Countess of Chester Hospital NHS Foundation Trust

Part B Pack

Board of Directors meeting – 1st December 2020

a. Nursing Bi-annual Safe Staffing Assurance Report (January-June 2020) b. Director of Infection Prevention and Control Annual Report 2019/20 c. Continuous Improvement Strategy (attached) d. Quality Accounts (attached) e. Council of Governors Report – 1 October 2020 (attached) f. Updated Board business cycle (attached) g. Finance Report – Month 6, September 2020 (attached)	

Meeting	**1st December 2020**		**Board of Directors**					
Report	**Agenda item 17.a**		**Nursing Bi-annual Safe Staffing Assurance Report (January-June 2020)**					
Purpose of the Report	Decision		Ratification	X	Assurance	X	Information	
Accountable Executive	Alison Kelly				Deputy CEO/Director of Nursing & Quality			
Author(s)	Melanie Kynaston				Deputy Director of Nursing			
Board Assurance Framework	Q1 Q2 Q3	Safety Quality Quality						
Strategic Aims								
CQC Domains	Safe, Effective, Caring , Responsive, Well Led							
Previous Considerations	Quality Governance Group on 26th August 2020 Nursing & Midwifery Workforce Steering Group on 27th August 2020 Quality & Safety Committee 15th September 2020							
Summary	This report is intended to provide assurance on the current nursing provision at the Countess of Chester Hospital NHS Foundation Trust. It will: • provide an overview of the national and local nursing workforce position; • outline the number of nurses needed for the acuity of patients seen (fill rates and CHPPD); • triangulate staffing numbers with key safety, quality and experience metrics; • provide compliance against a range of regulatory and commissioning 'safe staffing' requirements; • summarise the work concluded in phase 1 of the nurse establishment review; and • provide details on the nursing and midwifery workforce changes in response to COVID -19.							
Recommendation(s)	The Board is asked to: • note the content for Assurance that the Trust is currently operating safe nurse staffing levels; • ratify the Nursing Bi-annual Safe Staffing Assurance Report (January-June 2020).							
Corporate Impact Assessment								
Statutory Requirements	Report and content meets regulatory requirements							
Quality & Safety	Supports delivery of safe care in line with CQC and NHSE/I and Quality Board national safe staffing requirements							

NHS Constitution	Supports compliance with NHS Standards
Patient Involvement	n/a
Risk	Reflects key aspects of the Board Performance Report
Financial impact	Financial impact of establishment review articulated in the report
Equality & Diversity	n/a
Communication	n/a

Division / Directorate	Nursing and Midwifery
Department	Nurse Management
Author	Melanie Kynaston, Deputy Director of Nursing
Title	**Nursing Bi-Annual Safe Staffing Assurance Report (Jan – June 2020)**

Purpose

This paper has been produced to provide assurance on the current nursing provision at the Countess of Chester Hospital NHS Foundation Trust. It will:

- provide an overview of the national and local nursing workforce position;
- outline the number of nurses needed for the acuity of patients seen (fill rates and CHPPD);
- triangulate staffing numbers with key safety, quality and experience metrics;
- provide compliance against a range of regulatory and commissioning 'safe staffing' requirements;
- summarise the work concluded in phase 1 of the nurse establishment review; and
- provide details on the nursing and midwifery workforce changes in response to COVID -19.

For assurance against Midwifery staffing provision please refer to Appendix Six.

Introduction

It is recognised that there is a shortfall in healthcare workforce numbers across the United Kingdom (UK) and this problem has a direct impact on peoples care and experience. NHS hospitals, mental health and community providers are reporting shortages of more than 100,000 FTE staff (representing one in eleven posts), with greater affect seen in some key workforce groups. One of the greatest challenges is seen in nursing, with 41,000 FTE vacancies reported (one in eight posts)[1]. This position has worsened from the reported 10% gap in adult nursing (shortfall of 22,000 FTE) in 2017 and has exceeded the more pessimistic prediction of 38,000 FTE by 2020[2]. On current trends it is now predicted that there will be a shortfall of 108,000 FTE nurse by 2030[1]. To address this there is a need to increase the number of nurses joining the NHS for training, reduce the 'drop out' rate during training and encourage qualifying nurses to remain in the NHS. Steps have been taken nationally to start tackling this issue, 'cost of living' grants are being offered to nursing students, training place numbers are being increased and clinical placements are being expanded and maximised to facilitate the practice element. Further actions are being considered, including covering the costs of tuition fees and there is a focus on Trusts implementing apprenticeship routes for training and progressing overseas recruitment[1].

