the process of being agreed.
	Reusable medical devices should be reprocessed at one of the following three levels: - sterile (at point of use) - sterilised (i.e. having been through the sterilisation process) - clean (i.e. free of visible contamination)	2	Decontamination procedures take place on site, however assurrance required around monitoring of processes / compliance.
2.6	**The decontamination policy should demonstrate that:**		
	It complies with guidance establishing essential quality requirements and a plan is in place for progression to best practice	3	Trust Decontamination Policy in place
	Decontamination of reusable medical devices takes place in compliant facilities that are designed for the process of decontaminating medical devices through validated processing systems and controlled environmental conditions to ensure all potential environmental, cross-infection, handling and medical device usage risks are minimised	2	Decontamination procedures take place on site, however assurrance required around monitoring of compliance.
	Appropriate procedures are followed for the acquisition, maintenance and validation of decontamination equipment	2	Decontamination procedures take place on site, however assurrance required around monitoring of compliance.
	Staff are trained in cleaning and decontamination processes and hold appropriate competences for their role	3	Staff comptencies held within the the TSSU and Estates department.
	A record-keeping regime is in place to ensure that decontamination processes are fit for purpose and use the required quality systems	2	Decontamination procedures take place on site, however assurrance required around monitoring of compliance.
	Note: Undertaking the actions in NHS PAM's Self Assessment Question S14 "safe and compliant with well managed systems in relation to: Decontamination Processes" will assist organisations in ensuring they have the correct assurance in place with regards to decontamination.		
	Overall Compliance (%)	**89**	

Health and Social Care Act Compliance Assessment (February 2022)			
Criterion 3: Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance			
	Compliance requirements	**RAG (1 / 2 / 3)**	**Evidence / observations / notes**
3.1	Systems should be in place to manage and monitor the use of antimicrobials to ensure inappropriate and harmful use is minimised and patients with severe infections such as sepsis are treated promptly with the correct antibiotic. These systems draw on national and local guidelines, monitoring and audit tools such as NICE guidelines, guidance on patient group directions, the TARGET toolkit in primary care and Start Smart then Focus in secondary care (SSTF).	**3**	Quarterly point prevelance surveys (PPS) on antibiotic use are performed and entered into an Excel spreadsheet by the antibiotic pharmacist. Antimicrobial usage data is reported at the AMS Committee quarterly.
3.2	Where appropriate, providers should have in place an antibiotic stewardship committee responsible for developing, implementing and monitoring the organisation's stewardship programme. This must be supported by strong leadership across clinical specialties but it could be part of an existing committee such as a drug and therapeutic committee rather than a new body. Membership of this committee will vary dependent on the setting but should include representation from microbiology/infectious diseases, pharmacy and the organisations' director of infection prevention and control or equivalent. The committee should report antimicrobial stewardship activities to the Trust board via the organisation's Director of Infection Prevention and Control or equivalent.	**2**	Quarterly meeting in place, with upward reporting to IPC Committee. An opportunity to review membership and TOR.
3.3	Providers should develop a local antimicrobial stewardship policy drawing on national guidance (including the British National Formulary, Public Health England the Commissioners. Benchmarking should be used to demonstrate progress in antimicrobial stewardship. National Institute of Care Excellence) that takes account of local antimicrobial resistance patterns. Policy should cover diagnosis, treatment and prophylaxis of common infections and prescribers should be encouraged to record allergy status, reason for antimicrobial prescription, dose and duration of treatment. Adherence to prescribing guidance and compliance with in hospital post-prescribing review at 48-72 hours should be monitored and audited on a regular basis, with data fed back to prescribers and incorporated into patient safety reporting systems to Boards	**3**	Policy in place, available on the Trusts intranet.
3.4	Providers should have access to timely microbiological diagnosis, susceptibility testing and reporting of results, preferably within 48 hours. Prescribers should have access at all times to suitably qualified individuals who can advise on appropriate choice of antimicrobial therapy.	**3**	Turn around times of microbiology results reporting monitored by the laboratory at SaTH.
3.5	In secondary care providers should report local antimicrobial susceptibility data (drug-bug combinations) and information on antimicrobial consumption to the national surveillance body. Surveillance information should be used by the stewardship committee or equivalent to monitor local resistance patterns and guide local prescribing policy. This information should be communicated back to prescribers in primary and secondary care to improve prescribing quality.	**2**	Antibiotic policy contains antibiotic resistance data relevant to their region. Need assurrance around national body reporting.

3.6	Providers should ensure that all prescribers receive induction and training in prudent antimicrobial use and are familiar with the antimicrobial resistance and stewardship competencies	**2**	There is no antimicrobial training for doctors on induction
Overall Compliance (%)		**83**	

Health and Social Care Act Compliance Assessment (February 2022)			
Criterion 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			
	Compliance requirements	**RAG (1 / 2 / 3)**	**Evidence / observations / notes**
	Information for service users and visitors		
4.1	Information should be developed with local service user representative organisations, which could include Local Health watch and Patient Advice and Liaison Services (PALS).	3	IPC Patient Information Leaflets are agreed as per the trusts guidelines, which includes input from members of the patient panel.
4.2			
	General principles on the prevention of infection and key aspects of the registered provider's policy on infection prevention, which takes into account the communication needs of the service user	2	The supporting Excellence in IPC toolkit introduced in March 2021 has been adopted by the Trust Comms Team and will be implemented with immediate effect. The trust is currently reviewing and updating the intranet. The IPC data analysis is involved in the redesign of the IPC intranet page. Staff wellbeing aligns with toolkit already.
	The roles and responsibilities of particular individuals such as carers, relatives and advocates in the prevention of infection, to support them when visiting service users	3	Signage in corridors, wards etc. promoting hand hygiene, face mask use and the need for social distancing.
	The importance of appropriate use of antimicrobials	2	(assurance required) however pharmacy staff do discuss the need for antibiotics and patients with infections monitored by the IPC team during the weekly microbiologist ward round.
	Supporting service users' awareness and involvement in the safe provision of care	3	Patient kept update with their care by medical and nursing staff.
	The importance of compliance by visitors with hand hygiene	3	Hand hygience posters across all patient/vistor locations in the hospital
	The importance of compliance with the registered provider's policy on visiting	3	
	Reporting concerns relating to hygiene and cleanliness including hand hygiene	3	Patients / Visitors are encourgade to raise concerns locally or through PALS
	Explanations of incident/outbreak management and action taken to prevent recurrence	3	Patients and Visitors communicated with around outbreaks. Outbreak Policy available
4.3	Materials from national or local antimicrobial awareness campaigns could be used to develop information on appropriate antimicrobial use.	2	Anti microbial awareness campaign communicated through Comms. Plans to have the antimicrobial stewardship pharmacy group across ICS and link in with the system AMS work.
4.4	**A registered provider should ensure that:**		
	Accurate information is communicated in an appropriate and timely manner	2	No electronic flagging sysytem within the EPR
	This information facilitates the provision of optimum care, minimising the risk of inappropriate management and further transmission of infection	2	There may be a delay in recongising a patients infection status, due to the lack of electronic flagging system
	Where possible, information accompanies the service user	3	Discharge summaries detailing the patients care and infection status. Patient referrals to other care providers.
4.5	Provision of relevant information across organisation boundaries is covered by the regulation requirement 9 "Person Centred care". Due attention should be paid to service user confidentiality as outlined in national guidance and training material	3	Discharge summaries detailing the patients care and infection status Patient referrals to other care providers Consultant to Consultant referrals
	Overall Compliance (%)	88	

Health and Social Care Act Compliance Assessment (February 2022)			
Criterion 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			
Compliance requirements		**RAG (1 / 2 / 3)**	**Evidence / observations / notes**
5.1	Registered providers, excluding personal care providers, should ensure that advice is received from suitably informed practitioners and that, if advised, registered providers should inform their local health protection team of any outbreaks or serious incidents relating to infection in a timely manner.	**3**	Staff are aware of how to contact the Infection Prevention and Control team Microbiologits presence twice weekly 24hr Microbiology advice from SaTH
5.2	Arrangements should demonstrate that responsibility for infection prevention is effectively devolved to all groups in the organisation involved in delivering care.	**3**	Standard statement in relation to IPC included in all job descriptions
5.3	In an adult social care service, General Practitioners will provide the necessary initial advice when a service user develops infection. The General Practitioner may wish to draw on local expertise in infection prevention, nd health protection.	**3**	General Practitioners have access to 24 hr Microbiolgy advice
Overall Compliance (%)		**100**	

Health and Social Care Act Compliance Assessment (February 2022)			
Criterion 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.			
Compliance requirements		**RAG (1 / 2 / 3)**	**Evidence / observations / notes**
6.1	A registered provider should, so far as is reasonably practicable, ensure that its staff, contractors and others involved in the provision of care co-operate with it, and with each other, so far as is necessary to enable the registered provider to meet its obligations under the Code.	**3**	
6.2	Infection prevention would need to be included in the job descriptions and be included in the induction programme and staff updates of all employees (including volunteers). Contractors working in service user areas would need to be aware of any issues with regard to infection prevention and obtain 'permission to work'.	**2**	IPC training on induction. SFH IPC e-learning module: annually for clinical, 3yrly for non clinical, Face to face IPC training for wards. IPC training for domestic staff. IPC training for volunteers. Doctors training on induction does not allow enough time to do hand hygiene training. Agency local induction checklist to be reviewed.
6.3	Where staff undertake procedures, which require skills such as aseptic technique, staff must be trained and demonstrate proficiency before being allowed to undertake these procedures independently.	**2**	Venepuncture training, blood culture training, aseptic tecnique training . Competency documents in place. Basic ANTT and advanced training has been delivered by an external training company
Overall Compliance (%)		**78**	

Health and Social Care Act Compliance Assessment (February 2022)			
Criterion 7: Provide or secure adequate isolation facilities.			
	Compliance requirements	RAG (1 / 2 / 3)	Evidence / observations / notes
7.1	A healthcare registered provider delivering in-patient care should ensure that it is able to provide, or secure the provision of, adequate isolation precautions and facilities, as appropriate, sufficient to prevent or minimise the spread of infection. This may include facilities in a day care setting.	2	All wards have siderooms. Kenyon ward does not currently have bay doors on all bays, to be able to cohort patients with infections.
7.2	Policies should be in place for the allocation of patients to isolation facilities, based on a local risk assessment. The assessment could include consideration of the need for special ventilated isolation facilities. Sufficient staff should be available to care for the service users safely.	3	Isolation policy Isolation risk assessment matrix A-Z of infections on the Intranet
7.3	Registered providers of accommodation should ensure that they are able to provide or secure facilities to physically separate the service user from other residents in an appropriate manner in order to minimise the spread of infection.	3	NA to the organisation
Overall Compliance (%)		89	

Page 16 of 33

1. Part One - Public
2. HDU CQC Presentatio
3. Patient Story
4. Chief Executive
5. Quality & Safety
6. People
7. Performan ce and
8. Questions from the
9. Questions from the
10. Any Other Business

Health and Social Care Act Compliance Assessment (February 2022)			
Criterion 8: Secure adequate access to laboratory support as appropriate			
	Compliance requirements	RAG (1 / 2 / 3)	Evidence / observations / notes
8.1	A registered provider should ensure that laboratories that are used to provide a microbiology service, in connection with arrangements for infection prevention (including cleanliness), have in place appropriate protocols. These laboratories should operate according to the standards required by the relevant national accreditation bodies. In adult social care, the service user's General Practitioner will arrange such testing and take responsibility for submitting specimens to the laboratory when necessary for the treatment and management of disease.	3	The diagnostic laboratory services are provided through an SLA with SaTH. The laboratories have full UKAS accreditation. SaTH have a microbiology policy for investigation and surveillance of antimicrobial resistance, standard lab operating procedures and report in a timely manner.
8.2	**Protocols should include:**		
	A microbiology laboratory policy for investigation and surveillance of antimicrobial resistance and healthcare associated infections	3	As above
	Standard laboratory operating procedures for the examination of specimens	3	As above
	Timely reporting	3	As above
Overall Compliance (%)		100	

Health and Social Care Act Compliance Assessment (February 2022)			
Criterion 9: Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections.			
	Compliance requirements	**RAG (1 / 2 / 3)**	**Evidence / observations / notes**
9.1	A registered provider should, in relation to preventing, reducing and controlling the risks of infections, have in place the appropriate policies concerning the matters mentioned in a) to y) below. All policies should be clearly marked with a review date and the review date adhered to.	**3**	32 IPC policies in place as per the H&SC Act. The governance of policies is mamanged the IPC Quality Management System with oversite at IPC Committee.
9.2	A guide is given in Table 3 as to which policies may be appropriate to the regulated activities. A decision should be made locally following a risk assessment.	**3**	
9.3	Any registered provider should have policies in place relevant to the regulated activity it provides. Each policy should indicate ownership (i.e. who commissioned and retains managerial responsibility), authorship and by whom the policy will be applied. Implementation of policies should be monitored and there should be evidence of a rolling programme of audit and a date for revision stated.	**2**	2 policies currently out of date. A process of reviewing 'monitoring of compliance' for policies needs to be undertaken, enusring these are captured in the annual audits programme.
9.3a	**Standard infection prevention and control precautions**		
	Policy should be based on evidence-based guidelines, including those on hand hygiene at the point of care and the use of personal protective equipment;	**3**	
	Policy should be easily accessible and be understood by all groups of staff, service users and the public.	**3**	All IPC policies are avaialble on the Trusts intranet.
	Compliance with the policy should be audited	**2**	A process of reviewing 'monitoring of compliance' for policies needs to be undertaken, enusring these are captured in the annual audits programme.
	Provisions on regular refresher training, support for patients to clean their hands, and products for staff with occupational dermatitis are among the issues that should be covered in the hand hygiene policy	**2**	Annual hand hygiene competencies for clinical staff undertaken - focus on completing this for doctors. Patients provided and encouraged to wash hands before meals and after toileting. Staff can be referred to OH as per Trust Sickness Absence management policy. They can also self refer to OH Trust physio and have access to 24/7 EAP services
9.3b	**Aseptic technique**		
	Where aseptic procedures are performed:		
	Clinical procedures should be carried out in a manner that maintains and promotes the principles of asepsis	**3**	
	Education, training and assessment in the aseptic technique should be provided to all persons undertaking such procedures	**3**	
	The technique should be standardised across the organisation	**2**	Basic ANTT and advanced training has been delivered by an external training company
	An audit should be undertaken to monitor compliance with the technique	**2**	Review the process for monitoring compliance
9.3c	**Outbreaks of communicable infection**		
	The degree of detail in the policy should reflect local circumstances. A low risk, single-specialty facility or provider of primary care will not require the same arrangements as those providing the full range of medical and surgical care	**3**	Outbreak management policy in place

	Professional advice on infection prevention for regulated activities may be drawn from a number of expert sources. Table 2 outlines the most likely arrangements for the different regulated activities	3	IPC lead holds a IPC qualification, with 12 years experience in IPC. The IPC has acess to specialst supportand guidance from the Microbiologist and other IPC nurses in the ICS. Attendance at the IPC conference
	Policies for outbreaks of communicable infection should include initial assessment, communication, management and organisation, plus investigation and control, including vaccination where appropriate	3	Outlined in Outbreak management policy, with signposting.
	The contact details of those likely to be involved in outbreak management should be reviewed at least annually	3	Reviewed as part of scheduled policy review.
	All registered providers should report significant outbreaks of infection to their local health protection teams at an early stage, including outbreaks in service	3	HSA Mandatory reporting on the HCAI databse. Microbiology deaprtment report to CCDC
9.3d	**Isolation of service users with an infection**		
	The isolation policy should be evidence based and reflect local risk assessment	3	Isolation Policy in place.
	Indications for isolation should be included in the policy, as should procedures for the infection prevention and control management of service users in isolation	3	Included in the policy
	Information on isolation should be easily accessible and understood by all groups of staff, service users and the public	3	
9.3e	**Safe handling and disposal of sharps**		
	Risk management and training in the management of mucous membrane exposure and sharps injuries and incidents	3	Sharps Management Procedure. The procedure is communicated at Nursing/AHP forums and posters / boxes available in the clinical area.
	Provision of medical devices that incorporate sharps protection mechanisms where there are clear indications that they will provide safe systems of working for staff	3	Compliant with 'Safe Sharps' initiative and compliance in monitored through Health and Safety Committee
	A policy that is easily accessible and understood by all groups of staff	3	
	Safe use, secure storage and disposal of sharps	3	Monthly Audits undertaken / Review of incidents reported / monitored through H&S Committee
	Auditing of policy compliance	3	Monthly Audits undertaken / Review of incidents reported / monitored through H&S Committee
9.3f	**Prevention of occupational exposure to blood-borne viruses (BBVs) including prevention of sharps injuries**		
	Measures to avoid exposure to BBV's (hepatitis B and C and HIV) should include:		
	Immunisation against hepatitis B, as set out in Immunisation against infectious disease, better known as 'The Green Book' (published by Public Health England)	3	Occupational arrangements include the offer of relevant immunization e.g. Hepatitis B, influenza etc. and documentation of immune status post-immunization. Internal TP Immunisation policy, in line with national guidance, including that from DOH and PHE. Additionally immunisations are given in line with Trust matrix and risk assessments.
	The wearing of gloves and other protective clothing	3	PPE guidance incorporated in IPC Policy
	The safe handling and disposal of sharps, including the provision of medical devices that incorporate sharps protection where there are clear indications that they will provide safe systems of working for staff	3	Sharps Management Procedure. The procedure is communicated at Nursing/AHP forums and posters / boxes available in the clinical area. Compliant with 'Safe Sharps' initiative and compliance in monitored through Health and Safety Committee.
	Measures to reduce risks during surgical procedures	3	Compliant with 'Safe Sharps' initiative and compliance in monitored through Health and Safety Committee
9.3g	**Management of occupational exposure to BBVs and post-exposure prophylaxis**		
	Management should ensure:		

	That any member of staff who has a significant occupational exposure to blood or body fluids is aware of the immediate action required and is referred appropriately for further management and follow-up	3	Management of sharps injuries and exposures to blood borne viruses policy avaialble on the intranet. The procedure is communicated at Nursing/AHP forums and posters / boxes available in the clinical area.
	Provision of clear information for staff about reporting potential occupational exposure – in particular the need for prompt action following a known or potential exposure to HIV or hepatitis B	3	Management of sharps injuries and exposures to blood borne viruses policy avaialble on the intranet. The procedure is communicated at Nursing/AHP forums and posters / boxes available in the clinical area. Incidents monitored through Health and Safety Committee
	Arrangements for post-exposure prophylaxis for hepatitis B and HIV	3	As above
9.3h	**Closure of rooms, wards, departments and premises to new admissions**		
	A system should be in place for the provision of advice from the local health protection team/DIPC/ICT for the registered provider	3	Clinical Site Management Team, Liaison with IPC Team, Policies available on the intranet.
	There should be clear criteria in relation to closures and re-opening	3	Guided by IPC team - Outbreak Policy
	The policy should address the need for environmental decontamination prior to re-opening	3	Detailed in Policy and from Cleaning Schedules.
9.3i	**Disinfection**		
	The use of disinfectants is a local decision, and should be based on current accepted good practise.	3	Cleaning schedules/on recommendation of IPC team
9.3j	**Decontamination of reusable medical devices**		
	Decontamination involves a combination of processes and includes cleaning, disinfection and sterilisation, according to the intended use of the device. This aims to render a reusable item safe for further use on service users and for handling by staff	3	Decontamination policies and procedures. Policies/ guidelines / incidents / risks monitored through Decontamination Committee
	Effective decontamination of reusable medical devices is an essential part of infection risk control and is of special importance when the device comes into contact with service users or their body fluids. There should be a system to protect service users and staff that minimises the risk of transmission of infection from medical devices. This requires that the device or instrument set can be clearly linked in a traceable fashion to the individual process cycle that was used to decontaminate it, such that the success of that cycle in rendering the device safe for reuse can be verified	3	As above
	Reusable medical devices should be decontaminated in accordance with manufacturers' instructions and current national or local best practice guidance. This must ensure that the device complies with the 'Essential Requirements' provided in the Medical Devices Regulations 2002 where applicable. This requires that the device should be clean and, where appropriate, sterilised at the end of the decontamination process and maintained in a clinically satisfactory condition up to the point of use	3	As above
	Management systems should ensure adequate supplies of reusable medical devices, particularly where specific devices are essential to the continuity of care	3	As above
	Reusable medical devices employed in invasive procedures, for example, endoscopes and surgical instruments have to be either individually identifiable or identified to a set of which they are a consistent member, throughout the use and decontamination cycle in order to ensure subsequent traceability	3	As above
	Systems should also be implemented to enable the identification of service users on whom the medical devices have been used	3	As above
	Decontamination of single-patient use devices, i.e. that equipment designated for use only by one patient, should be subject to local policy and manufacturer's instructions	3	As above
9.3k	**Single-use medical devices The Health and Social Care Act 2008 Code of Practice on the prevention and control of infections**		
	Policies should be in place for handling devices for single use only. Single-use medical devices should be used once and disposed of safely.	3	
9.3l	**Antimicrobial prescribing**		

	Prescribing should generally be harmonised with that in the British National Formulary and draw on national guidance, including guidance for specific infections such as gonorrhoea. However, local guidelines may be required in certain circumstances	3	Antibiotic Policy in place
	Procedures should be in place to ensure prudent prescribing and antimicrobial stewardship. There should be an ongoing programme of audit, revision and update with feedback to management, prescribers and administrators. In healthcare settings this is usually monitored by the antimicrobial management team or local prescribing advisors. Antimicrobial pharmacists and CCG prescribing advisors can support these activities	3	Quarterly point prevelance surveys (PPS) on antibiotic use are performed and entered into an Excel spreadsheet by the antibiotic pharmacist. Antimicrobial usage data is reported at the AMS Committee quarterly.
9.3m	**Reporting of infection to Public Health England or local authority and mandatory reporting of healthcare associated infection to Public Health England**		
	This includes a requirement for NHS Trust Chief Executives to report all cases of MRSA, MSSA and E. coli bacteraemias and Clostridium difficile infection in patients aged two years or older that are identified in their institution. The independent sector hospitals are also expected to report cases in a similar manner. The requirements of this system will vary from time to time as directed by the Department of Health.	3	Data exported monthly.
	Health Protection (Notification) Regulations 2010		
	These require attending doctors (registered medical practitioners) to notify the Proper Officer of the local authority of cases of specified infectious disease or of other infectious disease or contamination, which present, or could present, significant harm to human health, to allow prompt investigation and response. The regulations also require diagnostic laboratories testing human samples to notify Public Health England of the identification of specified causative agents of infectious disease.	3	HSA Mandatory reporting on the HCAI databse. Microbiology deaprtment report to CCDC
9.3n	**Control of outbreaks and infections associated with specific alert organisms**		
	This should take account of local epidemiology and risk assessment. These infections must include, as a minimum, MRSA, MSSA and E.coli bloodstream infections, respiratory infection, viral haemorrhagic fever, diarrhoeal outbreaks, Clostridium difficile infection and transmissible spongiform encephalopathies.		
	MRSA The policy should make provision for:		
	Screening of NHS patients on emergency or elective admission to relevant high risk specialties. The arrangements for undertaking screening will be subject to local agreement		
	Suppression regimens for colonised patients when appropriate	3	Detailed in MRSA Policy. Monitored via monthly KPI
	Isolation of infected or colonised patients	3	
	Transfer of infected or colonised patients within organisations or to other care facilities	3	
	Antibiotic prophylaxis for surgery	3	
	Undertaking a post infection review (PIR) on patients with a MRSA bacteraemia	3	
	Clostridium difficile The policy should make provision for:		
	Surveillance of Clostridium difficile infection	3	Monitored via monthly KPI. Detailed in C-Diff Policy
	Diagnostic criteria	3	
	Isolation of infected service users and cohort nursing	3	
	Environmental decontamination	3	
	Antibiotic prescribing policies	3	
	Contraindication of anti-motility agents	3	
	Glycopeptide resistant enterococci (GRE) The policy should make provision for:		
	Identification of high-risk groups	3	VRE policy available. Cases/carriers monitored by the IPC Team
	Isolation and prevention of cross-infection	3	