Local Position

Considerable work has been undertaken pre-COVID and during COVID to improve staffing levels in areas with a higher than acceptable vacancy factor, or where models of service or care delivery have changed and additional resource has been required to safely execute the operational requirements. Recruitment activities during this reporting period include (but are not limited to):

- university engagement and early offers of employment;
- supporting paid placements (as part of national COVID-19 response);
- move to ward and department based recruitment (rather than corporate adverts);
- rolling programme of adverts (continuous recruitment drives in difficult to recruit areas);

- international recruitment drive (55 overseas nurse arriving in phases in the next reporting period); and
- return to practice, including temporary NMC registration (as part of national COVID-19 response).

Table 1 below provide details on the vacancy currently seen for registered and unregistered nursing staff by Division. It is important to note that in addition to the 'actual' vacancy, wards and departments are also managing gaps in response to sickness and maternity leave. During this reporting period the COVID-19 related absence (for symptomatic, isolating or shielding staff) has added a further pressure (as seen in graphs 3– 5).

Table 1: Vacancy, turnover, sickness and maternity statistics for registered and unregistered nursing staff by Division

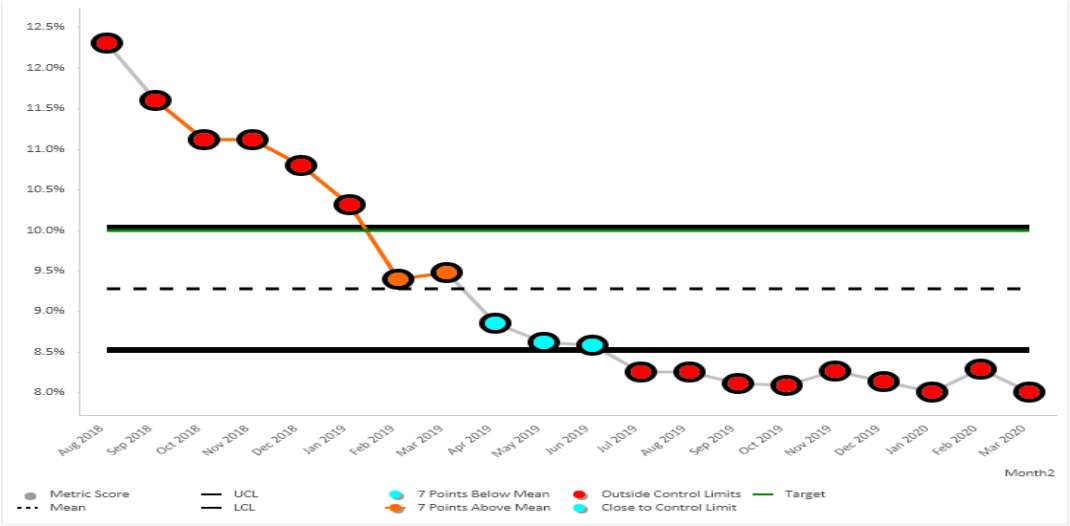
Nursing & Midwifery (Registered)				
	Turnover	Sickness	Maternity	Vacancy
Planned Care	3.15%	8.01%	4.18%	-16.01
Urgent Care	4.70%	9.29%	4.45%	-29.54
ICP	5.51%	10.43%	0%	1.91
Nursing & Midwifery (Unregistered)				
	Turnover	Sickness	Maternity	Vacancy
Planned Care	3.78%	15.81%	2.11%	1.5
Urgent Care	5.11%	14.04%	2.26%	-44.03
ICP	5.02%	16.27%	3.27%	-34.73

A number of initiatives to reduce the turnover rate (particularly in registered nursing) have been in place since 2018/19. These have continued during this reporting period and include:

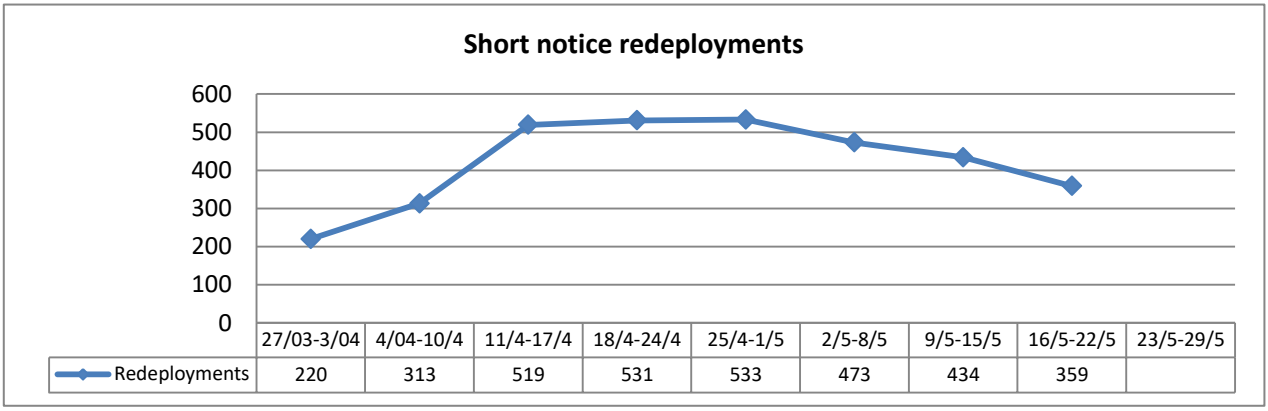
- preceptorship and beyond;
- career development;
- flexible working; and
- retire and return.

These have demonstrated a sustained improvement in retention (as seen graph 1). However as a result of COVID-19 there has been a need to redeploy staff on a short, medium and long term basis to manage safe staffing levels, support the needs of individuals and protect both staff and patients (in line with PHE guidance and risk assessments). The frequency in which staff have been moved by shift has increased (as seen in graph 2) and this as well as the additional strain of the changes in the work environment, have impacted on the wellbeing of staff. The COVID-19 experience has affected team working, changed ward locations and altered working practices. Additional risk reduction measures from an infection prevention and control perspective have impacted on visibility of patients, clustering of activities and changed ward routines, in addition to wearing PPE and socially distancing.

Graph 1: Registered nurse turnover

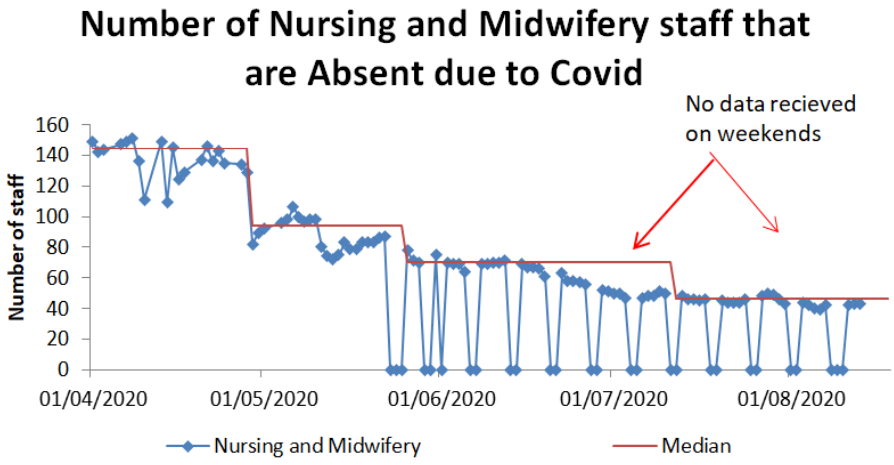


Graph 2: Staff moves (short notice redeployment)