	Prophylaxis for surgical and invasive procedures	3	
	Carbapenem resistant organisms (CROs), Acinetobacter, extended spectrum beta-lactamase (ESBLs) and other antibiotic resistant bacteria		
	Surveillance and/or screening of patients at high risk of drug-resistant infection	3	Multi-Resistant
	Procedures for managing infected patients to prevent spread of infection	3	
	Viral haemorrhagic fevers (VHF)		
	The policy should refer to the latest guidance from the Advisory Committee for Dangerous Pathogens (ACDP) and make provision for:		
	Appropriate staff to be trained in how to isolate and risk assess patients at risk of VHF	3	Policy in place, with the required knowledge at a level suitable to the organisation.
	Appropriate staff to be aware of the special measures to be taken for nursing VHF patients, and to be properly trained in the application of full isolation procedures and use and safe removal of personal protective equipment (PPE)		
	Patient risk assessment and categorisation		
	Confirmed cases to be handled under full isolation measures in a high- security infectious diseases unit or equivalent		
	Handling of patient specimens at the appropriate containment level		
	Follow-up of all staff in contact with the patient at every stage of care		
	Special measures for the handling, and on-site treatment, of all waste and laundry		
	Special measures for transporting patients with VHF		
	Creutzfeld-Jakob diease (CJD), variant CJD (vCJD) and other human prion diseases		
	The policy should make provision for the management of patients with, or at increased risk of, CJD/vCJD and other human prion diseases	3	Policy in place, available on the Trusts Intranet
	Relevant policies for other specific alert organisms		
	The specific alert organisms that follow may be relevant to any unit admitting, or treating as outpatients.		
	Control of tuberculosis, including multi-drug resistant tuberculosis		
	Isolation of infectious patients	3	Detailed in the Trust Policy which is available on the Trusts Intranet
	Transfer of infectious patients within care organisations or to other care facilities	3	Detailed in the Trust Policy which is available on the Trusts Intranet
	Contact tracing	3	Detailed in the Trust Policy which is available on the Trusts Intranet

	Treatment compliance	3	Detailed in the Trust Policy which is available on the Trusts Intranet
	Respiratory viruses:		
	Alert system for suspected cases	3	Detailed in the Trust Policy which is available on the Trusts Intranet
	Isolation criteria	3	Detailed in the Trust Policy which is available on the Trusts Intranet
	Infection prevention and control measures	3	Detailed in the Trust Policy which is available on the Trusts Intranet
	For influenza measures to avoid exposure should include immunisation, as set out in Immunisation against infectious disease, better known as 'The Green Book' (published by Public Health England)	3	Detailed in the Trust Policy which is available on the Trusts Intranet
	Diarrhoeal infections:		
	Isolation criteria;	3	Detailed in the Trust Policy which is available on the Trusts Intranet
	Infection prevention and control measures; and	3	Detailed in the Trust Policy which is available on the Trusts Intranet
	Cleaning and disinfection policy	3	Detailed in the Trust Policy which is available on the Trusts Intranet
9.3o	**CJD/vCJD**		
	Advice on the handling of instruments and devices in procedures on patients with known or suspected CJD/vCJD, or at increased risk of CJD/vCJD, including disposal/quarantine procedures, is provided in guidance from the Advisory Committee on Dangerous Pathogens (ACDP) TSE working group.	3	Detailed in the Trust Policy which is available on the Trusts Intranet
9.3p	**Safe handling and disposal of waste**		
	The risks from waste disposal should be properly controlled. In practice, in relation to waste, this involves:		
	Assessing risk	3	Risk ID: 817, 1867, 2700, 2269
	Developing appropriate policies	3	Waste Management Polciy & Proceedure in date & endorsed by IPCWG/Approved by H&S committee
	Putting arrangements in place to manage risks	3	Assurance provided via PAM assessment, reported through Q&S committee to Trust Board
	Monitoring, auditing and reviewing the way in which arrangements work	3	Assurance provided via PAM assessment, reported through Q&S committee to Trust Board

	Being aware of statutory requirements and; legislative change and managing compliance	3	Assurance provided via PAM assessment, reported through Q&S committee to Trust Board
	Training and information (including definition and classification of waste)	3	Assurance provided via PAM assessment, reported through Q&S committee to Trust Board
	Personal hygiene	3	Assurance provided via PAM assessment, reported through Q&S committee to Trust Board
	Segregation and storage of waste	3	Assurance provided via PAM assessment, reported through Q&S committee to Trust Board
	The use of appropriate personal protective equipment	3	Assurance provided via PAM assessment, reported through Q&S committee to Trust Board
	Immunisation	3	Assurance provided via PAM assessment, reported through Q&S committee to Trust Board
	Appropriate procedures for handling such waste	3	Assurance provided via PAM assessment, reported through Q&S committee to Trust Board
	Appropriate packaging and labelling	3	Assurance provided via PAM assessment, reported through Q&S committee to Trust Board
	Suitable transport on-site and off-site	3	Assurance provided via PAM assessment, reported through Q&S committee to Trust Board
	Clear procedures for dealing with accidents, incidents and spillages	3	Assurance provided via PAM assessment, reported through Q&S committee to Trust Board
	Appropriate treatment and disposal of such waste	3	Assurance provided via PAM assessment, reported through Q&S committee to Trust Board
	Systems should be in place to ensure that the risks to service users from exposure to infections caused by waste present in the environment are properly managed, and that duties under environmental law are discharged.		
	Duty of care in the management of waste	3	Pre acceptance audit completed by Trust waste specialist (external) annually, reported through H&S Committee
	Duty to control polluting emissions to the air		**TBC**
	Duty to control discharges to sewers		**TBC**
	Obligations of waste managers	2	Risk ID: 2269 Trust does not have competent waste manager, mitigated through training/competency and job descripotiosn of facilities & logistics management teams
	Collection of data and obligations to complete and retain documentation including record keeping	3	Pre acceptance audit completed by Trust waste specialist (external) annually, reported through H&S Committee
	Requirement to provide contingency plans and have emergency procedures in place	3	Facilities Contingency Procedure reviewed quarterly, central copy held on switchboard. Annual test excersises completed.
9.3q	**Packaging, handling and delivery or laboratory specimens**		
	Biological samples, cultures and other materials should be transported in a manner that ensures that they do not leak in transit and are compliant with current legislation. Staff who handle samples must be aware of the need to correctly identify, label and store samples prior to forwarding to laboratories. In addition, they must be aware of the procedures needed when the container or packaging becomes soiled with body fluids.	2	IPC Policy - Transport & Handling of Specimens *Trust appointed external contractor (from 1st April) provides transport of specimens to laboratory*
9.3r	**Care of deceased persons**		
	Appropriate procedures should include:		
	Risk assessment of potential hazards	3	Detailed in the Trust Policy, which is available on the Trusts Intranet.
	The provision of appropriate facilities and accommodation	3	
	Safe working practices	3	
	Arrangements for visitors	3	
	Information, instruction, training and supervision	3	
	Health surveillance and immunisation (where appropriate)	3	
9.3s	**Use and care of invasive devices**		
	Policy should be based on evidence-based guidelines and should be easily accessible by all relevant care workers. Compliance with policy should be audited. Information on policy should be included in infection prevention and control training programmes for all relevant staff groups.	3	Policy available on the Intranet. IPC audits completed for insertion/management of invasive devices.

9.3t	**Purchase, cleaning, decontamination, maintenance and disposal of equipment**		
	Policies for the purchase, cleaning, decontamination, maintenance and disposal of all equipment should take into account infection prevention and cleanliness advice that is given by relevant experts or advisory bodies or by the Infection prevention team.	**3**	Processes allow for IPC involvement. IPC Team attend Quarterly Decontamination Committee.
9.3u	**Surveillance and data collection**		
	For all appropriate healthcare settings, there should be evidence of local surveillance and use of comparative data, where available, to monitor infection rates, antimicrobial resistance and antimicrobial consumption and to assess the risks of infection. This evidence should include data on alert organisms, and other infections where appropriate, alert conditions and wound	**3**	SSI data collected and submitted externally. Data monitored internally via IPC Committee and weekly Infection MDT meeting.
	Electronic reporting to Public Health England of clinical laboratory isolates is recommended where the appropriate information technology is in place.	**3**	as detailed above
	There should also be timely feedback to clinical units, with a record of achievements and actions taken as a result of surveillance. Post-discharge surveillance of surgical site infection should be considered and, where practicable, should be implemented.	**3**	as detailed above
9.3v	**Dissemination of information**		
	There should be a local protocol on information sharing when referring, admitting, transferring, discharging and moving service users within and between health and adult social care facilities. This is to facilitate surveillance and optimal management of infections in the wider community. Guidance on data protection legislation also needs to be observed.	**3**	Discharge summaries detailing the patients care and infection status Patient referrals to other care providers Consultant to Consultant referrals
9.3w	**Isolation facilities**		
	There should be a policy concerning the appropriate provision and maintenance of isolation facilities.	**3**	Detailed in the Trusts Isolation Policy which is on the Intranet.
	This should address:		
	Potential sources of infection;	**3**	All detailed in the Trusts Isolation Policy which is on the Intranet.
	The types of isolation facility needed for different infections;	**3**	All detailed in the Trusts Isolation Policy which is on the Intranet.
	The use of protective measures and equipment; and	**3**	All detailed in the Trusts Isolation Policy which is on the Intranet.
	The management of outbreaks	**3**	All detailed in the Trusts Isolation Policy which is on the Intranet.
9.3x	**Uniform and dress code**		
	Uniform and workwear policies ensure that clothing worn by staff when carrying out their duties is clean and fit for purpose. Particular consideration should be given to items of attire that may inadvertently come into contact with the person being cared for. Uniform and dress code policies should specifically support good hand hygiene.	**2**	Trust uniform policy in place. A review of the method for monitoring compliance needs to be reviewed.
9.3y	**Immunisation of service users**		
	Registered providers should ensure that policies and procedures are in place with regard to the immunisation status of service users such that:		
	There is a record of all immunisations given	**3**	NA to this organisation
	The immunisation status and eligibility for immunisation of service users are regularly reviewed in line with Immunisation against infectious disease ('The Green Book') and other guidance from Public Health England	**3**	NA to this organisation
	Following a review of the record of immunisations, all service users are offered further immunisation as needed, according to the national schedule.	**3**	Flu and Covid vaccinations offered to all staff
Overall Compliance (%)		**97**	

Health and Social Care Act Compliance Assessment (February 2022)			
Criterion 10: Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection			
	Compliance requirements	**RAG (1 / 2 / 3)**	**Evidence / observations / notes**
10.1	**Registered providers should note that this criterion also covers staff education and training and ensure that policies and procedures are in place in relation to the prevention of infection such that**		
	All staff can access occupational health services or access appropriate occupational health advice	**3**	Staff can be referred to OH as per Trust Sickness Absence management policy. They can also self refer to OH Trust physio and have access to 24/7 EAP services.
	Occupational health policies on the prevention and management of communicable infections in care workers are in place	**3**	Trust policy (normally the sickness absence policy) would document this not OH policies. Once reported to management they would then be referred into OH for assessment of fitness to work in line with evidence based guidacne. Any identified BBV's require OHP involvment and where required for EPP workers are put onto the appropriate registers.
	Decisions on offering immunisation should be made on the basis of a local risk assessment as described in Immunisation against infectious disease ('The Green Book'). Employers should make vaccines available free of charge to employees if a risk assessment indicates that it is needed (COSHH Regulations 2002)	**3**	Pre-Placment Questionnaire is completed by every new starter, which highlights clinical exposure. Guidance deatiled above is then used to completed the approapirte screening.
	There is a record of relevant immunisations	**3**	Pre-Placment Questionnaire is completed by every new starter, which highlights clinical exposure. Guidance deatiled above is then used to completed the approapirte screening.
	The principles and practice of prevention of infection (including cleanliness) are included in induction and training programmes for new staff. The principles include: ensuring that policies are up to date; feedback from audit results; examples of good practice; and action needed to correct poor practice	**3**	All staff complete IPC training on induction.
	There is appropriate ongoing education for existing staff (including support staff, volunteers, agency/locum staff and staff employed by contractors), which should incorporate the principles and practice of prevention and control of infection. Clinical staff should have an ongoing understanding of the risk from existing, new and emerging infectious diseases and take this into account when assessing patients	**2**	A review of the current provision in training needs to be undertaken to give assurrance that all areas are covered and aqequate time for completion is provided.
	There is a record of training and updates for all staff	**3**	Training record available via ESR / Training Team

	The responsibilities of each member of staff for the prevention of infection are reflected in their job description and in any personal development plan or appraisal	**3**	Statement in job descriptions.
Occupational health services			
10.2	**Occupational health services for staff should include:**		
	Risk-based screening for communicable diseases and assessment of immunity to infection after a conditional offer of employment and ongoing health surveillance	**3**	Pre-Placment Questionnaire is completed by every new starter, which highlights clinical exposure. Guidance deatiled above is then used to completed the approapirte screening.
	Offer of relevant immunisations	**3**	as part of the above process
	Having arrangements in place for regularly reviewing the immunisation status of care workers and providing vaccinations to staff as necessary in line with Immunisation against infectious disease ('The Green Book') and other guidance from Public Health England	**3**	Arranged by Team Prevent (external from the Organisation) & People services
10.3	**Occupational health services in respect of BBVs should include:**		
	Having arrangements for identifying and managing healthcare staff infected with hepatitis B or C or HIV and advising about fitness for work and monitoring as necessary, in line with Department of Health guidance;	**3**	Pre-Placment Questionnaire is completed by every new starter, which highlights clinical exposure. Guidance deatiled above is then used to completed the approapirte screening.
	Liaising with the UK Advisory Panel for Healthcare Workers Infected with Blood-borne Viruses when advice is needed on procedures that may be carried out by BBV-infected care workers, or when advice on patient tracing, notification and offer of BBV testing may be needed;	**3**	Conducted by Team Prevent as part of the above process.
	A risk assessment and appropriate referral after accidental occupational exposure to blood and body fluids; and	**3**	Conducted by Team Prevent - Procedure available on the Intranet.
	Management of occupational exposure to infection, which may include provision for emergency and out-of-hours treatment, possibly in conjunction with accident and emergency services and on-call infection prevention and control specialists.	**3**	Conducted by Team Prevent - Procedure available on the Intranet.
	This should include a specific risk assessment following an exposure prone procedure.	**3**	Conducted by Team Prevent - Procedure available on the Intranet.
10.4	**Occupational health services in respect of influenza should include:**		
	Arrangements for provision of influenza vaccination for healthcare workers where appropriate	**3**	Supported by Team Prevent, with a designated Trust lead, leading on the seasonal flu campaign.
Overall Compliance (%)		**98**	

Health and Social Care Act Compliance Assessment		
Compliance requirements		RAG (% compliance)
Overall Summary of Compliance		
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 that their environment and other users may pose to them.	99
2	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.	89
3	Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.	83
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.	88
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.	100
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.	78
7	Provide or secure adequate isolation facilities.	89
8	Secure adequate access to laboratory support as appropriate.	100
9	Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections.	97
10	Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection.	98

Key to RAG rating	
	91-100%
	61-90%
	<60%

Health and Social Care Act Compliance Assessment								
Criterion	**Current Arrangements / Practices**	**Improvement Plan**	**Action Required**	**Owner**	**Date for completion**	**Evidence of compliance**	**Trust Position RAG**	**Review Date**
1.1	DIPC (Chief Nurse and Patient Safety Officer) in place. The organisational structure is being reviewed following an assessment of the IPC Governance/Assurrance structure by the Director of Governance.	New proposed structure agreed at SLG. Infection Prevention and control now sits under the Assurance and Standards Team, reporting to the Head of Clinical Governance & Quality. Case of need presented at SLG 22.3.22, which supports more infrastructure and expertise investment into IPC.	Progressing with post approvals and recruitment for agreed investment.	Chief Nurse	Jun-22			
1.2 & 1.5	Post infection reviews, root cause analysis, periods of inreased incidence of infection are undertaken however there is no standarised process/ attendance list etc	A review of the IPC Governance Framework, to be conducted and update/recommendations given to IPC Working Group / Committee.		IPC Team / Head of Clinical Governance & Quality	Apr-22			
1.1 & 4.4	Patients infection status is documented on Discharge Summary and EPR. However there is currently no electronic flagging system within EPR or PSAG to highlight a patients infection status, the process is heavily reliant on a paper based system.	IPC team scoping options to incorporate a suitable patient flagging system. IPC Assurance Lead liaising with Digital Services Team to determine whether flagging system can be incorporated into the tendering process of new EPR System.	Contact Simon Adams to scope what options are available	IPC Team / Digital	May-22			
2.1	Ensure Cleaning Operations Manual is updated on implementation of 2021 National Cleaning Standards	Implementation Plan in place	Launch of cleaning standards on Intranet; Align Cleaning Operations Manual to new standards; Posters around site publicising new standards.	Facilities Compliance	Apr-22	Intranet updated; Posters to be updated April 1st		
2.1	There is adequate provision of wash hand basins installed to the guidance at time of installation. Programme ongoing to update basins to latest guidance HBM 00-03 and HTM 01-04 E&F team rolling out upgrade to wash hand basins across the trust managed through backlog program and risk on register (1873, 1962)	Work plan for wards to have upgraded basins when closed.	Assurance required to determine adequate process for the provision of basins on Ludlow Ward where one basin is present in the ensuite for patients and staff.	Head of Estates and Facilities	Apr-24			
2.1	There are effective arrangements for the appropriate cleaning of equipment that is used at the point of care, for example hoists, beds and commodes – these should be incorporated within appropriate cleaning, disinfection and decontamination policies	Assurance required to ensure there are effective checklists and monitoring in place.		ACN/Matrons	May-22			

	Linen contract in place and monitored by quaeterly contract reviews against HTM 01-04. 6 monthly programe of audits compelted by contractor to ensure adequate supply & provision at ward level. 3 days storage on site	Continue to monitor through Working Group		Facilities Operational	May-22			
2.2	PPM's are continuously reviewed internally and overseen by PAM	Policy for PPM's	Policy for PPM's to be written	Estates Compliance Manager	Jun-22			
2.4	Requirement for additional resource to facilitate perdiodic (deep) cleaning idenified, paper submitted & awaiting ICS aporval for additional resource. Ensure cleaning policy is updated on implementation of 2021 National Cleaning Standards			Head of Estates and Facilities / ACN	May-22			
2.5	Decontamination of equipment – including cleaning and disinfection of items that come into contact with the patient or service user, but are not invasive devices (eg beds, commodes, mattresses, hoists and slings, examination couches)	Assurance required to ensure there are effective checklists and monitoring in place.		ACN/Matrons	Apr-22			
3.2	Quarterly Antimicrobial meeting in place, with upward reporting to IPC Committee.	An opportunity to review membership and TOR.		IPC Assurance Lead / Head of Clinical Governance & Quality	Apr-22			
3.5	Antibiotic policy contains antibiotic resistance data relevant to their region.	Need assurrance around national body reporting.		Antimicobial Pharmacist	Apr-22			
3.6	There is no antimicrobial training for doctors on induction	IPC induction has now been extended to 1 hour from the 1st April 22, to allow time for HH compentencies to be undertaken and for antimicrobial training.		IPC / Training Team	Apr-22			

4.2	The supporting Excellence in IPC toolkit introduced in March 2021 has been adopted by the Trust Comms Team and will be implemented with immediate effect. . Staff wellbeing aligns with toolkit already.	The trust is currently reviweing and updating the intranet. The IPC data analysis is involved in the redesign of the IPC intranet page.		Communications Team	Apr-22			
4.2	Assurance required that the importance of antimicrobial use, is discussed with patients.	pharmacy staff to discuss the need for antibiotics and patients with infections monitored by the IPC team during the weekly microbiologist ward round.		Antimicobial Pharmacist	Apr-22			
4.3	Anti microbial awareness campaign communicated through Comms. Plans to have the antimicrobial stewardship pharmacy group across ICS and link in with the system AMS work.			Antimicobial Pharmacist	May-22			
6.2	Doctors training on induction does not allow sufficient time to deliver hand hygiene training.	IPC induction has now been extended to 1 hour from the 1st April 22, to allow time for HH compentencies to be undertaken and for antimicrobial training.		IPC / Training Team	Apr-22			
6.3 & 9.3b	Basic ANTT and advanced training has been delivered by an external training company. Going forward a process is required to review competencies and monitor compliance.	Going forward a process is required to review competencies and monitor compliance.	Training needs analysis to be undertaken by the training and IPC team	IPC Team / Training	Apr-22			
7.1	The Trust has a number of siderooms and bays that can facilitate individual / cohort barrier nursing.	Additional bay doors on Kenyon and Gladstone to bolster the capacity to cohort patients with infections.		Estates Operational Manager	May-22			
9.3 & 9.3A	A process of reviewing 'monitoring of compliance' for policies needs to be undertaken, enusring these are captured in the annual audits programme.			IPC Assurance Lead	Apr-22			
9.3	Doctors Hand Hygiene Comptencies	IPC induction has now been extended to 1 hour from the 1st April 22, to allow time for HH compentencies to be undertaken and for antimicrobial training.		IPC / Training Team	May-22			
9.3p	Risk ID: 2269 Trust does not have competent waste manager, mitigated through training/competency and job descripotiosn of facilities & logistics management teams	No further mitigations required.		Facilities Compliance	Mar-22			
9.3q	IPC Policy - Transport & Handling of Specimens	Trust appointed external contractor (from 1st April) provides temperature controlled transport of specimens to laboratory, with tracking		Head of Estates and Facilities	Apr-22			

9.3x	Trust uniform policy in place. A review of the method for monitoring compliance needs to be reviewed.	Compliance monitored through IPC Audit Tool on tendable??		IPC Team / Matrons	Apr-22			
10.1	A review of the current provision in IPC training, needs to be undertaken to give assurrance that all areas are covered and aqequate time for completion is provided.		Training needs analysis to be undertaken by the training and IPC team	IPC Team / Training Team	Apr-22			

Chair's Assurance Report
People Committee 3 March 2022

0. Reference Information

Author:	Mary Bardsley, Assistant Trust Secretary	**Paper date:**	6 April 2022
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1. Purpose of Paper

1.1. Why is this paper going to the Trust Board and what input is required?

This paper presents a summary of the People Committee meeting held on3 March 2022 for assurance purposes. The Board of Directors is asked to consider the assurances provided and whether any additional assurances are required.

2. Executive Summary

2.1 Context

The Board of Directors has delegated responsibility for the oversight of the Trust's system of internal control to the People Committee. This Committee is responsible for seeking assurance that the Trust's workforce strategies and policies are aligned with the Trust's strategic aims and support a patient-focused, performance culture where staff engagement, development and innovation are supported. It seeks these assurances in order that, in turn, it may provide appropriate assurance to the Board.

2.2 Summary

- The meeting was well attended and quorate
- Updates were provided on workforce, recruitment, OJP and annual leave
- Standard agenda received included the performance report, training compliance and the committee work plan.
- Concerns to highlight relate to:
  - Staff turner over/vacancy rates/recruitment
  - Workforce growth
  - DBS check and training compliance

2.3. Conclusion

The Board of Directors is asked to note the Chair's Report for assurance purposes and consider any additional assurances required.

Chair's Assurance Report
People Committee 3 March 2022

3. Main Report

3.1 Introduction

This report has been prepared to provide assurance to the Board of Directors from the People Committee which met on 3 March 2022. The meeting was quorate with 2 Non-Executive Director and 4 Executive Directors in attendance. A full list of the attendance is outlined below:

Chair/ Attendance:	
Membership:	
Paul Kingston	Non-Executive Director (Chair)
Chris Beacock	Non-Executive Director
Stacey Keegan	Interim Chief Executive Officer
Sarah Sheppard	Chief People Officer
Craig Macbeth	Chief Finance and Planning Officer
Ruth Longfellow	Chief Medical Officer
In Attendance:	
Sue Pryce	Head of People Services
Mary Bardsley	Assistant Trust Secretary
Nia Jones	Head of Planning
Dawn Forrest	Managing Director for Specialist Unit
Hilary Pepler	Trust Board Advisor
Amber Scott	Minute Secretary
Apologies:	
Apologies were received from Kerry Robinson and Sara Ellis Anderson	

3.2 Actions from the Previous Meeting

The Committee noted the actions of the previous meeting and received an update on the progress of each. All actions which were due to be completed before the meeting were confirmed as accomplished.

3.3 Key Agenda

The Committee received all items required on the work plan with an outline provided below for each:

Agenda Item / Discussion	Assured (Y/N)	Assurance Sought
1. Declaration of Interest		
There were no declarations shared	N/A	
2. Performance Report		
Following a discussion regarding staff turnover the Committee asked for Deep dives to be completed into Health Support Worker Vacancy Ratings and Nursing Vacancy Ratings to highlight any trends or reasons to the increase. Both reports to be submitted to the next	Partial	Assurance gained on the reporting process of the performance report however further assurance to be given on actions completed

Chair's Assurance Report
People Committee 3 March 2022

Committee to offer assurance and support improvements.		to improve staff turnover.
3. Workforce Plan		
Following an in-depth presentation, the Committee asked for further information on: ▪ Workforce plan and growth and how to achieve 130% and new roles to be considered at unit level. ▪ MSK Unit to respond to concerns on the failure to recruit to Anaesthetist Vacancy and consider what RJAH is building into an offer that is different to other organisations. ▪ Anaesthetic combined roles to defined and then factored into unit level business/workforce plan ▪ Completion of Job Plans to be included within reporting monthly for overview and assurances of progress The Committee will continue to have oversight on ▪ Consultant Recruitment plans ▪ Nursing and Healthcare support worker plans ▪ Job planning assurance ▪ E-Rostering assurance	No	Assurance to be provided on the points noted. Workplan to be reviewed to ensure the Committee receive oversight on the topics.
4. Consultant Recruitment Update		
The Trust explained that although data is not showing growth in recruitment, in fact, recruitment is underway and is a lengthy process. It was highlighted that workforce plans need to be aligned to ensure absolute clarity on Consultants and Consultant growth. The Trust is working to align the consultant recruitment and work force plan which is to include the Veterans Centre	Yes	Clearer and more accurate data is required at the next meeting.
5. Consultant OJP and Annual Leave Update		
The update relating to the Committees concerns regarding OJP taken place whilst consultants are on annual leave. A deep dive has been completed, highlighting a total of 13 consultant which this relates too. The Trust agreed to widen the audit to include all consultant staff and not only surgeons. It was noted that as part of the routine contract management with LLP this is reviewed at an individual Consultant level to identify what proportion of their job plan work is undertaken, relative to the total work. OJP allocated must be linked to the fulfillment of IJP as well as annual leave, which is circular to the management and distribution of annual leave. The Committee requested for this to be reported on a quarterly basis.	Yes	Quarterly reports required.
6. DBS Checks Update		
Further information to be shared at the next meeting regarding the review of the repetition elements of the Employment Checks policy. Audits have been completed on the current compliance of the policy.	Partial	Assured on the actions taking place but concerns regarding the staff members which

		staff are overdue a DBS check
7. Recruitment Update		
The Trust continue to scrutinise the performance report and there is a meeting scheduled with the information team to gain support on the data analysis. The Trust have arranged an away day to focus on recruitment.	Yes	
8. MCSI Training Report		
There are currently 6 members of staff and 13 bank staff members are outstanding the training. The Trust confirmed conversations were held with the individual and the line managers to ensure the Trust can report 100% compliance next month.	Partial	Assured on the process and steps taken to progress the compliance target and encouraged further progress to gain full assurance.
9. Freedom to Speak Up		
The Committee were informed that the proposal will be presented to the meeting in April which outlines the reviewed reporting line of the role. The Trust are taking the opportunity to re-launch the initiative and ensuring conversations and triangulation of data is aligned.	No	Requested a written proposal to be presented at the next meeting – including the revised structure.
10. People Strategy		
The Committee received a brief outline of the system activity plan. An agenda item will be first on the agenda for the next meeting.	No	Further detail of the plan is to be provided.
11. Committee Terms of Reference		
The Committee received a copy of the terms of reference for information only as a reminder of the Committees roles and responsibilities	N/A	
12. Committee Workplan		
The Committee reflected upon the work plan and no amendments were requested.	N/A	

3.6 Risks to be Escalated

In the course of its business the Committee agreed there were no risks to be escalated to Board however further assurance and actions were requested on the following:

- Staff turner over and vacancy rates
- Workforce growth
- Recruitment for Consultant
- DBS check compliance
- Training compliance in relation to MSCI staff
- Freedom to speak up proposal and improvements
- People Strategy

4. Conclusion

The Board of Directors is asked to note the meeting that took place and the assurances obtained.

Staff Survey Briefing

0. Reference Information

Author:	Sarah Sheppard, Chief of People	Paper date:	6 April 2022
Executive Sponsor:	Sarah Sheppard, Chief of People	Paper Category:	Strategy / Governance and Quality / Performance
Paper Reviewed by:	N/A	Paper Ref:	N/A
Forum submitted to:	Board of Directors	Paper FOIA Status:	Full

1. Purpose of Paper

This paper updates the Board on the 2021 Staff Survey Results for RJAH.

2. Executive Summary

2.1. Context

The national staff survey was completed in the autumn of 2021 and the results were published on March 30th 2022.

2.2. Summary

Our results do show some deterioration from previous surveys reflecting the extremely tough and challenging period our staff have all experienced. It is vital that we reflect on what staff have told us and co-produce an improvement/action plan to improve the working environment and experience for each and every one of our staff.

2.3. Conclusion

We will work with our staff to explore actions we can now take and these will form an action plan for the organisation to be approved and monitored through the People Committee.

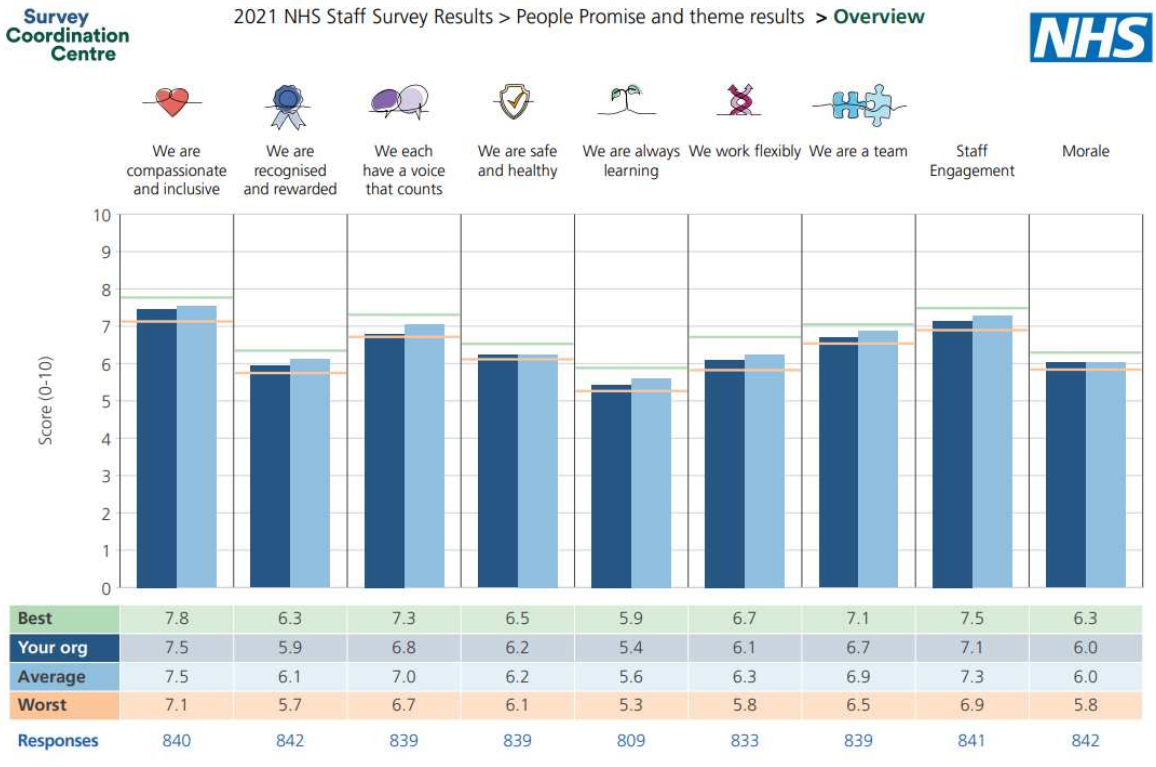
3.1. Introduction

The NHS Staff Survey was published on Wednesday 30 March. Our results do highlight more concerns than we have seen in recent times but there are still plenty of positives to be seen within it, and these are set out in the key messages below alongside the areas of concern.

We all recognise what an incredibly tough period it has been for our staff and this is reflected in our results and those across the NHS. We acknowledge that staff have important messages for us to hear and we will therefore work hard to listen to their feedback and commit to improving their working life. It is therefore important that we co-produce our actions with staff rather than developing action plans in isolation and this will influence our approach over the coming weeks. It is essential that we really do demonstrate our willingness and desire to listen to and act on the messages contained within the survey.

3.2 Our Results

The staff survey changed quite significantly this year, to align it more closely with the NHS People Plan, and the People Promise. The data has been benchmarked against each of the seven elements of the People Promise, plus two further themes – staff engagement and morale. This change means historical comparisons with our own results of previous years are not straight-forward. The People Promise and theme benchmarking results can be seen below, showing how we compare this year with our specialist peers. You will see that our results are typically around average for this peer group



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Best	7.8	6.3	7.3	6.5	5.9	6.7	7.1	7.5	6.3
Your org	7.5	5.9	6.8	6.2	5.4	6.1	6.7	7.1	6.0
Average	7.5	6.1	7.0	6.2	5.6	6.3	6.9	7.3	6.0
Worst	7.1	5.7	6.7	6.1	5.3	5.8	6.5	6.9	5.8
Responses	840	842	839	839	809	833	839	841	842

Key Messages

- We remain No 1 for staff saying they would be happy having a friend or family member treated by their organisation, with over 95% answering this question positively.

- The survey shows that the majority of our people are happy – staff don't want to leave. We have the best numbers in terms of staff saying they are actively looking for new jobs outside the organisation.

- We buck the downward trend among our specialist peers for giving opportunities for career progression. Our scores here have improved and are now one of the very best in the country.

3.2 Areas for focus

There are some clear themes that come out in this report where we have not done as well as we would like, and which we will need to start addressing over the coming months.

- Staff feeling less valued

    - Our scores for staff feeling the organisation values their work have declined sharply year on year. This is a common theme amongst our peers, but our decline is steeper than others in our benchmarking group (Specialist Trusts).

    - Staff are struggling with demands on their time and conflicting pressures. We see big drops here year on year – but our results seem to follow the general trend among our peers.

    - This feedback reflects what we have heard elsewhere – eg from our Corridor Conversations.

- Staff do not feel they can speak up

    - The data shows staff do not feel as safe speaking up about concerns as they have before. Our scores declined here, while the trend elsewhere is one of improvement.

    - Our scores have declined across all questions related to staff getting the opportunity to show initiative or make improvements. We recognise that we have been operating in a more command and control environment, but our results seem to decline much more severely than the average.

- Staff have concern about visibility and leadership from their managers

    - Our scores across all questions relating to managers have declined sharply year on year.
    - In order to develop and refine our approach we do need to understand more about what is not working and will be doing more to explore this over the coming weeks.
    - We have feedback from our corridor conversations which will also be used to corroborate the feedback.

Medical Staff have higher areas of concern across a number of the sections than other groups which warrants particular focus and attention.

3.3 Next steps

As part of the OD/cultural work being led by Kerry Robinson further 'diagnostics'/'appreciative enquiry' will be required first into the areas highlighted by the staff survey before we co-produce action plans to work through the improvements/actions which ware required.

This work will be presented to the People Committee for review and assurance.

4.0 Conclusion

The Board is asked to note the results and agree to be kept informed of progress in responding to the issues raised via the People Committee.

Chair's Assurance Report
Finance, Planning and Digital Committee - 21 March 2022

0. Reference Information

Author:	Mary Bardsley, Assistant Trust Secretary	**Paper date:**	6 April 2022
Executive Sponsor:	Sarfraz Nawaz, Chair of FPD Committee	**Paper written on:**	30 March 2022
Paper Reviewed by:	N/A	**Paper Category:**	Governance and Assurance
Forum submitted to:	Board of Directors	**Paper FOIA Status:**	Full

1. Purpose of Paper

1.1. Why is this paper going to the Trust Board and what input is required?

This paper presents a summary of the Finance, Planning and Digital Committee meeting held on 21 March 2022 for assurance purposes. The Board of Directors is asked to consider the assurances provided and whether any additional assurances are required.

2. Executive Summary

2.1 Context

The Board of Directors has delegated responsibility for the oversight of the Trust's financial performance to the Finance Planning and Digital Committee. This Committee is responsible for seeking assurance that the Trust is operating within its financial constraints and that the delivery of its services represents value for money. Further it is responsible for seeking assurance that any investments again represent value for money and delivery the expected benefits. It seeks these assurances in order that, in turn, it may provide appropriate assurance to the Board.

2.2 Summary

- The meeting was noted as quorate
- Updates were provided on the operational and financial plans for 2022/23, EPR update, and unit efficiency report.
- Standard agenda received included the performance report, finance performance report and the committee work plan.
- The Committee recommends the Board to approve the Performance Management Strategy and Accountability Framework
- Concerns to highlight relate to:
  - Deliverability of the operational plan and financial plan for 2022/23.

2.3. Conclusion

The Board of Directors is asked to note the Chair's Report for assurance purposes and consider any additional assurances required.

Chair's Assurance Report
Finance, Planning and Digital Committee - 21 March 2022

3. Main Report

3.1 Introduction

This report has been prepared to provide assurance to the Board of Directors from the Finance, Planning and Digital Committee which met on 21 March 2022. The meeting was quorate with 1 Non-Executive Director and 1 Executive Director in attendance. A full list of the attendance is outlined below:

Chair/ Attendance:	
Membership:	
Sarfraz Nawaz	Non-Executive Director (Chair)
Craig Macbeth	Chief Finance and Planning Officer
In Attendance:	
Nia Jones	Head of Planning
Dawn Forrest	Managing Director for Specialist Unit
Mark Salisbury	Operational Director of Finance
Steph Wilson	Performance Insight and Improvement Manager
Amber Scott	Minute Secretary
Apologies:	
Apologies were received from Kerry Robinson, David Gilburt and Alison Tumilty	

3.2 Actions from the Previous Meeting

The Committee noted the actions of the previous meeting and received an update on the progress of each. One action from the previous meeting was noted as outstanding which related to validation. The Committee were informed the Trust has approved to recruit further validators which will support the data cleanse of the waiting lists. A report on the trajectory is to be reported to the next meeting.

3.3 Key Agenda

The Committee received all items required on the work plan with an outline provided below for each:

Agenda Item / Discussion	Assured (Y/N)	Assurance Sought
1. Declaration of Interest		
There were no declarations shared	N/A	
2. Performance Report		
From presentation of the performance report, the following was noted, the Committee were content with the report process of the KPIs but areas to note in included: ▪ the outpatient trajectory - the Trust continue to improve DNA rates and offer virtual appointments. It was noted an outpatient flow audit was to be completed. ▪ Sickness in theatres – this is mainly due to Covid-19 cases	Yes	The Trust is taking action to address the issues identified.

Chair's Assurance Report
Finance, Planning and Digital Committee - 21 March 2022

▪ Long waiting spinal patients – plan to be implemented in theatre to prioritise 104 weeks waiters and P2 patients with consideration to flip and utilises short waiting list consultants' theatre session to outpatients' clinics		
3. English and Welsh Waiting Lists		
The Trust has previously agreed that a backstop of 104+ weeks is implemented within the organisation, this is to be balanced with clinical prioritisation. The Welsh waiting time priority measures differs from 2022/23 NHS England waiting time measures. The comparison of the Welsh and English expectations: ▪ English: - zero by July 2022 ▪ Welsh: - zero by 2024 The Committee thanked the Trust for the update which effects the NHS as a whole. The Committee noted the decision.	Yes	
4. RJAH and Midlands Comparisons		
The following information was highlighted: ▪ the Trust continues to be in the lower quartile in relation to elective outpatient recovery in comparison with the region ▪ the Trust continues to report on the changes in relation to the requirement to report on English patients within restoration going forward – discussion within the system and region are ongoing as the Trust flag as a risk The Trust agreed to share further information on the outpatients' improvements which support the increase in restoration at the next meeting	Partial	Further assurance and understanding to be obtained on the elective outpatient recovery following a review of the workforce practices
5. RJAH Financial Performance Report		
The Committee noted the following: ▪ Overall £56k favourable to plan in month and £2.6m favourable YTD ▪ Income £1m favourable in month due to £0.7m pass through costs from private patient income and RTA income. ▪ Expenditure £0.9m adverse in month ▪ Forecast outturn remains at £2.6m favourable to plan – similar to the forecast	Yes	
6. Support Services/Clinical Services Efficiency Delivery Update		
Unit year to date efficiency target is £595k and currently recorded £118k adverse to the target at M11. The forecasted efficiencies for 21/22 are £537k, which shows a £128k risk currently for 21/22. The Unit have non recurrent mitigations for this gap in 21/22. Further reflection is to be given on the PIFU scheme and timescales to which the Trust explained that going forward the team are considering OJP and PIFU together to support savings on utilisation within 2022/23.	Yes	
7. Draft Operational Plan 2022/23		

Chair's Assurance Report
Finance, Planning and Digital Committee - 21 March 2022

Concerns were raised regarding the volume of the plan and the risk of delivering effectively and asked the Committee to reflect on deliverability ahead of submission. The key areas of concerns related to: ▪ risk of increased Covid-19 patients having an effect is likely ▪ being penalised for not achieving activity	Partial	The Trust is to review and ensure the April forecast is aligned to the plan to give assurance.
8. Draft Financial Plan 2022/23		
The main areas of focus continue to be: ▪ £1.8m deficit which is an improvement from £4.2m ▪ Detailed allocation of the big-ticket item savings. These need to be agreed by individual organisations ▪ ERF income calculation and the associated costs ▪ System needs to review and prioritise the cost pressures and investments for each organisation (currently all are included) ▪ Triangulation of the final financial plan and the final operational plan	Partial	Further information to be provided on the ERF funding and investments/cost pressures
9. EPR Update		
The Trust have been scheduled (05/04/2022) a review of the business case by NHS Digital / NHS England and NHS X. No issues were raised.	Yes	
10. Performance Management Strategy and Accountability Framework		
The Trust have recommended that the framework is reviewed again throughout the new financial year to take into consideration the changes within the organisational structure.	Yes	
11. Chair Report ICS Sustainably Committee		
The following was highlighted: ▪ The system continues to develop the financial plan for 2022/23 which reports an identified gap of approx. £73m ▪ The 6 big ticket items relating to transformation across the system require an updated delivery assessment and trajectory. ▪ An area of concern shared regarding the assumptions reported to the financial plan in terms of delivering the targets and having oversight ▪ The end of year financial position reported an improvement by £0.5m although still a deficit as a result of some non-recurrent funding	Yes	
12. Chair Report MSK Programme Board		
The Committee noted the following areas of concern: ▪ Rheumatology services feedback to be reviewed following an engagement survey – this is being discussed at the senior leaders meeting and consideration to be given as to whether the	Yes	

Chair's Assurance Report
Finance, Planning and Digital Committee - 21 March 2022

Quality and Safety committee are to receive an assurance report. ▪ A business case is being commissioned to consider physio resource going forward to support the new model.		
13. Chair Report Trust Performance and Operational Board		
The report was noted by the Committee as it shared with the Committee for information.	Yes	
14. Chair Report Digital Steering Group		
It was noted that partial assurance was received on the following: ▪ Out of date servers – compliance in place to protect out of date servers. The Trust are to improve the reporting format to include a forward look. ▪ PAS system update – the system requires an update, a plan has been created to complete. ▪ Cyber attacks – awaiting a response from NHS centre regarding the reviewed assurance provided. The Trust is currently rated as low assurance.	Partial	Further information to be presented at the next meeting.
15. Committee Workplan		
The Committee reflected on the workplan and noted the BAF wasn't presented. The Committee were informed that due to the time of the year the BAF is currently undergoing a review to align the new Corporate Objectives and Corporate Risks.	Yes	The Committee were aware that the senior leaders are reviewing the BAF. Workplan to be updated.
16. Committee Attendance Matrix		
The Committee received the matrix for information only.	N/A	

3.4 Approvals

Approval Sought	Outcome
Performance Management Strategy and Accountability Framework	Recommend approval at the Board of Directors

3.5 Risks to be Escalated

In the course of its business the Committee agreed there were no risks to be escalated to Board however further assurance and actions were requested on the following:

- Deliverability of the operational and financial plans for 2022/23

4. Conclusion

The Board of Directors is asked to note the meeting that took place and the assurances obtained.

Month 11 Integrated Performance Report

0. Reference Information

Author:	Claire Jones	Paper date:	06/04/2022
Executive Sponsor:	Kerry Robinson	Paper Category:	Performance
Paper Reviewed by:	Executive Team	Paper Ref:	N/A
Forum submitted to:	Board of Directors	Paper FOIA Status:	Full

1. Purpose of Paper

1.1. Why is this paper going to Board of Directors and what input is required?

The committee is required to assure itself that the Trust is providing high quality, caring and safe health care services in accordance with national regulatory standards.

The purpose of the Integrated Performance Report (IPR) is to provide the committee with the evidence of achievement against the national regulatory standards, identification of emerging risks and the assurance that an improvement plan is in place and is effective.

This paper provides information summarising the key performance indicators, highlighting areas of high or low performance for operational and financial metrics.

The committee is asked to note the assurance provided on overall performance as presented in the month 11 (February) Integrated Performance Report, against all areas, and actions being taken to meet targets where missed, providing assurance on the process to meet the target.

2. Executive Summary

2.1. Context

The paper incorporates the monthly integrated performance report with associated narrative and descriptions of key actions.

The format of the IPR utilises Statistical Process Control (SPC) graphs and NHS EI recommended variation and assurance icons.

The reading guide within the IPR gives a full explanation on the interpretation of SPC graphs and the icons to support understanding.