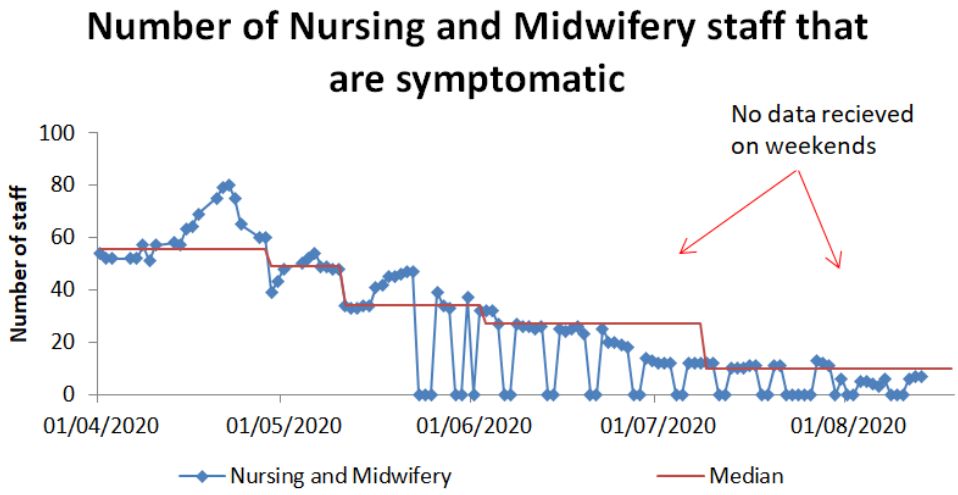


The overwhelming majority of staff redeployment has been to the intensive care unit, where during the initial COVID-19 surge occupancy levels for level 2 and 3 patients increased significantly. Surge 1 and surge 2 areas (for intensive care) were open and fully operation for a prolonged period of time.

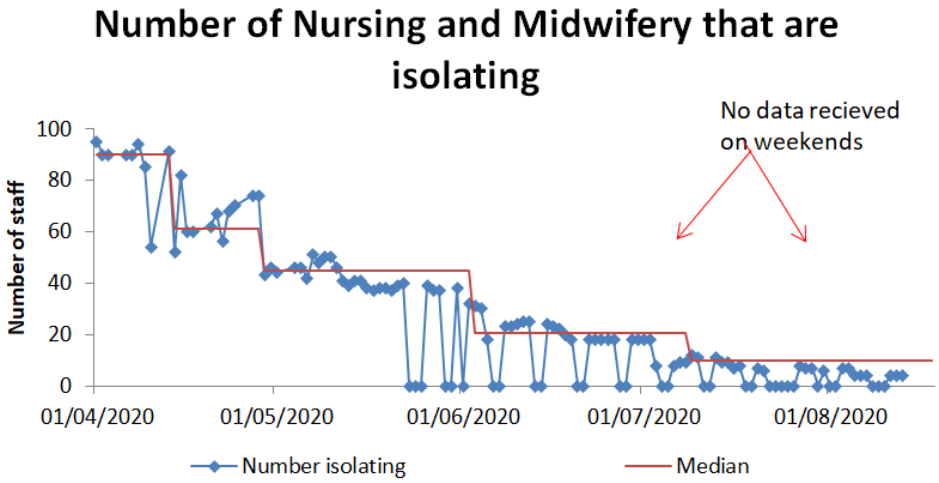
Graph 3: Absence due to COVID-19



Graph 4: Absence due to COVID-19 symptoms



Graph 5: Absence due to isolation



Staff Health and Wellbeing

Employee health and wellbeing influences whether staff are able to work at their peak, and are critical success factors for individual and organisational performance, and improved patient outcomes. Staff wellbeing during COVID-19 has been supported by communicating the range of mental and physical health advice available to all NHS staff. The trust intranet has a specific staff COVID-19 health and wellbeing support page, with information from occupational health and signposting to other external organisations. New information has been communicated to staff through the 'floor walkers' daily briefings. The Spiritual Care Centre and Macmillan Cancer Centre spaces have also provided 'Staff Wellbeing Hubs' to provide an area for colleagues to have some quiet time, a chat or a simple break. We recognise the ongoing need for staff to be able to access timely counselling, health advice, financial and legal advice. Our EAP service has provided a 24 hour confidential telephone helpline, counselling has been available either virtual or telephone, due to COVID restrictions, alongside an online health portal, and mobile phone health e-Hub App.

Last year's staff flu campaign concluded in February 2020 with 83.1% of our front line staff vaccinated, with 3,447 staff protecting our patients, themselves, and their family by having their flu vaccine. This year we will

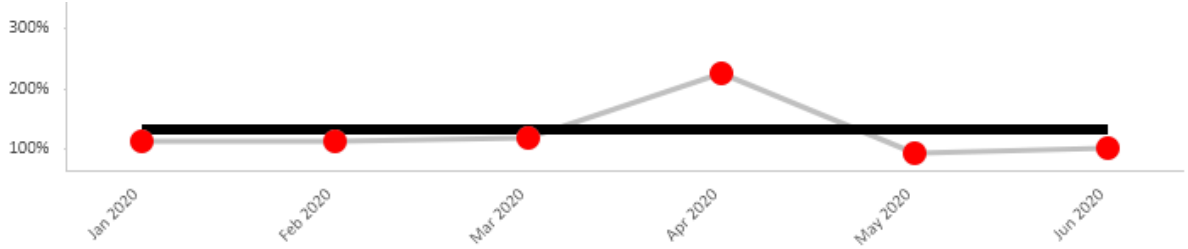
start the campaign in October and aim to reach the national target and offer the vaccine to 100% of our staff. The campaign will be planned to ensure the restrictions concerning COVID-19 are accommodated.