2.2. Overview

The Board through this IPR should note the following;

The impacts of covid continue to be seen in the delivery of our statutory targets and will continue not to be met due to pausing of elective services last year. Therefore, assurance cannot be given for meeting the targets, hence assurance should be through the processes in place to manage such impact as described in the action section of all exceptions.

Patients continue to be booked in line with guidance regarding clinical priority as a primacy rather than date order, illustrated in the long wait patients impact.

Month 11 Integrated Performance Report

Caring for Staff;

- Sickness Absence
  - Metric showing special cause variation of a concerning nature; remaining above control range
  - Short term sickness showing special cause variation of concern
  - Long term sickness within normal variation

Caring for Patients;

- Serious Incidents
  - Low number of incidents have taken place
- WHO
  - Quality Audit - % Compliance; Included to highlight process issues in data collection; resulted in fewer audits in February
  - Documentation Audit; reported below target
- Cancer Waits Standards
  - 62 Days Standard; reported below target
- 18 Weeks RTT Open Pathways
  - Metric is showing special cause variation of concerning nature and continues to fail the 92% target. As expected from covid impact, this will continue for a significant time.
  - Whilst this metric remains affected from the covid impact, and will not be met NHSEI H2 planning guidance has set out the expectation that Trusts should stabilise waiting list numbers at the level seen at the end of September 2021 as the assurance around process rather than target.
- Patients Waiting Over 52 Weeks
  - Both English and Welsh showing special cause variation with increases reported this month.
  - NHSEI H2 planning guidance documents that as a Trust we should hold or where possible reduce the number of patients waiting over 52 weeks. For month 11 our English patients waiting over 52 weeks is 216 patients below our planned trajectory and Welsh patients 167 below our planned trajectory.
- Patients Waiting Over 104 Weeks
  - English and Welsh individually showing special cause variation of concern
  - At RJAH the Trust has a trajectory to eliminate non-spinal 104+ week waits by March 2022. The Trust however is expecting spinal disorder 104+ weeks to still be present by March 2022.
  - Currently 94 patients below our planned trajectory (English & Welsh).
- 6 and 8 Week Wait for Diagnostics
  - Both metrics shown as normal variation but remain off target

Caring for Finances;

- Total Elective Activity
  - 81.38% of plan delivered in February
  - 75.74% of 19/20 baseline
- Total Outpatient Activity
  - 81.66% of plan achieved in February
  - 77.13% of 19/20 baseline
- Bed Occupancy – All Wards – 2pm
  - Metric shown as special cause variation of an improving nature, although consistently failing target
- Expenditure
  - Adverse in month

2.3. Conclusion

The Board is asked to **note** the assurances provided on overall performance as presented in the month 11 (February) Integrated Performance Report, against all areas and actions being taken to meet targets providing assurance on process to meet the target and where insufficient assurance is received seek additional assurance.

Integrated Performance Report
February 2022 – Month 11

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Aspiring to deliver world class patient ca

SPC Reading Guide

SPC Charts

SPC charts are line graphs that employ statistical methods to aid in monitoring and controlling processes. An area is calculated based on the difference between points, called the control range. 99% of points are expected to fall within this area, and in doing so are classed as 'normal variation'. There are a number of rules that apply to SPC charts designed to highlight points that class as 'special cause variation' - abnormal trends or outliers that may require attention.

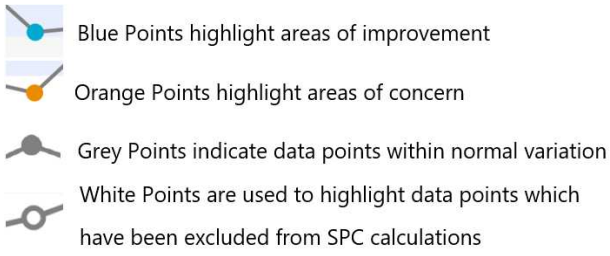
There are situations where SPC is not the appropriate format for a KPI and a regular line graph has been used instead. Examples of this are list sizes, KPIs with small numbers and little variation, and zero tolerance events.

SPC Chart Rules

The rules that are currently being highlighted as 'special cause' are:

- Any single point outside of the control range
- A run of 7 or more consecutive points located on the same side of the mean (dotted line)
- A run of 6 or more consecutive points that are ascending or descending
- At least 2 out of 3 consecutive points are located within or beyond the outer thirds of the control range (with the mean considered the centre)

Different colours have been used to separate these trends of special cause variation:



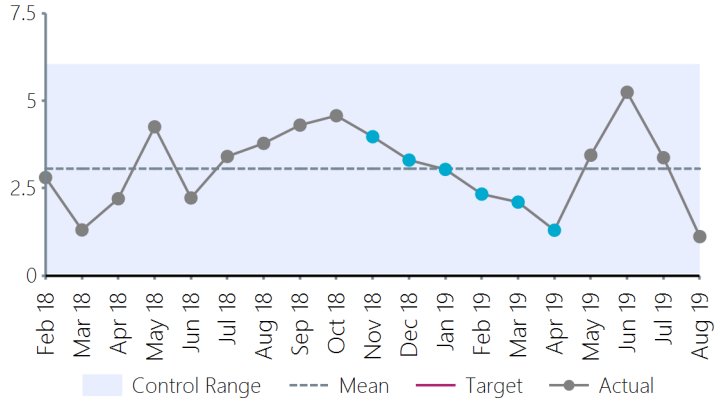
Some examples of these are shown in the images to the right:

a) shows a run of improvement with 6 consecutive descending months.

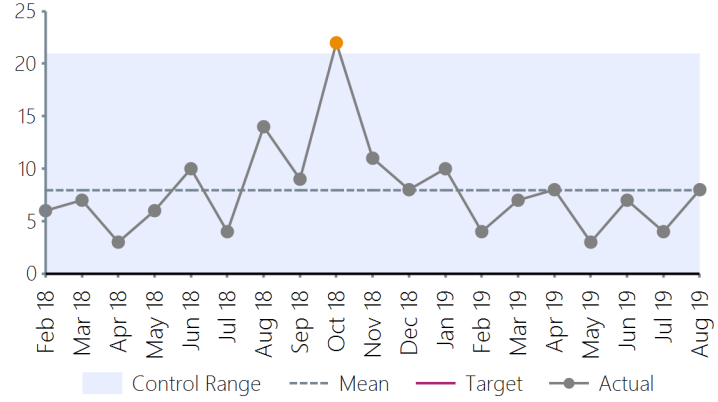
b) shows a point of concern sitting above the control range.

c) shows a positive run of points consistently above the mean, with a few outlying points that are outside the control limits. Although this has highlighted them in red, they remain above the target and so should be treated as a warning.

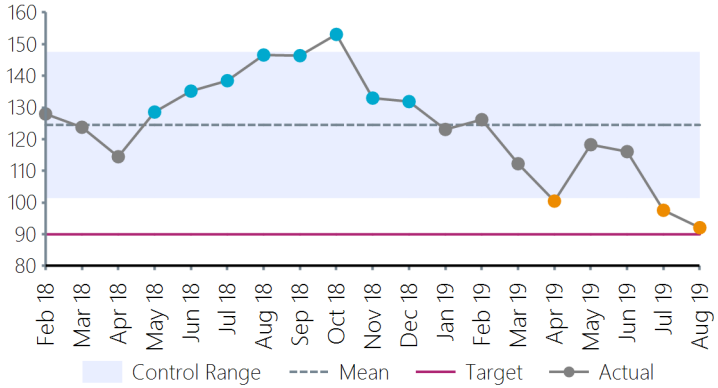
a)



b)



c)



Summary Icons Reading Guide

With the redesign of the IPR you will now see 2 summary icons against each KPI, which have been designed by NHSI to give an overview of how each measure is performing at a glance. The first icon is used to show whether the latest month is of concerning or improving nature by using SPC rules, and the second icon shows whether or not we can reliably hit the target.

Exception Reporting

Instead of showing a narrative page for every measure in the IPR, we are now only including these for those we are classing as an 'exception'. Any measure that has an orange variation or assurance icon is automatically identified as an exception, but each KPI has also been individually checked and manually set as an execption if deemed necessary. Summary icons will still be included on the summary page to give sight of how measures without narrative pages are performing.

For KPIs that are not applicable to SPC; to identify exceptions we look at performance against target over the last 3 months - automatically assigning measures as an exception if the last 3 months have been falling short of the target in line with how we're calculating the assurance icon for non-SPC measures.

Variation Icons

Are we showing improvement, a cause for concern, or staying within expected variation?

Orange variation icons indicate special cause of **concerning nature** or high pressure do to (H)igher or (L)ower values, depending on whether the measure aims to be above or below target.

Blue variation icons indicate special cause of improving nature or lower pressure do to (H)igher or (L)ower values, depending on whether the measure aims to be above or below target.

A grey graph icon tells us the variation is common cause, and there has been no significant change.

For measures that are not appropriate to monitor using SPC you will see the "N/A to SPC" icon instead.

The special cause mentioned above is directly linked to the rules of SPC; for variation icons this is if the latest point is outside of the control range, or part of a run of consecutively improving or declining points.

Assurance Icons

Can we expect to reliably hit the target?

An orange assurance icon indicates consistently (F)alling short of the target.

A blue assurance icon indicates consistently (P)assing the target.

A grey assurance icon indicates inconsistently passing and falling short of the target.

For measures without a target you will instead see the "No Target" icon.

Currently shown for any KPIs with moving targets as assurance cannot be provided using existing calculations.

Assurance icons are also tied in with SPC rules; if the control range sits above or below the target then F or P will show depending on whether or not that is meeting the target, since we can expect 99% of our points to fall within that range. For KPIs not applicable to SPC we look at the last 3 months in comparison to the target, showing F or P icons if consistently passing of falling short.

Data Quality Rating Reading Guide

The Data Quality (DQ) rating for each KPI is included within the 'heatmap' section of this report. The indicator score is based on audits undertaken by the Data Quality Team and will be further validated as part of the audit assurance programme.

Colours

When rated, each KPI will display colour indicating the overall rating of the KPI

Blue	Green	Amber	Red
No improvement required to comply with the dimensions of data quality	Satisfactory - minor issues only	Requires improvement	Siginficant improvement required

Dates

The date displayed within the rating is the date that the audit was last completed.

Summary - Caring for Staff

KPI (*Reported in Arrears)	Latest Target/Baseline	Latest Value	Trajectory/Plan (H1&H2)	Variation	Assurance	Exception	DQ Rating
Sickness Absence	3.60%	5.81%		H	?	+	27/02/20
Voluntary Staff Turnover - Headcount	8.00%	8.71%		H	?	+	24/06/21

Summary - Caring for Patients

KPI (*Reported in Arrears)	Latest Target/Baseline	Latest Value	Trajectory/Plan (H1&H2)	Variation	Assurance	Exception	DQ Rating
Serious Incidents	0	1		N/A to SPC	?	+	
Never Events	0	0		N/A to SPC	P		16/04/18
Number of Complaints	8	13			?		
RJAH Acquired C.Difficile	0	0		N/A to SPC	?		24/06/21
RJAH Acquired E. Coli Bacteraemia	0	0		N/A to SPC	?		24/06/21
RJAH Acquired MRSA Bacteraemia	0	0		N/A to SPC	P		24/06/21
RJAH Acquired Klebsiella spp	0	0		N/A to SPC	P		
RJAH Acquired Pseudomonas	0	0		N/A to SPC	P		
Unexpected Deaths	0	0		N/A to SPC	?		16/04/18
WHO Quality Audit - % Compliance	100%	100%		N/A to SPC	P	+	

Summary - Caring for Patients

KPI (*Reported in Arrears)	Latest Target/Baseline	Latest Value	Trajectory/Plan (H1&H2)	Variation	Assurance	Exception	DQ Rating
WHO Documentation Audit - % Compliance	100%	97%		N/A to SPC	?	+	
31 Days First Treatment (Tumour)*	96%	100%		H	?		24/06/21
Cancer Plan 62 Days Standard (Tumour)*	85.00%	33.33%			?	+	24/06/21
6 Week Wait for Diagnostics - English Patients	99.00%	74.81%			?	+	
8 Week Wait for Diagnostics - Welsh Patients	100.00%	73.41%			?	+	
18 Weeks RTT Open Pathways	92.00%	53.99%		L	F	+	24/06/21
Patients Waiting Over 52 Weeks – English	0	1,740	1,956	H	F	+	24/06/21
Patients Waiting Over 52 Weeks – Welsh	0	806	973	H	F	+	24/06/21
Patients Waiting Over 104 Weeks - English	0	112	148	H	F	+	
Patients Waiting Over 104 Weeks - Welsh	0	88	146	H	F	+	

Summary - Caring for Finances

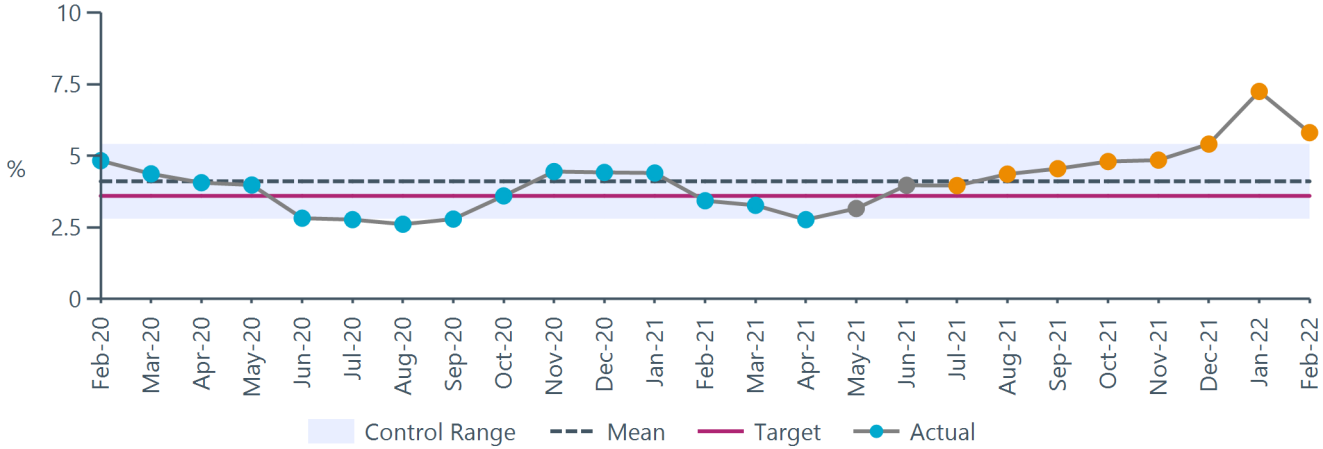
KPI (*Reported in Arrears)	Latest Target/Baseline	Latest Value	Trajectory/Plan (H1&H2)	Variation	Assurance	Exception	DQ Rating
Total Elective Activity	1,010	765	941		Moving Target	+	24/06/21
Bed Occupancy – All Wards – 2pm	87.00%	82.82%		H	F	+	09/03/22
Total Outpatient Activity	14,880	11,477	14,054	N/A to SPC	Moving Target	+	24/06/21
H1 & H2 Plan Performance	275	331	275	N/A to SPC	Moving Target		
Income	10,534	11,516	10,816	N/A to SPC	Moving Target		
Expenditure	10,304	11,231	10,478	N/A to SPC	Moving Target	+	
Efficiency Delivered	217	226	216	N/A to SPC	Moving Target		
Cash Balance	21,649	28,155		H	Moving Target		
Capital Expenditure	1,175	699		N/A to SPC	Moving Target		
Recurrent Financial Performance (Sustainability Plan)	-246	-256	-246	N/A to SPC	Moving Target		

Sickness Absence

FTE days lost as a percentage of FTE days available in month 211161

Exec Lead
Chief People Officer

Latest Target/Baseline	Latest Value	Variation	Assurance
3.60%	5.81%	H	?



Trajectory/Plan (H1&H2)

What these graphs are telling us

Metric is experiencing special cause variation of a concerning nature. The assurance is indicating variable achievement (will achieve target some months and fail others) as the target line sits within the control range.

Narrative

The sickness absence reported for February is 5.81% (4.26% sickness without covid). This remains above target and is shown as special cause variation. Unit level detail below for those areas that are above target:
* MSK Unit - 7.73%, above target for nine consecutive months, 'Infectious Diseases' as highest reason
* Specialist Unit - 5.65%, above target for nine consecutive months, 'Infectious Diseases' as highest reason
* CSU - 6.20%, above target for ten consecutive months, 'Infectious Diseases' as highest reason
* Assurance & Standards Team - 4.12%, remaining above target for a second month, 'Benign and malignant tumours' as highest reason

Staff groups with the highest levels of sickness absence were:
* Healthcare Assistants - 10.54%
* Registered Nursing Staff - 8.36%
* Physiotherapists - 6.40%
* Radiographers - 5.61%

Actions

In light of increased covid-related pressures, the Trust instigated silver tactical meetings in December to discuss daily operational issues, of which sickness levels are included. These tactical meetings remain in place. Internal reporting was adapted in January to support these meetings with analysis by staff groups.

Mitigating actions were put in place to help address some of the gaps in ward areas by instigating an enhanced rate for some staff groups.

Utilisation of the sickness absence policy continues with pro-active milestone management. The Specialist Unit have held a training session with Senior Nursing staff in supporting staff through sickness absence. An additional session is now planned later in March for both Specialist and MSK Units.

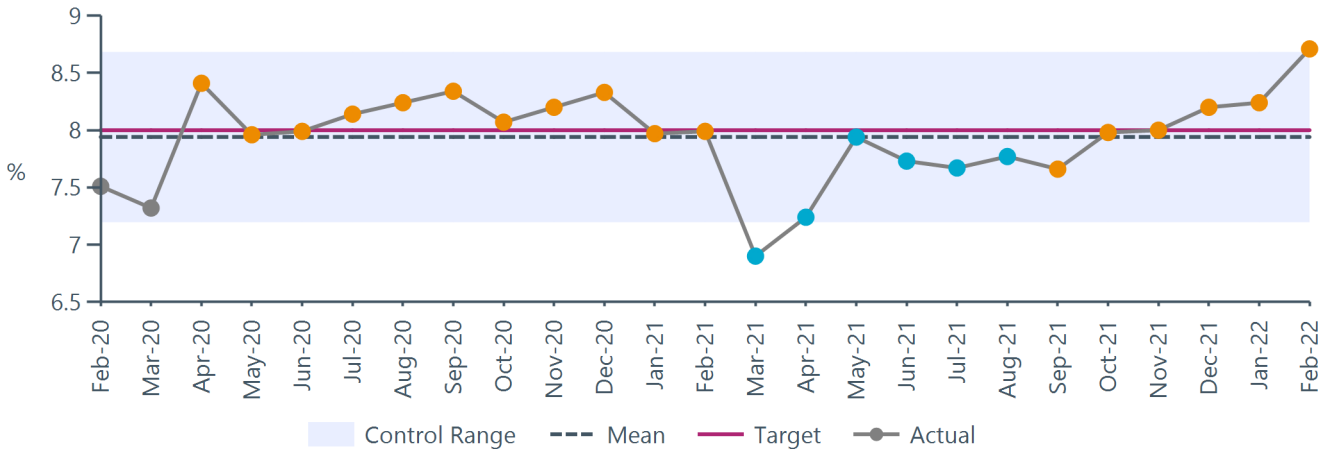
Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
3.43%	3.27%	2.77%	3.16%	3.97%	3.96%	4.36%	4.55%	4.80%	4.85%	5.41%	7.25%	5.81%

Voluntary Staff Turnover - Headcount

Total numbers of voluntary leavers in the last 12 months as a percentage of the total employed 217394

Exec Lead
Chief People Office

Latest Target/Baseline	Latest Value	Variation	Assurance
8.00%	8.71%	H	?



Trajectory/Plan (H1&H2)

What these graphs are telling us

Metric is experiencing special cause variation of a concerning nature. The assurance is indicating variable achievement (will achieve target some months and fail others) as the target line sits within the control range.

Narrative

Voluntary Staff Turnover, at Trust level, has now exceeded the 8% target for three months, and is shown as special cause variation. In the latest twelve month period, March-21 to February-22, there have been 144 leavers throughout the Trust. This is in relation to a headcount in post of 1653, as at 28th February 2022. This is the highest % turnover reported since June 2018 when it was 9.31%.
The staff groups with turnover above target are; Estates and Ancillary - 11.92%, Add Prof Scientific - 10.26%, Nursing and Midwifery - 9.63%, Additional Clinic - 9.49%, Administrative and Clinical - 8.80%

Following an action last month, additional analysis has been undertaken to review the reasons for leaving. The top three reasons (that accounts for 62%) at Trust level were:
* Retirement age 47 / 33%
* Voluntary Resignation - Other/Not Known - 25 / 17%
* Voluntary Resignation - Promotion - 17 / 12%
This is based on the leaving reasons listed on termination form/ESR. There are three categories for Retirement - Age, ill health and flexi retirement. The total for these three categories was 58 leavers in the last twelve months. Of the 58 leaving due to retirement, 34 returned in some capacity (59%).

Actions

Increased analysis of this data continues with next steps for the Information Workforce Team to provide a demographic view of the Trust workforce. This will then be provided to the People Business Partners to review and highlight any areas and/or staff groups that may have increased levels of retirement approaching. This can then prompt relevant discussions within Units.

In line with the NHS People Plan, the Trust is proactively promoting and supporting staff with agile/flexible working with the recent release of an updated Trust policy and communications highlighting this.

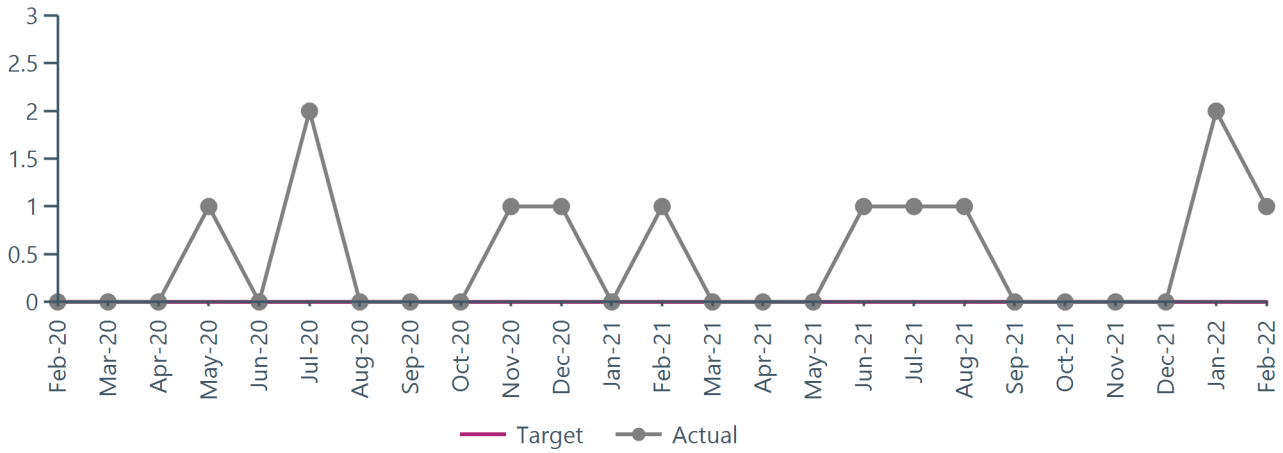
Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
7%	6%	7%	7%	7%	7%	7%	7%	7%	8%	8%	8%	8%

Serious Incidents

Number of Serious Incidents reported in month 211160

Exec Lead
Chief Nurse and Patient Safety Office

Latest Target/Baseline	Latest Value	Variation	Assurance
0	1	N/A to SPC	?



Trajectory/Plan (H1&H2)

What these graphs are telling us

This measure is not appropriate to display as SPC. The assurance is indicating variable achievement (will achieve target some months and fail others).

Narrative

There was one serious incident reported in February whereby a patient who was admitted for surgery required further treatment by the Anaesthetics team in order to prevent serious harm.

Actions

An internal patient safety alert has been sent out to the Theatres & Anaesthetics teams to raise awareness on the starving times before surgery. The WHO checklist has also been updated to include relevant prompt.

Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
1	0	0	0	1	1	1	0	0	0	0	2	1

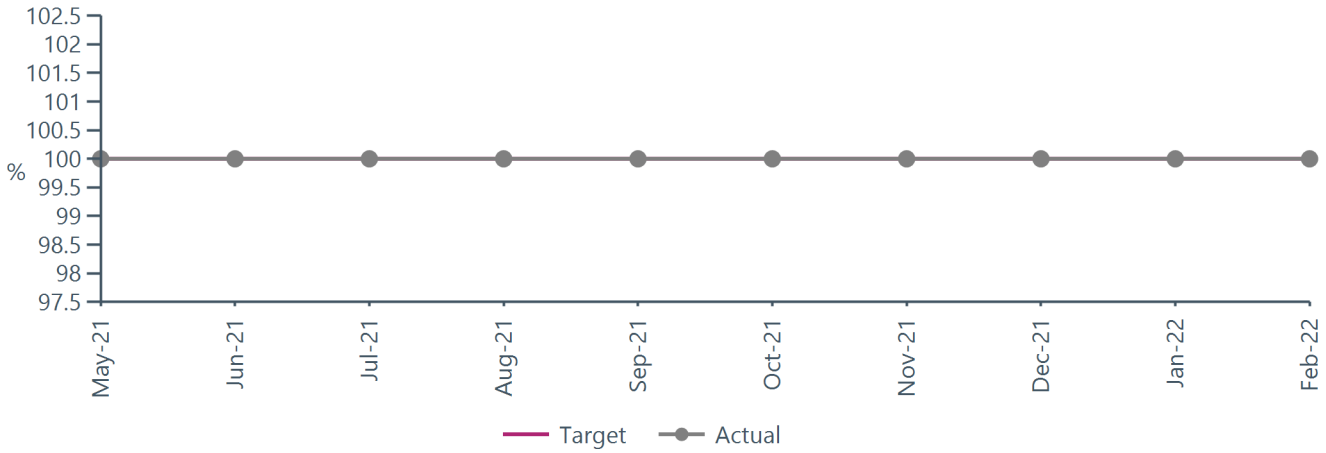
- Staff - Patients - Finances -

WHO Quality Audit - % Compliance

% of audited sessions where whole/part WHO process was implemented as part of patient care 217717

Exec Lead
Chief Medical Office

Latest Target/Baseline	Latest Value	Variation	Assurance
100%	100%	N/A to SPC	P



Trajectory/Plan (H1&H2)

Actual
Trajectory

What these graphs are telling us

This measure does not have enough data points for robust reporting in SPC so is displayed as a line graph. The assurance is indicating the metric will consistently pass the target.

Narrative

WHO Quality Audit - % Compliance in February is reporting 100%. This measure is included as an exception as only 6 of the required 10 audits were recorded on Tendable in February.

As a result of COVID-19 related absence amongst Registered Nurses, 8 quality audits were completed, of which 6 were input into Tendable - back-up paper records are no longer kept. The 6 audits undertaken and recorded on Tendable reported 100% compliance in all stages of the WHO process.

Actions

The staff have been advised to input audit results directly into Tendable which is not yet fully embedded and will be addressed for March reporting. A process to ensure there is a backup person to undertake and record audits in someone's absence will be formulated by the Matron and senior members of the Theatres team.

Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
			100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

WHO Documentation Audit - % Compliance

% of sticker compliance for steps one to five of WHO documentation 217718

Exec Lead
Chief Medical Office

Latest Target/Baseline	Latest Value	Variation	Assurance
100%	97%	N/A to SPC	?

Trajectory/Plan (H1&H2)

What these graphs are telling us

This measure does not have enough data points for robust reporting in SPC so is displayed as a line graph. The assurance is indicating variable achievement (will achieve target some months and fail others).

Narrative

The WHO Documentation Audit - % Compliance in February is reporting 97%.
A total of 40 paper documentation audits were undertaken by the Recovery team, where staff were checking for stickers evidencing adherence to each of the WHO five steps, result of which showed:
* Steps 1-Brief and 5-Debrief were 98% compliant
* Steps 2-Sign In and 3-Time Out were 100% compliant
* Step 4-Sign Out was 90% compliant
The aim of the audit is to ascertain how well the team are recording compliance in patients' notes. A full and complete record of the background evidence of the audit is retained by Theatres and the outcomes of the audit are being reviewed for common themes and, where appropriate, actions to improve. As a result of COVID-19 sickness related absence amongst Registered Nurses these audits were not recorded in the Tendable App (formerly known as Perfect Ward).

Actions

Recovery staff collect the data for the documentation audit on paper as multiple staff members can undertake each audit of 10 patients; this is then submitted onto Tendable. Staff absence meant that this was submitted in paper format this month. This weakness in the current system for capturing WHO data is being addressed by the Matron - to remove duplication and ensure adequate cross cover amongst staff from March 2022.

Documentation audit results and observations have been shared with the Matron, Assistant Chief Nurse and the Chief Medical Officer, and the detail behind the audit results and actions to improve compliance will be discussed at the fortnightly Theatre User Group meeting. A recommendation in relation to the 100% target compliance leve will be brought to Patient Safety Committee by the Assistant Chief Nurse.

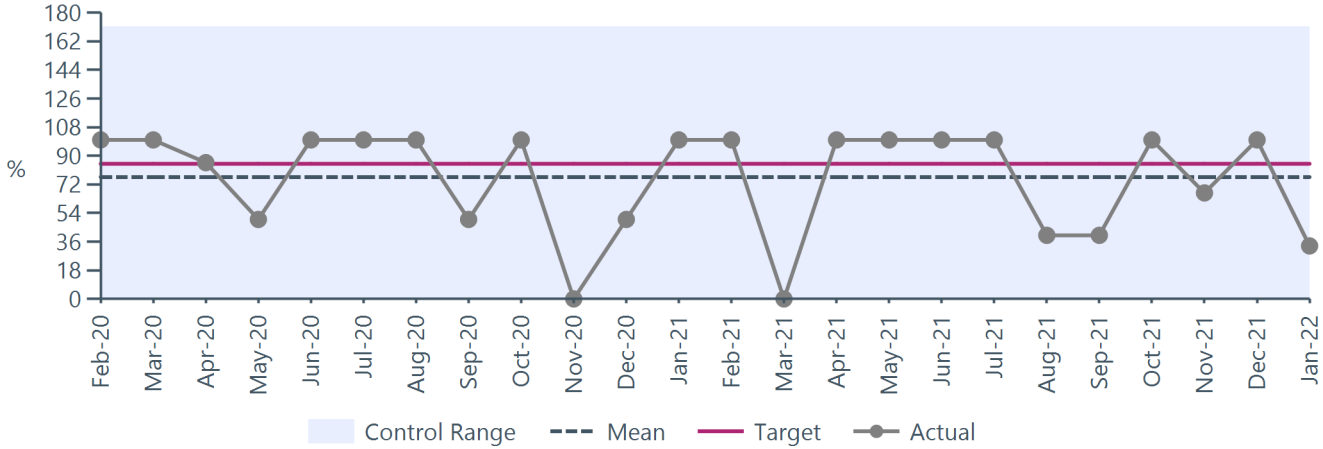
Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
				94%	90%	95%	96%	93%	98%	100%	99%	97%

Cancer Plan 62 Days Standard (Tumour)*

% of cancer patients treated within 62 days of referral (*Reported one month in arrears) 211045

Responsible Unit
Specialist Services Unit

Latest Target/Baseline	Latest Value	Variation	Assurance
85.00%	33.33%		



Trajectory/Plan (H1&H2)

What these graphs are telling us

Metric is experiencing common cause variation. The assurance is indicating variable achievement (will achieve target some months and fail others).

Narrative

The Cancer 62 Day Standard was not met in January (reported one month in arrears). A breakdown of the patients reported against the standard is outlined below (with RJAH accountability of pathway shown in brackets):
- Patient 1 - Breach (1) - shared pathway with another provider but RJAH accountable for the full breach
- Patient 2 - Breach (1) - shared pathway with another provider but RJAH accountable for the full breach
- Patient 3 - In Target (0.5) - shared pathway with another provider
- Patient 4 - In Target (0.5) - shared pathway with another provider

Of the two breaches reported against this standard, one was due to patient choice. The second is currently being investigated by the Assistant Performance Manager, along with the Tumour Team, to understand the reasons for the breach from the tracking notes available.

Indicative data provided by the Cancer Pathway Co-ordinator states that the standard will be met in February.

Actions

Enhanced monitoring has been undertaken with a renewed emphasis on robust procedures and appropriate escalation. Tracking notes provided by the team have been vastly improved and a new tracking spreadsheet is being utilised to enable appropriate scrutiny. The Assistant Performance Manager is monitoring and communicating tracking and wider issues with the Managing Director in a weekly basis.

Following the recent process mapping exercise, a joint workshop for both Tumour and Radiology teams is being scheduled for Q1. The actions and improvements identified are still being embedded across the teams.

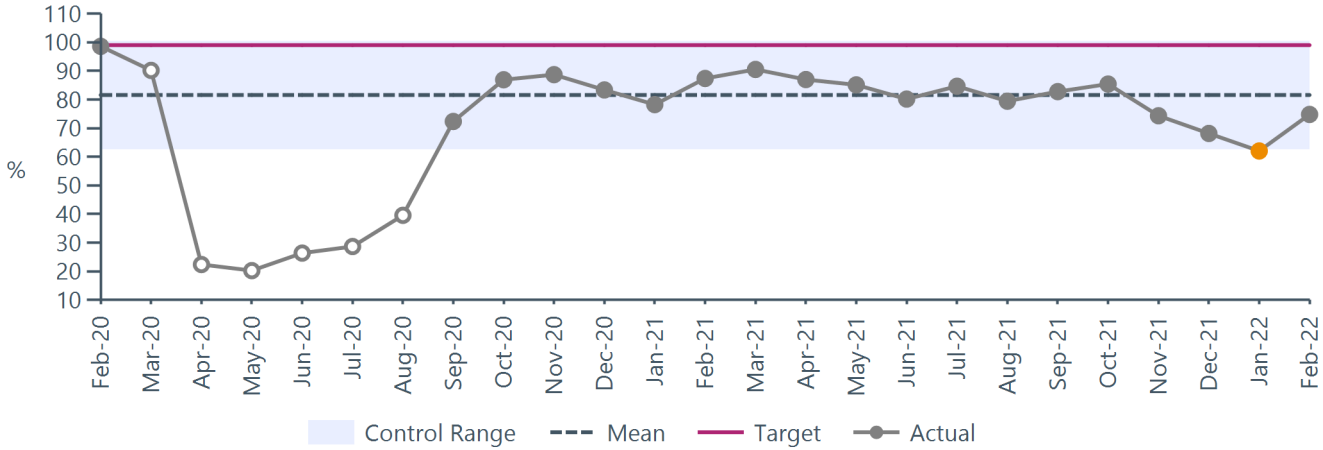
Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
100%	0%	100%	100%	100%	100%	40%	40%	100%	66%	100%	33%	

6 Week Wait for Diagnostics - English Patients

% of English patients currently waiting less than 6 weeks for diagnostics 211026

Responsible Unit
Clinical Services Unit

Latest Target/Baseline	Latest Value	Variation	Assurance
99.00%	74.81%		



Trajectory/Plan (H1&H2)

What these graphs are telling us

Metric is experiencing special cause variation of a concerning nature. The assurance is indicating variable achievement (will achieve target some months and fail others).

Following guidance from NHS EI we have updated the SPC graph to make allowance for the months impacted by covid. The data points from March-20 to August-20 have now been excluded in the control limits calculation and a step change has been introduced from September-20 after trauma was repatriated and services resumed. At present we are displaying our latest control range based on performance from September-20. We will continue to monitor the control range as we include further data points.

Narrative

The 6 week standard for diagnostics was not achieved this month and is reported at 74.81%. This equates to 325 patients who waited beyond 6 weeks. Breakdown below outlines performance and breaches by modality:
- MRI - 64.73% (D2 (Urgent - 0-2 weeks) - 1 dated, D3 (Routine - 4-6 weeks) - 1 dated, D4 (Routine - 6-12 weeks) - 302 with 235 dated)
- CT - 91.43% (D3 (Routine - 4-6 weeks) - 1 dated, D4 (Routine - 6-12 weeks) - 8 with 6 dated)
- Ultrasound - 96.09% (D4 (Routine - 6-12 weeks) - 12 with 10 dated)

The number of patients waiting over 6 weeks has improved since last month, although some activity was lost in February due to sickness. The trust continues to treat by clinical priority, the D2 (Urgent - 2 weeks) breach in MRI was due to a change in priority of initial referral from D4 to D2.

Both Ultrasound and CT activity was over 100% of the H2 plans.

Actions

Actions include:
- A paper is due for presentation to SLG and Board outlining a proposal to increase staffing that would enable increased capacity in MRI
- Currently reviewing skill mix within Diagnostics to train and then utilise established staff across multiple modalities

- Continue to monitor the impact of COVID 19 within Radiology in the tactical operational meeting.

It is anticipated that the actions above well help to improve the current performance although not meet the target. The national expectations are not for this target to be achieved throughout 22/23.

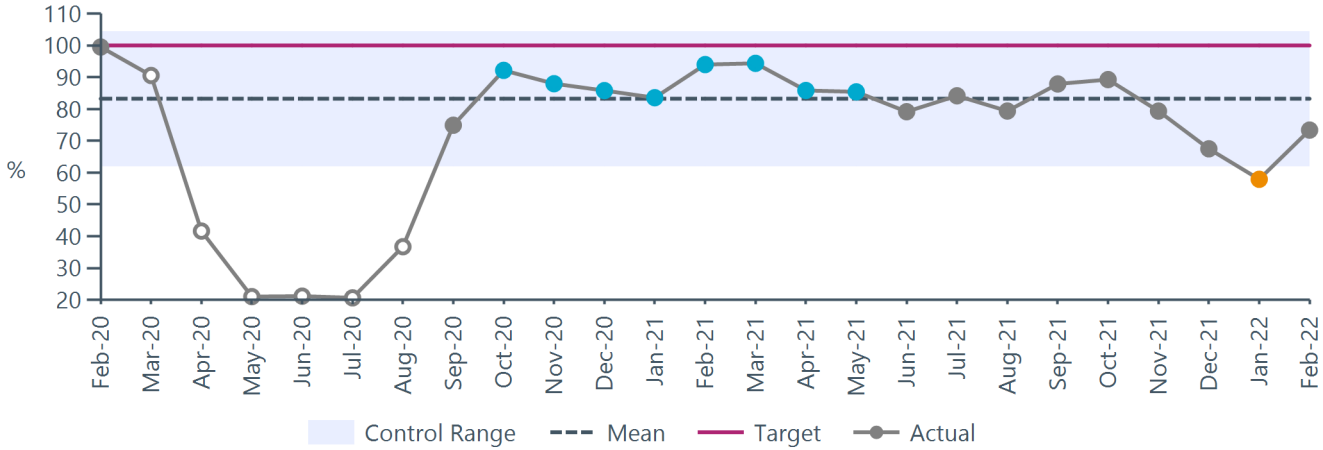
Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
87.38%	90.53%	86.99%	85.13%	80.17%	84.66%	79.43%	82.78%	85.42%	74.35%	68.16%	62.04%	74.81%

8 Week Wait for Diagnostics - Welsh Patients

% of Welsh patients currently waiting less than 8 weeks for diagnostics 211027

Responsible Unit
Clinical Services Unit

Latest Target/Baseline	Latest Value	Variation	Assurance
100.00%	73.41%		



Trajectory/Plan (H1&H2)

What these graphs are telling us

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Narrative

The 8 week standard for diagnostics was not achieved this month and is reported at 73.41%. This equates to 163 patients who waited beyond 8 weeks. Breakdown below outlines performance and breaches by modality:
- MRI - 69.47% (D4 (Routine 6-12 weeks) -156 with 144 dated)
- CT - 84.38% (D4 (Routine - 6-12 weeks) - 5 with 4 dated)
- Ultrasound - 97.06% (D4 (Routine - 6-12 weeks) - 2 dated)

The number of patients waiting over 6 weeks has improved since last month, although some activity was lost in February due to sickness.

Both ultrasound and CT activity was over 100% of the H2 plans.

Actions

Actions include:
- A paper is due for presentation to SLG and Board outlining a proposal to increase staffing that would enable increased capacity in MRI
- Currently reviewing skill mix within Diagnostics to train and then utilise established staff across multiple modalities

- Continue to monitor the impact of COVID 19 within Radiology in the tactical operational meeting.

It is anticipated that the actions above well help to improve the current performance although not meet the target. The national expectations are not for this target to be achieved throughout 22/23.

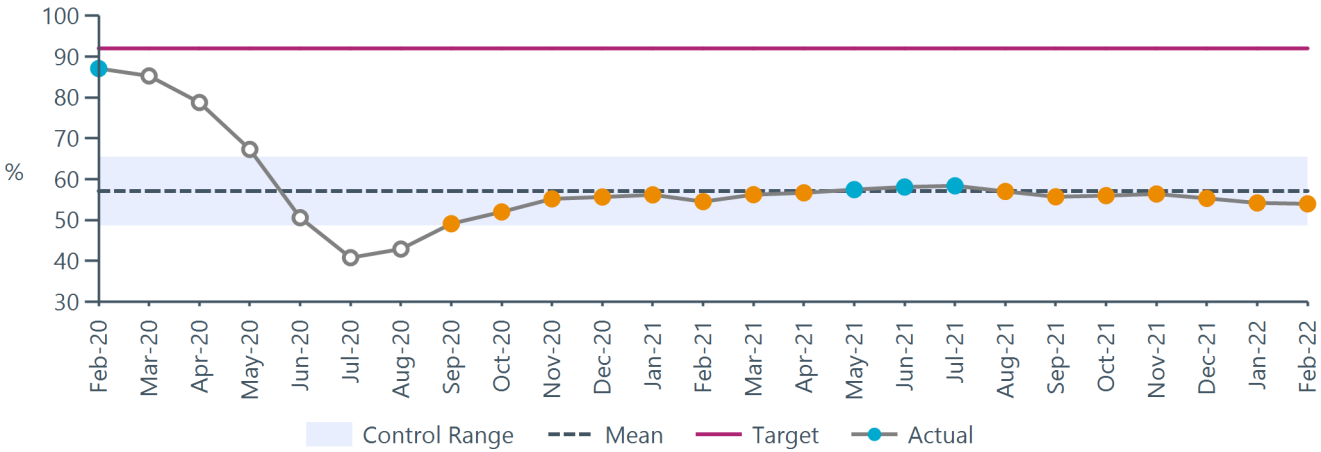
Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
94%	94%	85%	85%	79%	84%	79%	87%	89%	79%	67%	57%	73%

18 Weeks RTT Open Pathways

% of English patients on waiting list waiting 18 weeks or less 211021

Responsible Uni
Support Services Uni

Latest Target/Baseline	Latest Value	Variation	Assurance
92.00%	53.99%	L	F



Trajectory/Plan (H1&H2)

What these graphs are telling us

Metric is experiencing special cause variation of a concerning nature. Metric is consistently failing the target.

Following guidance from NHS EI we have updated the SPC graph to make allowance for the months impacted by covid. The data points from March-20 to August-20 have now been excluded in the control limits calculation and a step change has been introduced from September-20 after trauma was repatriated and services resumed. At present we are displaying our latest control range based on performance from September-20. We will continue to monitor the control range as we include further data points.

Narrative

Our February performance was 53.99% against the 92% open pathway performance for patients waiting 18 weeks or less to start their treatment. The performance breakdown by milestone is as follows: MS1 - 7215 patients waiting of which 1957 are breaches, MS2 - 1211 patients waiting of which 787 are breaches, MS3 - 4691 patients waiting of which 3291 are breaches.

Actions

H2 planning guidance documents that as a Trust we should stabilise waiting lists around the level seen at the end of September 2021. We continue with the Trust's plans and actions to manage demand. These are inclusive of:
- Increasing available Theatre sessions
- Exploring options to increase Cases per Session (CPS): - CPS when compared with 2019/20 is being impacted by complexity of patients presenting as high priority
- More clock stops in non-admitted pathways - Capacity in delivery area (i.e. Radiology or MOPD) is continually assessed

Despite this, we anticipate an impact on RTT performance as a result of reductions in planned activity due to recent pandemic pressures.

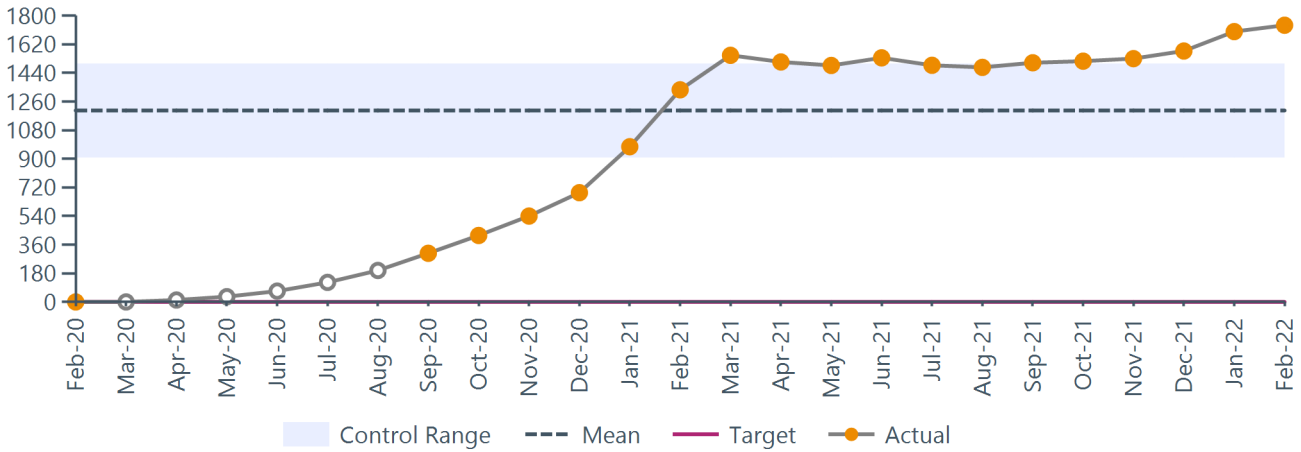
Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
54.53%	56.23%	56.68%	57.46%	58.10%	58.40%	57.02%	55.71%	55.99%	56.39%	55.33%	54.21%	53.99%

Patients Waiting Over 52 Weeks – English

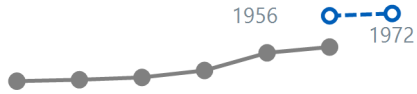
Number of English RTT patients waiting 52 weeks or more at month end 211139

Responsible Unit
Specialist Services Unit

Latest Target/Baseline	Latest Value	Variation	Assurance
0	1,740	H	F



Trajectory/Plan (H1&H2)



What these graphs are telling us

Metric is experiencing special cause variation of a concerning nature. Metric is consistently failing the target.