Supporting the wellbeing of our staff to enable safe, kind and effective care is delivered by the Trust's SEQOHS (Safe, Effective, Quality, Occupational Health Service) accredited Occupational Health & Wellbeing Department. The trust's health and wellbeing strategy is currently being reviewed in light of the recent NHS People Plan, and in conjunction with the NHS Wellbeing framework and action plan. This will inform future developments and plans going forward and into 2021.

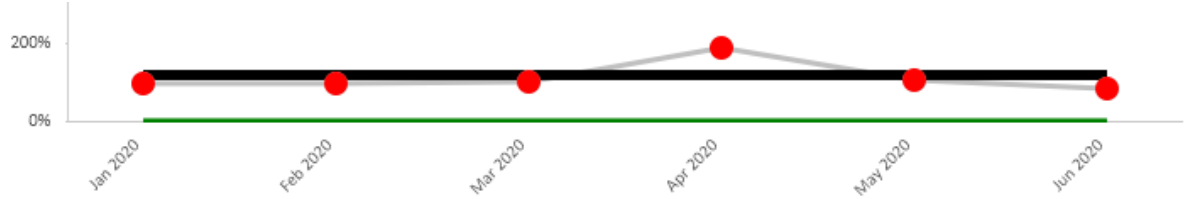
Staffing Fill Rates & CHPPD

Safe staffing roster templates have been designed based on the needs of patients commonly seen within each ward and department. All inpatient areas have recently been reviewed (please refer to phase 1 of Nursing and Midwifery Establishment Review section). The following information provides details on the trust ability to maintain the staffing levels expected to meet patients' needs. This is presented as a % of shifts filled and is split between registered and unregistered staff (graphs 6 and 7).

Graph 6: Registered Nurse Fill rates (Jan – June 2020)



Graph 7: Unregistered Nurse Fill Rates (Jan – June 2020)



A more meaningful measure of nurse staffing and whether staffing levels are suitably matched to patients needs is the measurement of Care Hours Per Patient Day (CHPPD). This provides a single, consistent and nationally comparable way of recording and reporting nursing staffing in inpatient wards and departments. CHPPD has developed as the single metric to:

- Give a single comparable figure that can simultaneously represent both staffing levels and patient requirements, unlike actual hours or patient requirements alone which has been used traditionally; and
- Facilitate comparisons between wards within a trust and also nationally with wards of the same specialty. As CHPPD has been divided by the number of patients in an area, the value does not increase due to the size of the ward and this facilitates comparisons between wards of different sizes. CHPPD measures how many hours of care are provided collectively by registered nurses, healthcare assistants and therapists (if included in the ward establishment model) per patient in a 24 hour period. CHPPD is calculated by dividing the total number of nursing hours on a ward or department by the number of