Following guidance from NHS EI we have updated the SPC graph to make allowance for the months impacted by covid. The data points from March-20 to August-20 have now been excluded in the control limits calculation and a step change has been introduced from September-20 after trauma was repatriated and services resumed. At present we are displaying our latest control range based on performance from September-20. We will continue to monitor the control range as we include further data points.

Narrative

At the end of February there were 1740 English patients waiting over 52 weeks; below our trajectory figure of 1956 by 216.

The patients are under the care of the following sub-specialities; Spinal Disorders (877), Knee & Sports Injuries (328), Arthroplasty (235), Upper Limb (123), Spinal Injuries (79), Foot & Ankle (60), Metabolic Medicine (14), Tumour (11), Paediatric Orthopaedics (9), Neurology (2), Rheumatology (1) and Paediatric Medicine (1).

The number of patients waiting, by weeks brackets is:
- >52 to <=78 weeks - 1271 patients
- >78 to <=95 weeks - 297 patients
- >95 to <=104 weeks - 60 patients
- >104 weeks - 112 patients

Actions

H2 planning guidance documents that as a Trust we should hold, or where possible, reduce the number of patients waiting over 52 weeks. The submitted plans are reflected in the trajectory line above for future months.

The Trust is constantly monitoring waiting list movements alongside capacity available for our clinically urgent patients. The Trust continues to follow clinical prioritisation national guidance to book patients and has a noted risk for its Spinal Disorders services. We are exploring the use of an emergency P2 list in theatres and discussions are underway with the independent sector for potential capacity there.

At present, we do anticipate an impact on the number of patients currently waiting whilst the Trust has to reduce planned activity due to pandemic pressures.

Planning guidance for 22/23 stipulates that Trusts should eliminate 104+ weeks by July 2022 (except for patient choice) and make plans to reduce waits over 52 weeks.

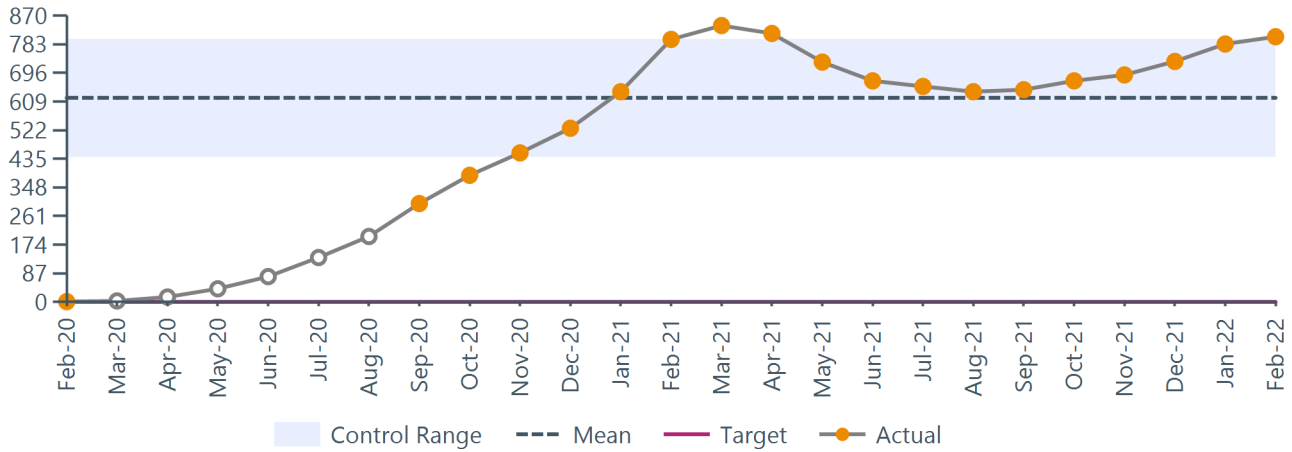
Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
1334	1551	1509	1487	1535	1488	1475	1504	1514	1530	1578	1700	1740

Patients Waiting Over 52 Weeks – Welsh

Number of RJAH Welsh RTT patients waiting 52 weeks or more at month end 211140

Responsible Uni
Specialist Services Uni

Latest Target/Baseline	Latest Value	Variation	Assurance
0	806	H	F



Trajectory/Plan (H1&H2)

What these graphs are telling us

Metric is experiencing special cause variation of a concerning nature. Metric is consistently failing the target.

Following guidance from NHS EI we have updated the SPC graph to make allowance for the months impacted by covid. The data points from March-20 to August-20 have now been excluded in the control limits calculation and a step change has been introduced from September-20 after trauma was repatriated and services resumed. At present we are displaying our latest control range based on performance from September-20. We will continue to monitor the control range as we include further data points.

Narrative

At the end of February there were 806 Welsh patients waiting over 52 weeks; below our trajectory figure of 973 by 167. The patients are under the care of the following sub specialties; Spinal Disorders (496), Knee & Sports Injuries (105), Arthroplasty (88), Upper Limb (52), Foot & Ankle (26), Spinal Injuries (17), Metabolic Medicine (7), Tumour (7), Paediatric Orthopaedics (4), Neurology (3) and Geriatrics (1).

The patients are under the care of the following commissioners; BCU (431), Powys (360), Hywel Dda (12), Aneurin Bevan (2) and Cardiff & Vale (1).
The number of patients waiting, by weeks brackets is:
- >52 to <=78 weeks - 589 patients
- >78 to <=95 weeks - 96 patients
- >95 to <=104 weeks - 33 patients
- >104 weeks - 88 patients

Actions

H2 planning guidance documents that as a Trust we should hold, or where possible, reduce the number of patients waiting over 52 weeks. The submitted plans are reflected in the trajectory line above for future months.

The Trust is constantly monitoring waiting list movements alongside capacity available for our clinically urgent patients. The Trust continues to follow clinical prioritisation national guidance to book patients and has a noted risk for its Spinal Disorders services. We are exploring the use of an emergency P2 list in theatres and discussions are underway with the independent sector for potential capacity there.

At present, we do anticipate an impact on the number of patients currently waiting whilst the Trust has to reduce planned activity due to pandemic pressures.

Planning guidance for 22/23 stipulates that Trusts should eliminate 104+ weeks by July 2022 (except for patient choice) and make plans to reduce waits over 52 weeks.

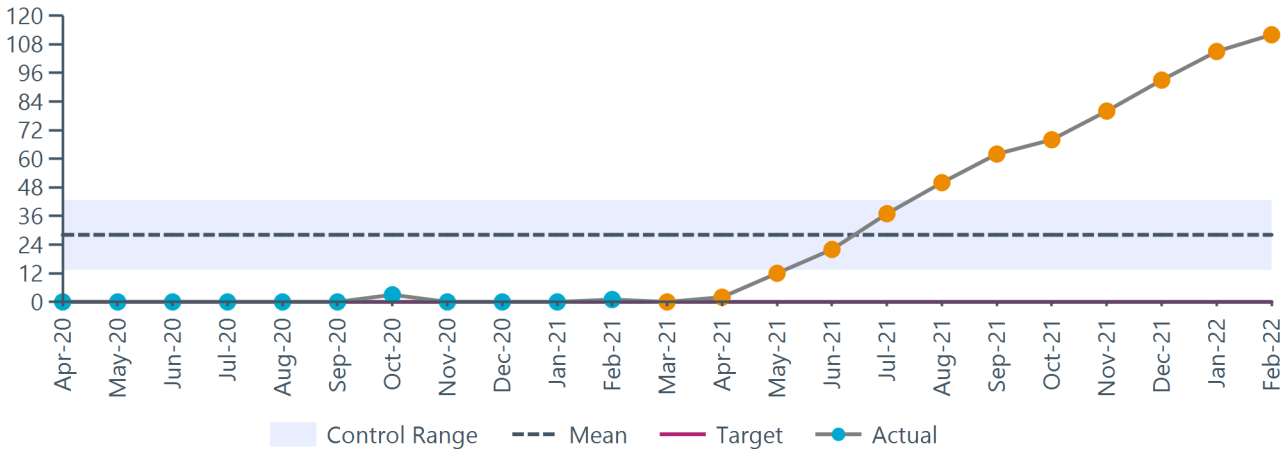
Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
798	840	816	729	672	655	639	645	672	690	731	784	806

Patients Waiting Over 104 Weeks - English

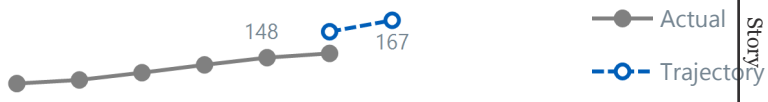
Number of English RTT patients waiting 104 weeks or more at month end 217588

Responsible Unit
Specialist Services Unit

Latest Target/Baseline	Latest Value	Variation	Assurance
0	112	H	F



Trajectory/Plan (H1&H2)



What these graphs are telling us

Metric is experiencing special cause variation of a concerning nature. Metric is consistently failing the target.

Narrative

At the end of February there were 112 English patients waiting over 104 weeks, below our trajectory figure of 148 by 36. The patients are under the care of the following sub-specialities, with further details on the volume by priority;

- Spinal Disorders (91) - P2 (1), P3 (25), P4 (51), P6 (7), Not on Elective WL yet so no priority (7)
- Arthroplasty (11) - P2 (1), P3 (5), P4 (3), P6 (2)
- Knee & Sports Injuries (7) - P3 (3), P4 (2), P6 (2)
- Foot & Ankle (2) - P3 (1), P6 (1)
- Upper Limb (1 - P4)

Actions

H2 planning guidance documents that as a Trust we should eliminate non-spinal 104+ week waits by March 2022. The Trust however is expecting spinal disorder 104+ weeks to still be present by March 2022. This is due to national pressures for this specialist service and continued demand. Mutual aid discussions are in progress with the independent sector who can provide us with some capacity. We are currently identifying patients who are suitable, and agree, to transfer. As acknowledged through the planning guidance, there may also be patients who choose to wait. This forms part of our H2 planning submission and the submitted plans are reflected in the trajectory line above for future months.

At present, we do anticipate an impact on the number of patients currently waiting whilst the Trust has to reduce planned activity due to pandemic pressures but every effort has been made to ensure those patients waiting over 104 weeks are not impacted.

Planning guidance for 22/23 stipulates that Trusts should eliminate 104+ weeks by July 2022 (except for patient choice) and make plans to reduce waits over 52 weeks.

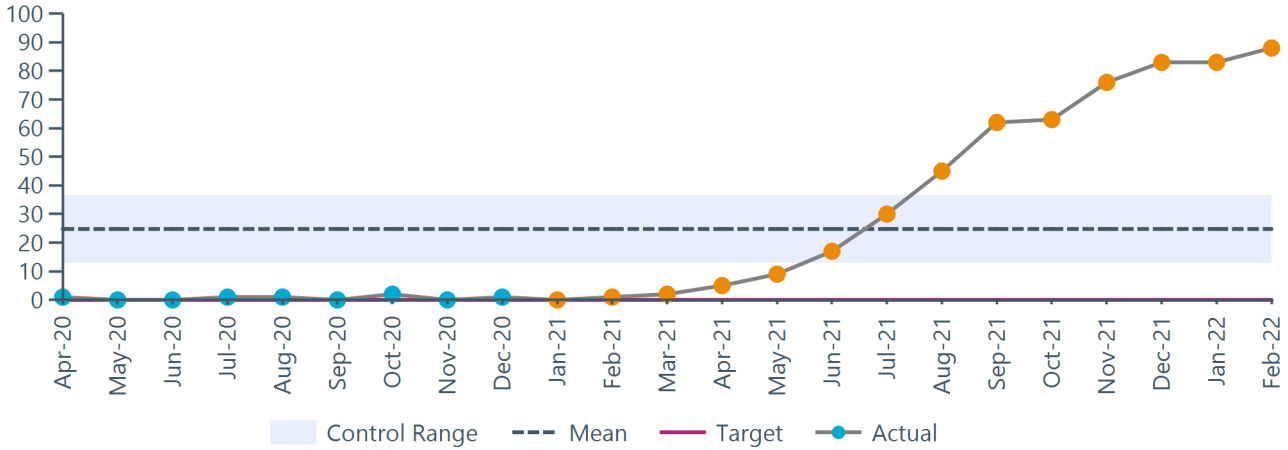
Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
1	0	2	12	22	37	50	62	68	80	93	105	112

Patients Waiting Over 104 Weeks - Welsh

Number of RJAH Welsh RTT patients waiting 104 weeks or more at month end 217592

Responsible Unit
Specialist Services Unit

Latest Target/Baseline	Latest Value	Variation	Assurance
0	88	H	F



Trajectory/Plan (H1&H2)

What these graphs are telling us

Metric is experiencing special cause variation of a concerning nature. Metric is consistently failing the target.

Narrative

At the end of February there were 88 Welsh patients waiting over 104 weeks, below our trajectory figure of 146 by 58. The patients are under the care of the following sub-specialities, with further details on the volume by priority;

- Spinal Disorders (84) - P2 (1), P3 (22), P4 (54), Not on Elective WL yet so no priority (7)
- Knee & Sports Injuries (2) - P4 (1), Not on Elective WL yet so no priority (1)
- Arthroplasty (1 - P3)
- Spinal Injuries (1 - P3)

Actions

H2 planning guidance documents that as a Trust we should eliminate non-spinal 104+ week waits by March 2022. The Trust however is expecting spinal disorder 104+ weeks to still be present by March 2022. This is due to national pressures for this specialist service and continued demand. Mutual aid discussions are in progress with the independent sector who can provide us with some capacity. We are currently identifying patients who are suitable, and agree, to transfer. As acknowledged through the planning guidance, there may also be patients who choose to wait. This forms part of our H2 planning submission and the submitted plans are reflected in the trajectory line above for future months.

At present, we do anticipate an impact on the number of patients currently waiting whilst the Trust has to reduce planned activity due to pandemic pressures but every effort has been made to ensure those patients waiting over 104 weeks are not impacted.

Planning guidance for 22/23 stipulates that Trusts should eliminate 104+ weeks by July 2022 (except for patient choice) and make plans to reduce waits over 52 weeks.

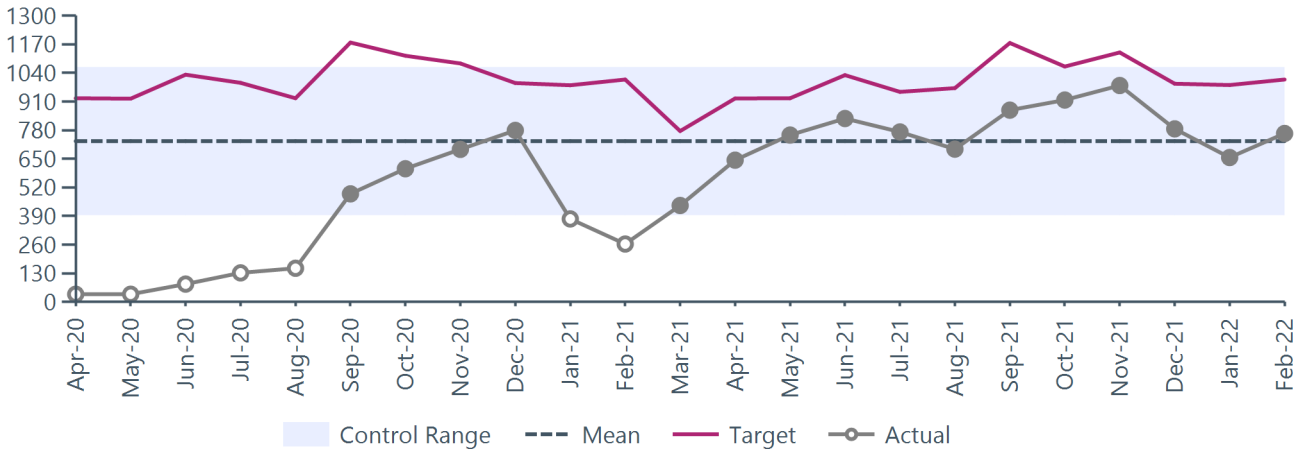
Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
1	2	5	9	17	30	45	62	63	76	83	83	88

Total Elective Activity

All elective activity in month rated against 19/20 baseline activity adjusted for working days and the impact of Covid-19 217556

Responsible Uni
MSK Uni

Latest Target/Baseline	Latest Value	Variation	Assurance
1,010	765		Moving Target



Trajectory/Plan (H1&H2)

What these graphs are telling us

Metric is experiencing common cause variation. This measure has a moving target.

Following guidance from NHS EI we have updated the SPC graphs throughout the IPR to make allowance for the months impacted by covid. The data points from March-20 to August-20 have now been excluded in the control limits calculation and a step change has been introduced from September-20 after trauma was repatriated and services resumed. To recognise all elective work following the impact of COVID-19 , this new committee measure was added in 21/22 and there is now enough data points to display this in SPC.

Narrative

Total elective activity in February was 765, behind the H2 plan of 941 as represented in the trajectory line above. February activity represents 75.7% of the 19/20 baseline figure of 1010; the February target, as set by NHS EI, was to meet 85% of baseline 19/20 activity. The aim of the Trust is to ensure elective activity continues according to plan, to reduce long waits and prevent further lengthening of waiting lists. As of 7th February, elective bookings were reported at 802 against the H2 plan of 941 - 85.2%. As a result of the extreme pressures felt from Omicron impacts, bookings fell short of the trajectory at the start of the month and did not recover. A higher rate of cancellations was seen in February due to multiple factors; absence amongst critical Theatre staff accounted for 16 cancellations on the day and a further 68 ahead of the day can be attributed to wider staff sickness /shortfall /isolation. The Trust has a known shortfall in Theatre staffing that is currently impacted by vacancies and maternity leave and there is a recruitment plan in place to address this. Mitigations currently include flexibility of current workforce and agency staff on a short-term basis. Furthermore, February saw an increase in patient-initiated cancellations and DNA's, some of which were due to Covid-19 related illness and concerns. In February, the Trust achieved 83.6% of its IJP capacity and all core staffed Theatre sessions were utilised. Plans were to deliver 290 cases via OJP; the Trust achieved 186 (64.1%) due to current constraints of staffing and mitigations. As of 7th March, elective activity is reported at 877 against a plan of 1135, equating to 77.3%.

Actions

In February there were multiple factors relating to the Omicron variant which led to lost activity. At the tactical operational meeting all cancellations are reviewed and prior to cancelling elective operations control mechanisms are in place where patients are assessed by priority and longest waiters, according to clinical need. Staffing levels are evaluated and aligned with beds and Theatres requirements, and longer-term actions to improve staffing levels for Theatres and wards is underway. The 6-4-2 process remains focused on theatre session scheduling to allow ample time to optimise patient booking, whilst the daily Comm Cell focuses on filling any gaps resulting from late notice cancellations. Since the onset of Omicron and the extreme pressures felt from its impacts, significant resource in the Bookings team has been spent on re-work resulting from increased cancellations. The plan was, and is, to maximise patient bookings within the constraints presented by the pandemic. The Trust is closely monitoring the COVID-19 situation daily whilst ensuring elective activity continues. Impacts from staff absence, some of which are COVID-19 related, are expected to continue into March. The ongoing programme of estates work causing temporary ward closures / reduced ward bed capacity will also impact elective activity in March.

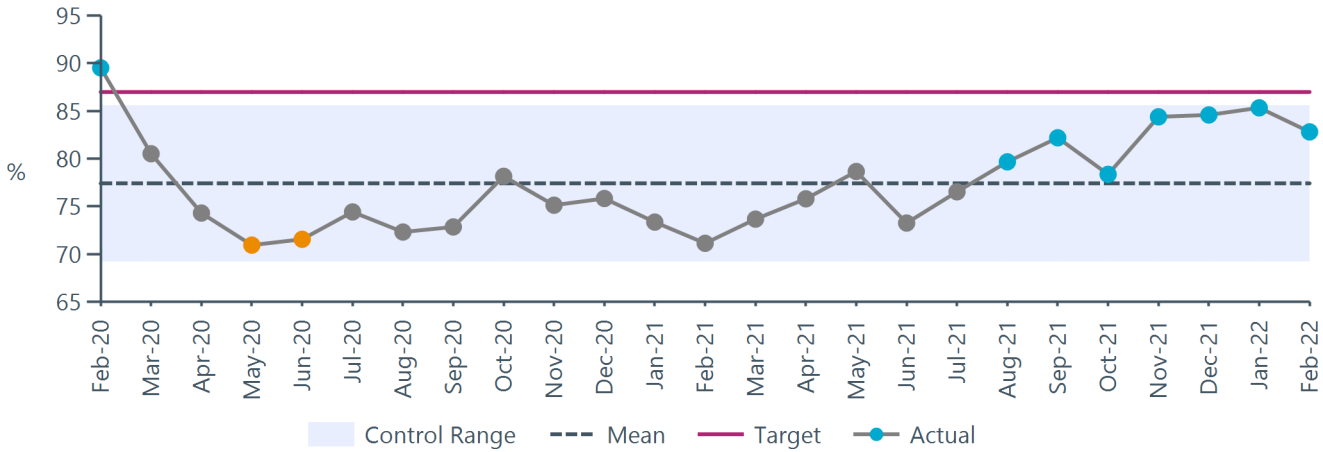
Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
263	438	644	758	833	772	694	871	917	983	786	656	765

Bed Occupancy – All Wards – 2pm

% Bed occupancy at 2pm (NHS & Private Beds) 211039

Responsible Unit
MSK Unit

Latest Target/Baseline	Latest Value	Variation	Assurance
87.00%	82.82%	H	F



Trajectory/Plan (H1&H2)

What these graphs are telling us

Metric is experiencing special cause variation of an improving nature. Metric is consistently failing the target.

Narrative

The occupancy rate for all wards is reported at 82.82% for February and remains shown as special cause variation of an improving nature. Breakdown provided below:
MSK Unit:
- Clwyd - ward closed throughout January
- Powys - 84.16% - compliment of 22 beds open throughout month
- Kenyon - 76.78% - compliment of 12 beds open, additional 10 beds open throughout month
- Ludlow - 86.95% - compliment of 16 beds open throughout month

Specialist Unit:
- Alice - 34.70% - compliment of 16 beds; open to 4-12 beds dependant on weekday/weekend
- Oswald - 85.35% - compliment of 10 beds open throughout month
- Gladstone - 87.30% - compliment of 29 beds open throughout month
- Wrekin - 87.56% - compliment of 15 beds open throughout month
- Sheldon - 96.91% - compliment of 20 beds open throughout month

Actions

With regular review, we continue to flex our bed base whenever possible to have sufficient beds open for the anticipated activity numbers based on the existing bed model. This includes assessing the variability of occupancy by weekday. Flexing has included ward and bed closures and redeployment of staff to other areas of the Trust. IPC guidance is reviewed as updates are issued. Consideration and assessment of length of stay and delayed transfers of care are considered when monitoring our occupancy.

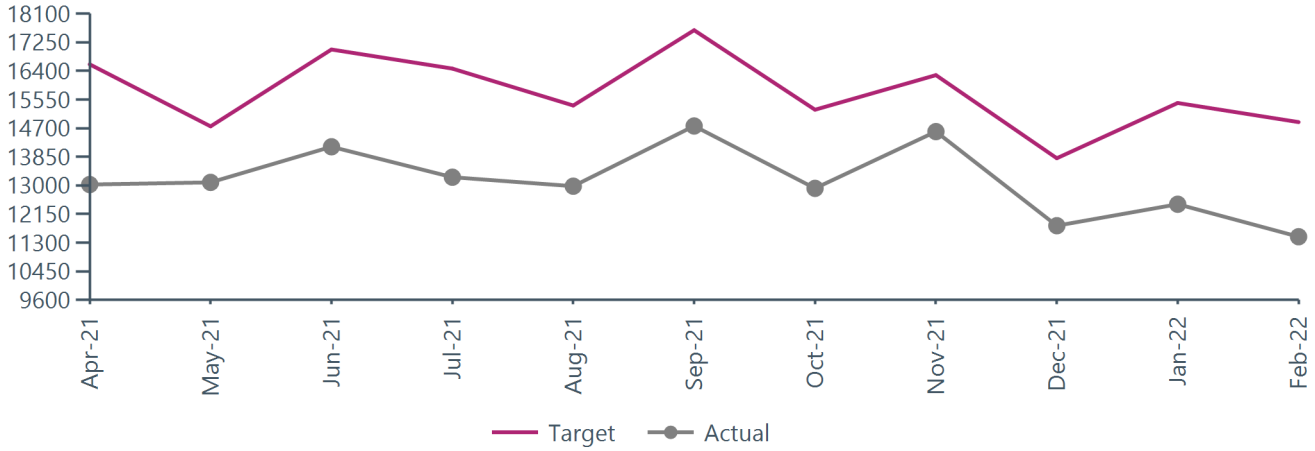
Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
71.15%	73.68%	75.81%	78.67%	73.27%	76.54%	79.68%	82.21%	78.37%	84.40%	84.60%	85.35%	82.82%

Total Outpatient Activity

Total Outpatient Activity (Against Unadjusted External Plan (H2), Catchment Based) 217580

Responsible Unit
Clinical Services Unit

Latest Target/Baseline	Latest Value	Variation	Assurance
14,880	11,477	N/A to SPC	Moving Target



Trajectory/Plan (H1&H2)

What these graphs are telling us

Currently this measure is not appropriate to display as SPC. Analysis will improve as more data points are added. It is recommended that 15+ data points are required for robust analysis. This measure has a moving target.

Narrative

This measure aligns with the NHS E/I inclusions and exclusions for restoration monitoring, effectively monitoring consultant-led activity and non consultant-led activity. The target for this measure is the 2019/20 baseline activity that was delivered, with the H2 plan included as a trajectory in the trajectory graph.
In February the total Outpatient activity undertaken in the Trust was 11477; 2577 cases below our H2 plan. This is broken down as follows:
- Consultant led - 84.58% (8945 against target of 10576)
- Non consultant-led - 72.80% (2532 against target of 3478)
Outpatient activity was lost in February due to higher number of DNAs and cancellations, impact of Covid and increase of re-work for booking cancellations. The booking team experienced 40-60% of rework from patient cancellations within 48 hours, where there is less likelihood to fill that slot with another patient that led to under-utilisation. As at 7th March (5th working day) there were 197 missing outcomes so once administrative actions are taken with these data entries, the February position will alter. Taking into account the missing outcomes, this would mean that the Outpatient activity for February was 11674, 2380 below our H2 plan of 14054. It must be acknowledged that within that missing outcomes figure, some of those appointments may be recorded later as DNAs.

Actions

Actions include:
- Monitor the impact of COVID 19 within Outpatients in the tactical operational meeting; expected improvement from less cancellations and IPC adjustments.
- Review trauma provision required in system.
- The Trust is also reviewing further clinical practice changes that have been implemented since 2019/20 with agreed improvement actions in place.

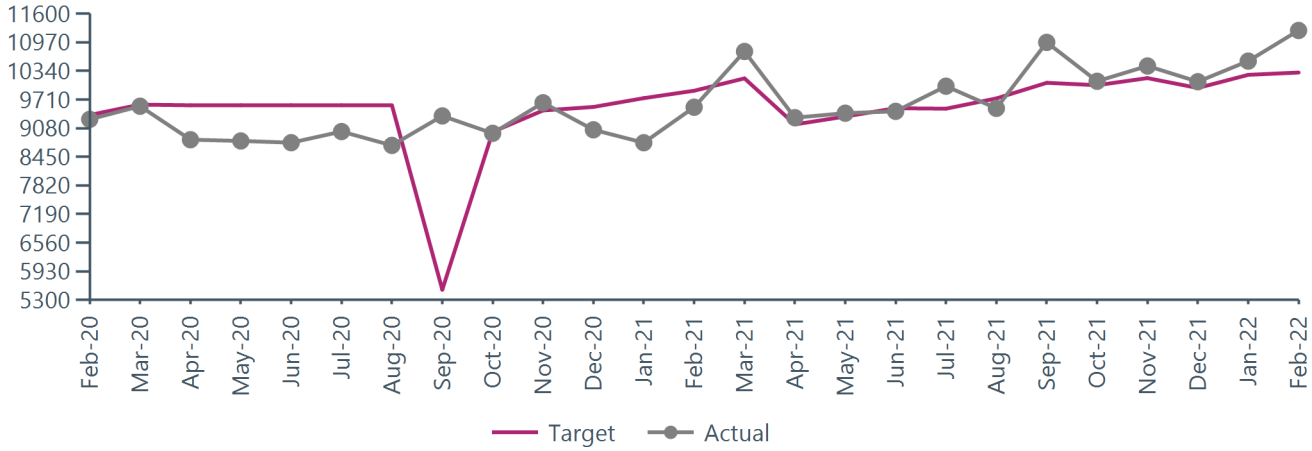
Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
		13027	13091	14148	13244	12978	14765	12914	14599	11804	12442	11477

Expenditure

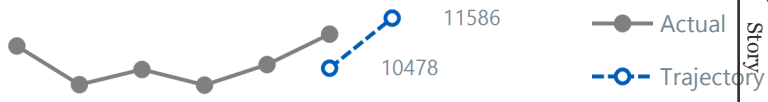
All Trust expenditure including Finance Costs 216334

Exec Lead
Chief Finance and Planning Office

Latest Target/Baseline	Latest Value	Variation	Assurance
10,304	11,231	N/A to SPC	Moving Target



Trajectory/Plan (H1&H2)



What these graphs are telling us

This measure is not appropriate to display as SPC. This measure has a moving target.

Narrative

Overall £927k adverse in month:

Pay £240k adverse
- Increased annual leave accrual and recognition of pass through costs

Non Pay £687k adverse
- Pass through costs (High Cost Drugs, Digital spend for EPR & Health Education England funding)
- IPC and Covid estates works
- Private patient implants adverse (offset by income)
- Offset by NHS activity adverse to plan driving favourable variance on direct costs (implants. consumables, OJP)

Note: Vaccination hub/workforce services £90k of costs recharged to SCHT in month (excluded from the above figures).

Actions

Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
9542	10769	9311	9409	9451	10004	9517	10969	10113	10449	10103	10557	11231

Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust
Finance Dashboard 28th February 2022

Performance Against Plan £'000s							
Category	Annual Plan	In Month Position			21/22 YTD Position		
		Plan	Actual	Variance	Plan	Actual	Variance
Clinical Income	101,699	8,946	9,226	280	92,650	95,223	2,572
System Top Up Funding	4,842	373	373	0	4,462	4,469	8
Non NHS income support	1,537	110	110	0	1,427	1,427	0
Covid-19 Funding	2,822	228	228	0	2,594	2,594	0
Private Patient income	4,101	321	392	71	3,757	6,242	2,484
Other income	6,365	556	1,186	630	5,807	6,343	536
Pay	(71,131)	(6,158)	(6,398)	(240)	(64,934)	(65,711)	(776)
Non-pay	(40,925)	(3,598)	(4,281)	(683)	(37,069)	(39,315)	(2,246)
EBITDA	9,308	778	837	58	8,693	11,271	2,578
Finance Costs	(6,616)	(548)	(552)	(4)	(6,069)	(6,090)	(21)
Capital Donations	4,750	656	265	(391)	4,122	2,433	(1,689)
Operational Surplus	7,443	886	549	(337)	6,747	7,615	868
Remove Capital Donations	(4,750)	(656)	(265)	391	(4,122)	(2,433)	1,689
Add Back Donated Dep'n	540	45	46	1	494	514	19
Control Total	3,232	276	331	56	3,119	5,696	2,576
EBITDA margin	8.0%	7.4%	7.3%	-0.1%	7.9%	9.7%	1.8%

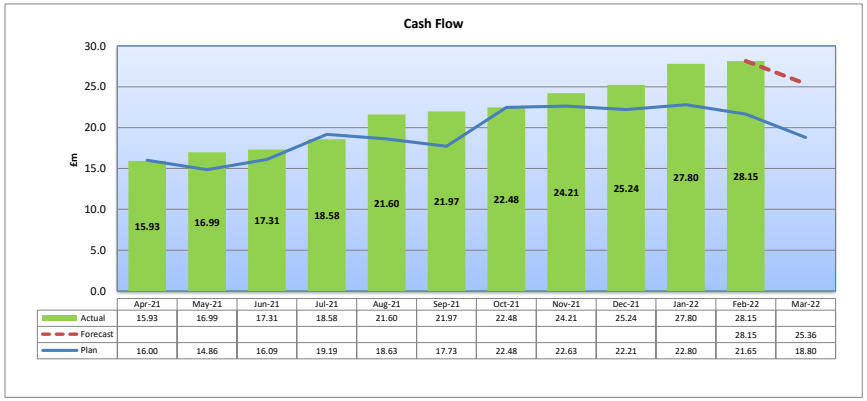
Sustainability (Recurrent) Plan 2021/22						
Category	In Month Position (£'000)			Year To Date Position		
	Recurrent Plan	Recurrent Actual	Variance	Recurrent Plan	Recurrent Actual	Variance
Clinical Income	8,764	8,764	(0)	96,403	96,402	(1)
System Top Up Funding	0	0	0	0	0	0
Non NHS income Support	0	0	0	0	0	0
Covid-19 Funding	0	0	0	0	0	0
Private Patient income	417	417	0	4,988	4,988	(0)
Other income	553	538	(15)	6,084	6,067	(17)
Pay	(5,993)	(5,993)	0	(65,938)	(65,938)	0
Non-pay	(3,470)	(3,470)	0	(38,415)	(38,429)	(14)
EBITDA	**271**	**255**	**(15)**	**3,122**	**3,090**	**(32)**
Finance Costs	(562)	(557)	5	(6,178)	(6,178)	(0)
Operational Surplus	**(291)**	**(302)**	**(11)**	**(3,056)**	**(3,088)**	**(32)**
Add Back Donated Dep'n	45	46	1	494	513	19
Control Total	**(246)**	**(256)**	**(10)**	**(2,563)**	**(2,575)**	**(13)**

Statement of Financial Position £'000s				
Category	Jan-22	Feb	Movement	Drivers
Fixed Assets	79,708	84,823	5,115	Land & buildings revaluation and additions
Non current receivables	1,103	1,177	74	
Total Non Current Assets	80,811	86,000	5,189	
Inventories (Stocks)	1,410	1,424	14	
Receivables (Debtors)	5,550	4,900	(650)	Decrease in prepayments, outstanding invoices and accrued receivables
Cash at Bank and in hand	27,804	28,155	351	
Total Current Assets	34,764	34,479	(285)	
Payables (Creditors)	(18,305)	(18,581)	(276)	Increase in revenue and capital accrued payables off set by decrease in deferred income
Borrowings	(1,347)	(1,317)	30	
Current Provisions	(416)	(290)	126	
Total Current Liabilities (< 1 year)	(20,068)	(20,188)	(120)	
Total Assets less Current Liabilities	95,507	100,291	4,784	
Non Current Borrowings	(4,053)	(3,465)	588	DH loan principal payment made
Non Current Provisions	(946)	(952)	(6)	
Non Current Liabilities (> 1 year)	(4,999)	(4,417)	582	
Total Assets Employed	90,508	95,874	5,366	
Public Dividend Capital	(36,108)	(36,108)	0	
Retained Earnings	(22,396)	(22,396)	0	
Revenue Position	(7,066)	(7,614)	(548)	Current period surplus
Revaluation Reserve	(24,938)	(29,756)	(4,818)	Land & buildings revaluation increase
Total Taxpayers Equity	(90,508)	(95,874)	(5,366)	

Draft Finance Metrics (New Single Oversight Framework)

Performance against Financial Plan		Underlying financial plan	
Expenditure run rate		Overall trend in reported financial position	

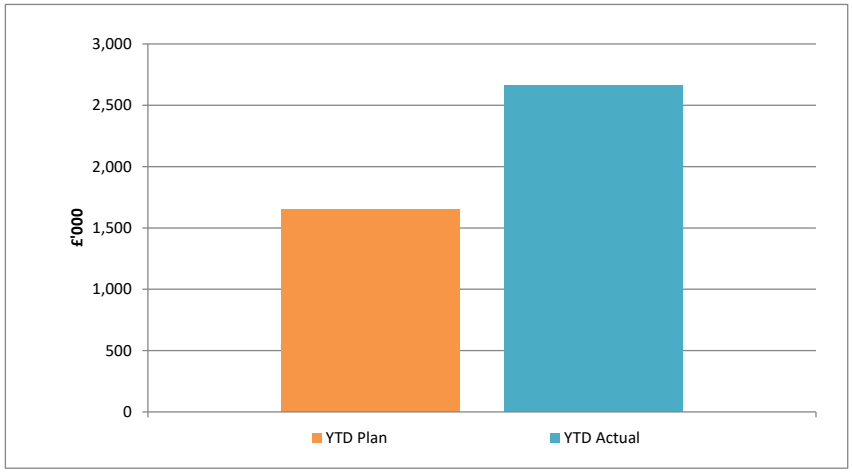
	YTD
Debtor Days	13
Creditor Days	46



Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust
Finance Dashboard 28th February 2022

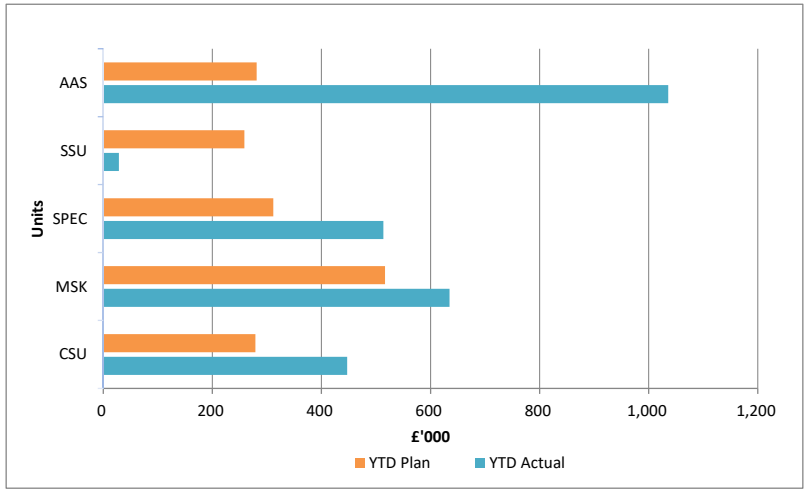
Efficiencies Total

Trust YTD Achievement Against YTD Plan £000's



YTD Efficiencies

YTD Efficiencies Achievement £000's



Capital

Position as at	2122-11	Capital Programme 2021-22						
Project	Annual Plan £000s	In Month Plan £000s	In Month Complete d £000s	In Month Variance £000s	YTD Plan £000s	YTD Complete d £000s	YTD Variance £000s	Forecast Outturn
Backlog maintenance	600	32	1	31	583	457	126	750
I/T investment & replacement	300	0	84	-84	220	111	109	300
Capital project management	100	8	8	-0	91	108	-17	120
Equipment replacement	500	50	79	-29	450	523	-73	524
Diagnostic equipment replacement	1,701	0	38	-38	800	224	576	2,094
Diagnostic equipment replacement (PDC)	99	0	0	0	0	0	0	116
Diagnostic digital capability (PDC)	0	0	112	-112	0	112	-112	130
Contingency	500	100	110	-10	400	470	-70	958
EPR planning & implementation	2,000	500	0	500	1,400	0	1,400	0
Invest to save	200	0	0	0	150	25	125	62
Donated medical equipment	200	0	0	0	175	235	-60	300
Veterans' centre	4,500	485	267	218	4,015	2,201	1,814	2,700
Total Capital Funding	10,700	1,175	699	476	8,284	4,466	3,818	8,054
Donated medical equipment	-200	0	0	0	-175	-235	60	-300
Veteran's facility	-4,500	-485	-267	-218	-4,015	-2,201	-1,814	-2,700
Capital Funding (NHS only)	6,000	690	432	258	4,094	2,030	2,064	5,054

Forecast

Category	Forecast			
	Plan	Actual	Variance	Notes
Clinical Income	101,699	104,438	2,739	Overperformance driven by pass through drugs, elective recovery fund and impact of pay award;
CCG Growth Funding	4,842	4,842	0	
System Top up Funding	1,537	1,537	0	
Covid-19 Funding	2,822	2,822	0	
Private Patient income	4,100	6,683	2,583	Overperformance and volume gains
Other income	6,366	7,731	1,365	Non recurrent HEE /Digital/ Workforce income offsetting in spend.
Pay	(71,128)	(72,026)	(898)	Impact of pay award offset by covid underspends and vacancies
Non-pay	(40,928)	(44,079)	(3,151)	Pass through (drugs, devices, workforce) and PP volume.
EBITDA	9,310	11,948	2,638	
Finance Costs	(6,616)	(6,644)	(24)	
Capital Donations	4,750	3,185	(1,566)	
Operational Surplus	7,444	8,488	1,048	
Remove Capital Donations	(4,750)	(3,185)	1,566	
Add Back Donated Dep'n	539	562	23	
Control Total	3,233	5,865	2,636	

Performance Management Strategy and Accountability Framework

Author:	Stephanie Wilson, Performance Oversight, and Improvement Manager	Paper date:	6 April 2022
Executive Sponsor:	Kerry Robinson, Chief Performance, Improvement and OD Officer	Paper Category:	Performance
Paper Reviewed by:	Finance. Planning & Digital Committee	Paper Ref:	N/A
Forum submitted to:	Board of Directors – Public Meeting	Paper FOIA Status:	Full

Purpose of Paper

1.1. Why is this paper going to Board of Directors Meeting and what input is required?

An annual review of the Performance Management Framework has been undertaken. This paper is has been presented to Finance, Planning and Digital (FPD) Committee for review and approval of recommended changes.

A further review during 2022/23 is also recommended.

2. Executive Summary

2.1. Context

This paper is refreshing the Performance Management Framework that had been approved by FPD in March 2021.

The Trust's Performance Management Framework (PMF) was previously reviewed in light of the changing environmental conditions in relation to covid-19 and restoration of services.

Refreshing and reviewing this framework is to support with focus and to ensure no duplication together with clarity between delivery forums and assurance forums.

2.2. Summary

In summary the framework has had slight amendments to support greater emphasis on areas of learning during 2021/22, namely;

- To recognise a constant cascade of priorities is required as new guidance is received.
- Focus on transformation and clear trajectories to ensure performance plans are met.
- Clarity on governance arrangements for performance monitoring changes.

2.3. Conclusion

The Finance, Planning and Digital Committee recommended the changes to the Performance Management Framework to the Board.

The Board of Directors is requested to note that this framework will require further review following in-year management structure changes.

1. Introduction

1.1 This paper provides an overview of the mechanisms in place to ensure effective oversight of the delivery of the operational objectives and priorities.

1.2 The Trust continues to operate in changing environmental conditions in relation to covid-19 and restoration of services. The Trust and system (Shropshire, Telford and Wrekin) are currently preparing draft 2022/23 activity submissions and assessing new national expectations and guidance as it is received.

1.3 The Performance Management Framework document has been revised to reflect and learn from changes made during 2021/22.

1.4 A further review will be required to reflect management structure changes occurring within the Trust during 2022/23.

2. 2021/22 IPR Changes

2.1 The IPRs within our committees during 2021/22 had 50 metric changes/additions in-year. This is recognising the constantly changing environment and to increase oversight aligning to internal and national pressures and expectations. The changes have been summarised and categorised to support with the Performance Management Framework review and are noted below:

Reason for Change	Change	Committee(s) Impacted	Metric change summary
Restoration sub-committee and FPD committees combined.	18 additional metrics @ FPD	FPD	2019/20 baseline restoration monitoring: - elective, outpatients and diagnostics. Plan monitoring: - elective, outpatients and diagnostics. Financial plan monitoring. Additions/refinements in year too e.g., PP Theatre activity and sessions delivered.
Further breakdown of aggregated metrics: - request(s) for further detail	13 additional metrics	People	Sickness, vacancy rates and voluntary staff turnover further breakdowns.
New metrics: - Internal concerns	5 additional metrics	People and Q&S	- '% of Headcount on Temp/Fixed Term/Secondment - Trust' @ People committee - 'Number of Spinal Injury Patients Fit for Admission to RJAH' @ Q&S committee - 'RJAH acquired Klebsiella' and 'RJAH acquired Pseudomonas' @ Q&S committee - Surgical Site Infections @ Q&S committee
New metrics: - National guidance planning expectations	4 additional metrics	FPD	- 104 weeks (English, Welsh and combined) x 3 metrics @ FPD - % of RTT Clock Stops Against Baseline x 1 metric @ FPD
New metrics: - National guidance transformation expectations	5 additional metrics	FPD	Advice and Guidance, PIFU and virtual outpatients' expectations.
Existing metrics redesigned/redefined	5 x redesigned oversight metrics at Q&S	Q&S	- Complaints x 3 new metrics @ Q&S to recognise complexity requirements and complaints reopened. - WHO compliance x 2 new metrics @ Q&S to split quality audit % and documentation audit %

A review of changes made to committee performance monitoring during the year has been made. The alignment of these changes with the performance management framework has been assessed. The following amendments have been made to the framework to support with strengthened focus, clarity and governance of performance monitoring:

- 6) Line Management Responsibilities
  - 6.1: - update to wording to change from *"on an annual basis"* to *"as it is received into the Trust".* This is to recognise the constantly changing landscape we are currently in and to ensure priorities are constantly cascaded.
  - 6.2: - addition of two further bullet points. These bullet points are to recognise the level of transformation required to achieve Trust performance plans. This aligns with NHS England '2022/23 priorities and operational planning guidance' to *"Make the most effective use of our resources – moving back to and beyond pre pandemic levels of productivity when the context allows this."* Forward look trajectories ensure our aims are deliverable and on track. The bullet points inserted are:
    - *"Transformation opportunities and expectations are clearly understood and communicated."*
    - *"Trajectories are in place to flag risks and/or projected improvements in performance with clear timelines of impacts/achievements."*

- 8) Performance targets, objectives and KPI's
  - Addition of 8.5. to recognise and ensure new additions and internal monitoring aligns with external monitoring and guidance where this exists.
    - *"8.5: - The Trust's performance targets, and Key Performance Indicators are counted and calculated as per national guidance where this exists."*

- 9) Performance monitoring and escalation
  - Addition of 9.6. to strengthen governance of changes being made to committee IPRs in year.
    - *"9.6: - If, following review of performance measures within the Trust a change in monitoring is recommended, the changes need to have authorisation of the Exec Lead (or Accountable Unit). Approval through the reporting committee should take place ahead of any changes. Once agreed, changes are to be documented on the front sheet of the IPR for the relevant committee/board informing why the change and when from."*

3. Structure Changes

Role responsibilities and expectations were previously communicated following the introduction of the 2021/22 Performance Management Framework. It is recognised that the Trust is currently undergoing structural changes with the appointment of a Chief Operating Officer as one example. The current Chief Performance Officer is also due to leave the Trust during 2022/23. There are also further executive appointments expected in-year.