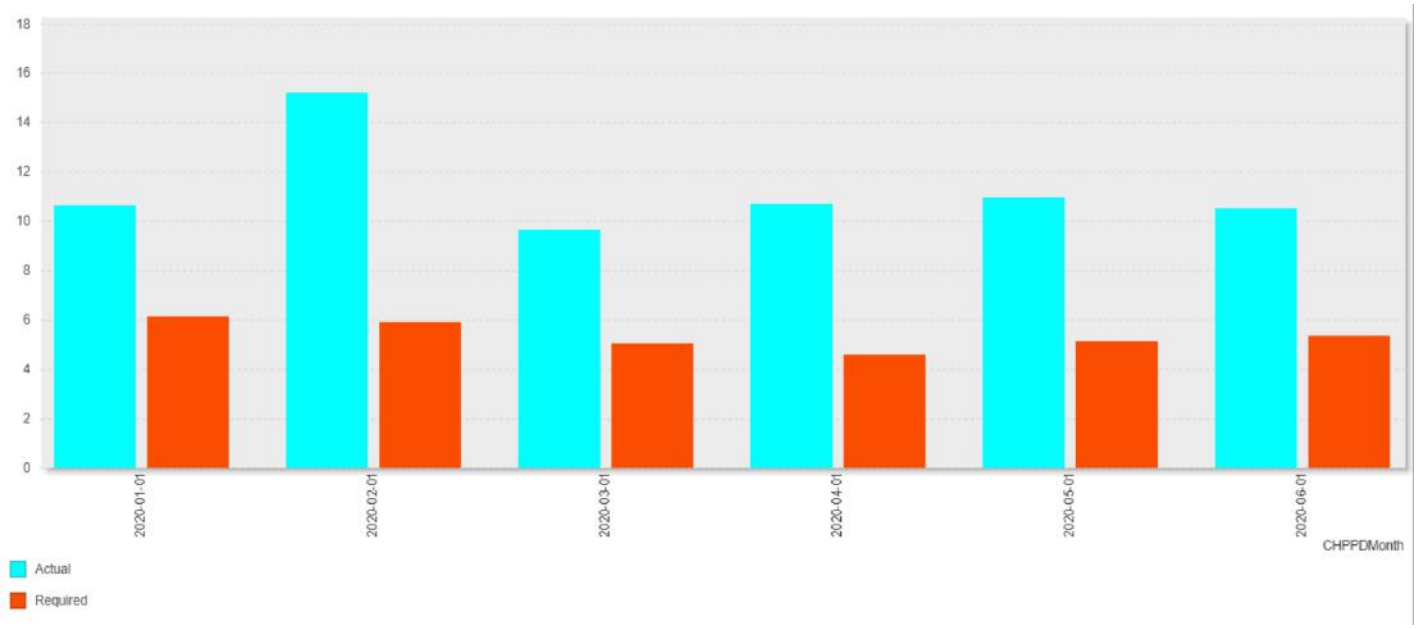
patients in beds at the midnight census, representing the number of nursing hours that are available to each patient.

$$\text{Care Hours per Patient Day (CHPPD)} = \frac{\text{Hours of RN + Hours of NA over 24 hour period}}{\text{Total Number of In Patients (Midnight Census)}}$$

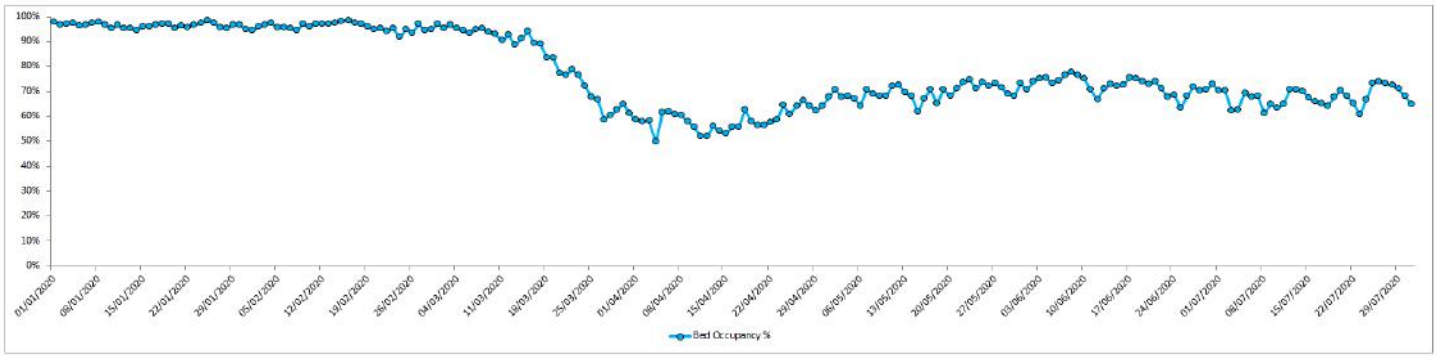
In this reporting period there has been a significant increase in CHPPD delivered across inpatient areas (as seen in chart 1), this is due to a number of factors including:

- Reduced bed occupancy (seen in graph 8);
- Step down of elective work (national response to COVID-19);
- Redeployment of staff outside of ward areas into ward areas (clinical nurse specialists, theatre, endoscopy, and outpatient staff);
- National drive for retire and return, including temporary reinstatement to NMC register; and
- Paid student placement (included in safe staffing numbers).