It is recommended that this policy is reviewed in-year as an exception for 2022/23 to reflect these changes. Structure changes will need to be updated and reflected in the Performance Management Framework appropriate sections recognising any changes in roles and responsibilities.

- Recommendation that the Performance Management Framework policy is further reviewed during 2022/23 to reflect the new structure.

4. Performance Reporting: - 2022/23 KPIs

It is recognised that planning is underway with draft submissions being submitted for the Trust and the system to NHS England. Welsh commissioner discussions are on-going and national recovery guidance is still being received and finalised.

A review of current KPIs is due with subsequent changes expected to 'appendix 1' to recognise changes in Welsh/English waiting time targets, 2022/23 NHS England national priorities and recovery guidance.

Reviews will also ensure alignment with internal priorities.
Recommendations for changes will be reviewed by the appropriate executive leads. This will follow appropriate governance as referenced in the additional new section 9.6. of the Performance Management Framework.

5. Conclusion

5.2 This paper sets out the Performance Management Framework review and changes made. This framework is to support and ensure effective oversight and delivery of the operational objectives and priorities, demonstrating clear accountabilities and corporate responsibility for the delivery of the plan (see Performance Management Framework, Appendix 3).

Changes have been made to insure inclusion of:

- Line Management responsibility to cascade performance objectives and targets as received into the Trust. Recognising this is currently more frequent than annual notifications.
- Line Management responsibility to ensure transformation is clear, understood and trajectories in place.
- Clarity to ensure KPIs are counted and calculated as per national guidance where this exists.
- Increased governance when KPI changes are recommended to ensure changes have the authorisation of the Exec Lead (or Accountable Unit).

Current KPIs are to be reviewed to align with updated 2022/23 national guidance and evolve as further guidance is received. KPIs should also align with internal priorities.

As this framework is evolved and embedded, these strengthened performance management arrangements, combined with the implementation of leadership and management development programmes, should result in improved delivery and assurance relating to agreed operational objectives and priorities.

FPD is asked to review and agree to the recommended changes following review. FPD is also asked to agree to a further review of this framework during 2022/23 to recognise the management structure changes expected during 2022/23.

The Robert Jones and Agnes Hunt Orthopaedic Hospital

NHS Foundation Trust

Title:	Performance Management Framework		
Unique Identifier:	SGY022	**Document Type:**	Strategy
Version Number:	7.0	**Status:**	For Approval
Responsible Director:	Chief Performance Officer		
Author:	Chief Performance Officer		
Scope:	Trust wide		
Replaces:	Version 6.0		
To be Read in Conjunction with the Following Documents: (list related policies)	Trust Strategy, Board Assurance Framework, Risk Management Policy, Performance Review Terms of Reference		
Keywords:	performance, unit management, clinical management, integrated performance report		

Considered By Executive Owner:	Chief Executive Officer	**Date Considered:**	Mar 2022
Endorsed By:	Finance, Planning and Digital Committee	**Date Endorsed:**	
Approved By:	Trust Board	**Date Approved:**	
Issue Date:		**Review Date:**	1st July 2022
Security Level:	**Open Access** ✓	**Restricted**	**Confidential**

Trust Values

1. Introduction

1.1. The Trust's Performance Management Framework (PMF), Board Assurance Framework (BAF) and other wider governance arrangements when combined, are integral to the Trust's governance framework. To provide a full and comprehensive implementation of strategic and operational plans, including the delivery of quality and financial improvement programmes.

1.2. The Performance Management Framework (PMF) aims to foster a culture of responsibility and accountability at all levels in the Trust and helps teams and staff to understand the roles they play in successful delivery of the Trust's objectives. The PMF specifies the structure, systems and processes used to embed a performance management culture in the Trust and identifies the responsibilities for performance management.

1.3. A devolved accountability structure managed through a performance framework is in place at the Trust supported by a clinical leadership model. The underlying principles of this framework are to ensure that delivery of the Trust's strategy and corporate objectives are managed in a systematic way from 'Ward to Board' and 'Board to Ward'.

2. Objectives of the PMF

2.1. The PMF sets out the systems and processes through which the organisation manages the delivery of its strategic and operational goals, as well as ensuring that the regulatory and statutory requirements that apply to the Trust are met (including those outlined in the NHS Constitution).

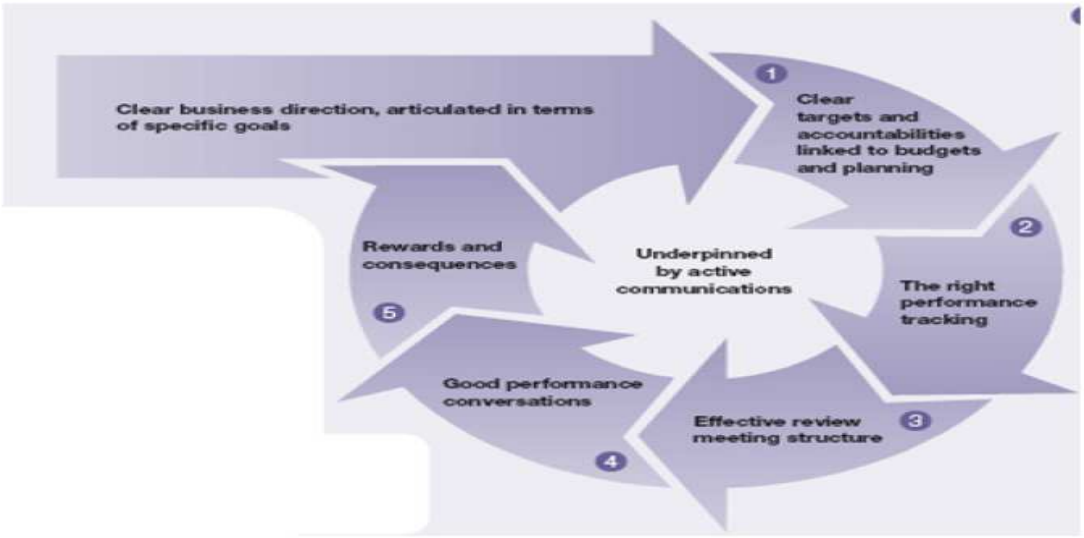
2.2. The PMF drives the implementation of best practice performance assurance processes throughout the organisation, aligned to our Board committees, ensuring that;

- Accountability arrangements are in place across the organisation to drive the delivery of all agreed objectives, targets and standards. Performance is seen as a continuous process which is embedded in all aspects of organisational activity.
- Agreed performance objectives and targets are Specific, Measurable, Agreed, Realistic and Time bound (SMART) and transparent measurements are set to monitor performance.
- Timely information is available to enable appropriate understanding, monitoring and assessing of the Trust's quality and performance, prompting appropriate action to be taken if performance is forecast to fall below set objectives and targets.
- Staff, teams and Committees understand what is expected of them and are supported and motivated to deliver, with a clear line of sight between their contributions and the overall success of the Trust.
- Mitigation plans are developed as soon as risks to the achievement of required targets or standards and/or barriers to effective performance are identified.

3. Key Management Principles

3.1. The following key management principles underpin this framework:

- ***Focused on improvement*** **-** All teams and staff members are encouraged to embrace a culture of continuous performance improvement and to speak up with suggestions and concerns. Initial interventions will focus on recovery to sustain improvement and will include actions to address the root causes of issues.
- ***Transparent*** – Clear and pre-determined performance measures and interventions. Teams and individuals will understand how performance is being assessed and what to expect if performance falls below acceptable levels.
- ***Consistent*** - Clear accountabilities through a uniform approach across RJAH, at different levels of the organisation and across different departments will ensure that all parties are clear of where accountabilities lie.
- ***Proactive*** **-** Delivery focused on improved performance through an integrated and action-oriented approach, with thresholds for intervention that identify underperformance at an early stage so that it can be swiftly addressed.
- ***Proportionate*** **-** Performance management interventions and action is related to the scale of risk and maintains an appropriate balance between challenge and support.



4. Link to Senior Leadership Roles and Responsibilities

4.1. Board of Directors

- The Board is required to ensure that the Trust remains at all times compliant with the relevant conditions of its NHS Provider License and has regard to the NHS Constitution.
- The Performance Management Framework works in conjunction with the Board Assurance Framework to provide the Board of Directors with the assurance required in relation to the full and comprehensive implementation of strategic and operational plans.
- The Board has overall accountability for the implementation of the Performance Management Framework.

4.2. Chief Executive

- The Board delegates responsibility for delivery of the objectives, targets and standards outlined in the Trust's Strategy, Business Plan and Operational Plan to the Chief Executive. The Chief Executive, supported by the Chief Officers, Clinical Chairs and Managing Directors, ensures that the associated activities are carried out efficiently, effectively and economically and in a manner appropriate for the proper conduct of public affairs.
- This Performance Management Framework describes the governance arrangements through which the Chief Executive delegates and manages the delivery of those responsibilities.

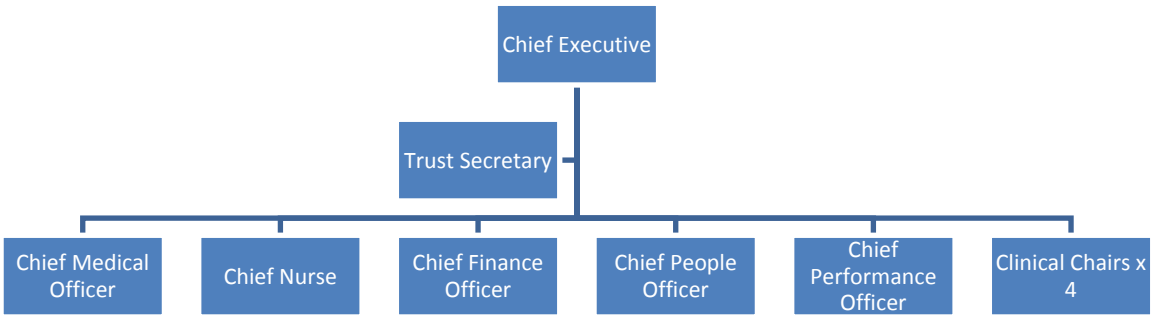
4.3. Chief Performance Officer

- Has delegated responsibility for the leadership, development and implementation of the Performance Management Framework.

5. Performance Management Roles and Responsibilities

5.1. The Trust's Performance Management Framework describes how the Chief Executive delegates responsibility for the delivery of strategic and operational plans, targets and objectives. There are two main ways in which those responsibilities are delegated – through line management structures and through a small number of management meetings (including Unit meetings).

5.2. The primary way in which responsibilities are delegated is through the Trust's line management structure to individuals, and then through to relevant members of their teams.



5.3. The Chief Officers and Clinical Chairs have individual responsibility for delivering the objectives that relate directly to their role, and for supporting their colleagues to deliver their objectives. Also, they are collectively responsible for delivering the Operational Plan objectives as a team.

RJAH sub-committees have been established to support the work of the Board committees. These have a focus on delivery and ensure that appropriate assurance can be provided upwards to Board committees;

- Health & Safety Committee
- Infection, Prevention and Control Committee
- Safeguarding Committee
- Information Governance Committee
- Drugs and Therapeutics Committee
- Equality, Diversity and Inclusion Committee

5.4. In a number of specific cases where objectives span across multiple officers, a sub-committee (chaired by a Chief Officer) may be established by a Board Committee with the delegated responsibility for delivery e.g. Health and Safety Committee.

6. Line Management Responsibilities

6.1. Responsibility for the majority of the Trust's performance objectives and targets is cascaded through to relevant line managers on an annual basis (or more frequently if required).

6.2. Line managers are responsible for delivery of their agreed targets in accordance with the key principles and approach outlined in this framework. Line management responsibilities include ensuring that:

- Teams and staff members have a clear understanding of their role, responsibilities and performance targets (with individual targets agreed and documented through the appraisal process).
- Teams and staff members work in an environment that embraces feedback and learning and staff members are encouraged to speak up about issues and concerns.
- Performance delivery is actively and proactively managed.
- Performance issues and risks are captured, managed and escalated where appropriate.
- Excellent performance is recognised and rewarded.
- Transformation opportunities and expectations are clearly understood and communicated.
- Trajectories are in place to flag risks and/or projected improvements in performance with clear timelines of impacts/achievements.

7. Sub-Committee Responsibilities

7.1. A number of Sub-Committees support the Board and Senior Leadership Team in effectively discharging their obligations by taking responsibility for the delivery of agreed objectives and targets.

7.2. Unit meetings and Sub-Committees are responsible for the delivery of relevant unit and/or functional objectives and targets within their areas of accountability.

7.3. Various other forums also play an important role in taking responsibility for the delivery of specific objectives and targets and in securing wider organisational buy-in to plans and developments.

7.4. A review of sub-committees and other groups has been undertaken, with the aim of:

- Clarifying scope and alignment of scope to support plan objectives
- Improving effectiveness and efficiency
- Ensuring right people attend and right governance structures are in place

8. Performance targets, objectives and KPI's

8.1. The Trust's strategic and operational plans are updated on an annual basis (or more frequently if required) in accordance with the Trust's planning cycle.

8.2. The Trust's performance targets, objectives and Key Performance Indicators are also updated on an annual basis (linked to the content of strategic and operational plans) and may be further updated during the financial year if needed.

8.3. Agreed performance targets, objectives and KPIs are cascaded to relevant line managers or to accountable Committees.

8.4. Effective performance management mechanisms are key to an organisation being 'well led' and are essential to the delivery of strong and consistent performance.

8.5. The Trust's performance targets, and Key Performance Indicators are counted and calculated as per national guidance where this exists.

9. Performance monitoring and escalation

9.1. The Chief Performance Officer and supporting personnel monitors and assesses all aspects of the delivery of strategic and operational plan targets, having the following key responsibilities:

- Providing assurance that all statutory, regulatory, quality, operational, workforce, financial and project targets, objectives and KPIs are fully understood and have been assigned to an appropriate Chief Officer, managerial lead and assurance committee.
- Sourcing high quality, accurate information in a timely fashion to measure performance against each objective and target (single version of the truth), proactively supporting projections to the end of the plan year.
- Driving consistency and alignment of performance dashboards and reports at all levels (including Trust Board) – using 'exception-based' reporting wherever possible.
- Constructively challenging performance delivery against agreed targets and recommending action(s) where appropriate.

- Reviewing performance against comparative benchmarks to recognise areas of good performance and identify areas where further improvement is needed.

9.2. All unit meetings and Sub-Committees are required to formally review progress against performance objectives and targets at least once a month (more frequently if required) and confirm that those targets are still expected to be delivered.

9.3. If a unit meeting and/or Sub-Committee forecasts that it is unlikely to be able to deliver the agreed objectives and/or targets at any point, then the associated issue(s) and/or risk(s) should be formally escalated to the next layer of the Trust's accountability matrix (N.B. escalation of an issue does not transfer the responsibility for delivery).

9.4. If a Unit meeting or Sub-Committee's or individual's performance regularly falls below the required levels, more formal escalation processes may be instigated (e.g. Performance Improvement Plans).

9.5. The Office of Assurance and Standards will meet regularly (monthly) with the leadership team of each Unit to review performance and progress. The focus and content of those meetings will vary depending on the quality of information available and the level of assurance provided by the unit leadership team.

9.6. If, following review of performance measures within the Trust a change in monitoring is recommended, the changes need to have authorisation of the Exec Lead (or Accountable Unit). Approval through the reporting committee should take place ahead of any changes. Once agreed, changes are to be documented on the front sheet of the IPR for the relevant committee/board informing why the change and when from.

10. Recognition and Reward

10.1. Where objectives are delivered and/or performance is exceeded the Trust actively seeks to recognise and reward that good performance.

10.2. The successes of units and other functions in delivering key elements of the Trust's Operational Plan, will be routinely reported and celebrated as part of monthly communication processes.

10.3. There are a wide variety of routes through which performance is currently recognised and rewarded, including;

- Staff and team communication
- Health Hero awards
- Celebration of Achievement awards
- Recognition of learning
- Long Service awards
- Volunteer celebration

- Bright ideas

11. Board Committees

11.1. Board Committees (BCs) provide an additional layer of independent assurance over and above organisational assurance processes, helping the Board to ascertain whether the PMF is operating effectively.

11.2. BCs provide an additional mechanism for Non-executive Directors to hold Chief Officers to account by testing the level of assurance available to support reported progress towards delivery of operational plan objectives.

11.3. BCs will routinely review performance reports but may also, from time to time and as necessary, undertake more in-depth assessments of aspects of performance delivery (where significant, this may involve establishing additional time-limited sub-committees or groups).

11.4. The effectiveness of the BCs will be reviewed annually or more frequently if required.

Appendix 1 – Integrated Performance KPI Accountability

KPI	Accountable Role	Assurance Committee
Sickness Absence Measurements	Chief People Officer	People
Vacancy Rate Measurements	Chief People Officer	People
Voluntary Staff Turnover Measurements	Chief People Officer	People
% of Headcount on Temp/Fixed Term/Secondment - Trust	Chief People Officer	People
Proportion of Temporary Staffing	Chief People Officer	People
Staff Appraisal	Chief People Officer	People
Mandatory Training	Chief People Officer	People
Serious Incidents	Chief Nurse	Quality & Safety
Never Events	Chief Nurse	Quality & Safety
Patient Falls measurements	Chief Nurse	Quality & Safety
Patient Safety Alerts	Chief Nurse	Quality & Safety
Pressure Ulcer measurements	Chief Nurse	Quality & Safety
Patient Friends & Family	Chief Nurse	Quality & Safety
Complaint Measurements	Chief Nurse	Quality & Safety
Safe staffing	Chief Nurse	Quality & Safety
Delayed Discharge	Chief Nurse	Quality & Safety
Mixed sex accommodation	Chief Nurse	Quality & Safety
Number of Spinal Injury Patients Fit For Admission to RJAH	Chief Nurse	Quality & Safety
Infection control measurements	Chief Nurse	Quality & Safety
Medication errors	Chief Medical Officer	Quality & Safety
Unexpected deaths	Chief Medical Officer	Quality & Safety
VTE measurements	Chief Medical Officer	Quality & Safety
Emergency readmissions	Chief Medical Officer	Quality & Safety
WHO compliance measurements	Chief Medical Officer	Quality & Safety
% cancellations	MSK Clinical Chair	FPD
Cancellations not rebooked within 28 days	SSU Clinical Chair	FPD
Cancer two week wait	Specialist Clinical Chair	FPD
31 days first treatment (tumour)	Specialist Clinical Chair	FPD
31 days subsequent treatment (tumour)	Specialist Clinical Chair	FPD
Cancer plan 62 days standard (tumour)	Specialist Clinical Chair	FPD
Cancer 62 days consultant upgrade	Specialist Clinical Chair	FPD
Faster diagnosis standard	Specialist Clinical Chair	FPD
18 weeks RTT open pathways	SSU Clinical Chair	FPD
Patients waiting over 52 weeks – English	Specialist Clinical Chair	FPD
Patients waiting over 52 weeks – Welsh	Specialist Clinical Chair	FPD
Patients waiting over 52 weeks – Combined	MSK Clinical Chair	FPD
Patients waiting over 104 weeks – English	Specialist Clinical Chair	FPD
Patients waiting over 104 weeks – Welsh	Specialist Clinical Chair	FPD
Patients waiting over 104 weeks – Combined	MSK Clinical Chair	FPD
% of RTT Clock Stops Against Baseline	MSK Clinical Chair	FPD

English list size	SSU Clinical Chair	FPD
Welsh list size	SSU Clinical Chair	FPD
Combined list size	SSU Clinical Chair	FPD
6 week wait diagnostics – English patients	CSU Clinical Chair	FPD
8 week wait for diagnostics – Welsh patients	CSU Clinical Chair	FPD
Overdue follow up backlog	MSK Clinical Chair	FPD
Advice and Guidance	MSK Clinical Chair	FPD
% sessions used against plan	MSK Clinical Chair	FPD
Number of sessions delivered	MSK Clinical Chair	FPD
Touch time utilisation	MSK Clinical Chair	FPD
Total elective activity	MSK Clinical Chair	FPD
Total Elective Against Plan	MSK Clinical Chair	FPD
Total Elective Against Baseline	MSK Clinical Chair	FPD
Theatre Activity measurements	MSK Clinical Chair	FPD
Average length of stay	MSK Clinical Chair	FPD
Bed occupancy – all wards – 2pm	MSK Clinical Chair	FPD
Referrals Received	CSU Clinical Chair	FPD
Outpatient activity measurements	CSU Clinical Chair	FPD
Total Outpatients against Baseline	CSU Clinical Chair	FPD
Total Outpatients against Plan	CSU Clinical Chair	FPD
Total Outpatient Activity - % Virtual	CSU Clinical Chair	FPD
Total Number of Episodes on Active PIFU Pathway	CSU Clinical Chair	FPD
Number of Episodes Moved to PIFU Pathways	CSU Clinical Chair	FPD
Total Outpatient Activity - % Moved to PIFU Pathway	CSU Clinical Chair	FPD
Outpatient DNA rate (Consultant led activity)	SSU Clinical Chair	FPD
Total MRI against Baseline - English Only	CSU Clinical Chair	FPD
Total MRI against Plan - English Only	CSU Clinical Chair	FPD
Total U/S against Baseline - English Only	CSU Clinical Chair	FPD
Total U/S against Plan - English Only	CSU Clinical Chair	FPD
Total CT against Baseline - English Only	CSU Clinical Chair	FPD
Total CT against Plan - English Only	CSU Clinical Chair	FPD
Data Quality Maturity Index	SSU Clinical Chair	FPD
Plan Performance	Chief Finance Officer	FPD
Income	Chief Finance Officer	FPD
Expenditure	Chief Finance Officer	FPD
Efficiencies delivery	Chief Finance Officer	FPD
Agency core	Chief Finance Officer	FPD
Agency non-core	Chief Finance Officer	FPD
Cash balance	Chief Finance Officer	FPD
Capital expenditure	Chief Finance Officer	FPD
% invoices paid within 30 days	Chief Finance Officer	FPD
Recurrent Financial Performance (Sustainability Plan)	Chief Finance Officer	FPD

Appendix 2 – Lead Officer for Board Committees

Board Committee	Lead Officer
Quality and Safety Committee	Chief Nurse
People Committee	Chief People Officer
Finance, Planning & Digital Committee	Chief Finance Officer
Charitable Funds Committee	Chief Finance Officer
Audit & Risk Committee	Chief Finance Officer
Remuneration Committee	Chief People Officer

NHS
The Robert Jones and Agnes Hunt Orthopaedic Hospital

Appendix 3

Board of Directors (BoD)

The BoD holds the Chief Officers to account for delivery of plan targets and objectives.

The BoD receives progress/performance reports.

The BoD delegate's assurance activities (focused on the areas identified in the Board Assurance Framework).

The BoD receives 'independent' assurance from Board Committees

The Chief Officers manage performance delivery by delegating responsibility through line management structure and to a number of responsible teams / units

Principles underpinning the Performance Management Framework;

- Ensuring all operational, financial and project targets, objectives and kpi's are fully understood and have been assigned to an appropriate unit owner.
- Sourcing high quality, accurate information in a timely fashion to measure performance against each objective and target.
- Driving consistency and alignment of performance information and reports at all levels – exception based reporting were possible.
- Constructively challenge performance delivery against agreed targets, confirming escalation criteria and recommending timely actions where appropriate.

Board Committees

Board Committees;
Audit & Risk Committee
Quality and Safety Committee
Finance, Planning and Digital Committee
People Committee
Charitable Funds Committee

Other Board Committees;
Remuneration Committee