Chart 1: Care Hours per patient per Day (CHPPD)



Graph 8: Bed Occupancy

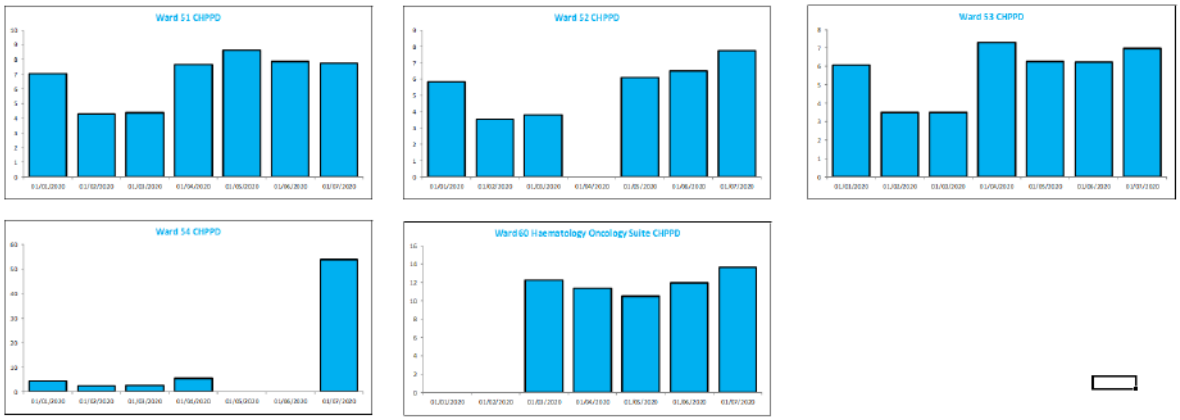


Bed occupancy fell significantly during March 2020 in response to the national emergency; this has impacted on CHPPD as there has been less inpatients' for the staff to care for at any given time. The occupancy is now

returning to pre-COVID levels and with the re-set and restoration work well under way (phase 3 of national recovery), it is expected that CHPPD will return to previous levels. However, with the establishment review and the redistribution of resource (and updating of roster templates) there will continue to be an improvement in areas which previously had less CHPPD than needed.

Although it is helpful to collate CHPPD into a Trust position, this measure provides the most accurate assessment of safe staffing levels when considered at ward or department level. Chart 2 below provides details by ward on CHPPD delivered across this reporting period. It shows (with the exception of the renal unit and children's ward) that since the step down of elective activity, redeployment of none ward staff and the deployment of aspirant nurses (paid student nurse placements), there has been a significant increase in CHPPD since April 2020.

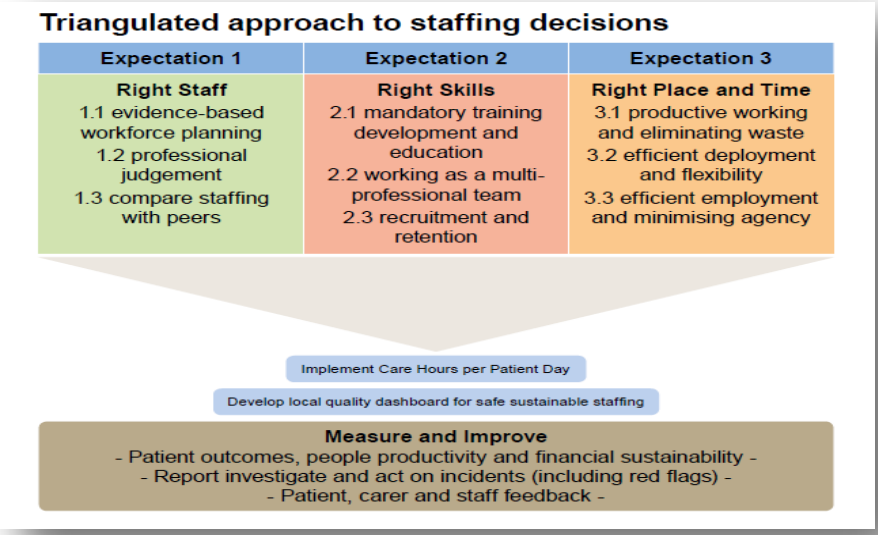
Chart 2: CHPPD Dashboard by ward or department (January 2020 – July 2020)



Safety, Quality and Experience

When considering safe staffing levels across wards and departments it is imperative that this is triangulated with key safety, quality and experience metrics. With a particular focus on patient harm and compliance to a range of regulatory and commissioning standards[3,4,5,6]. These recommendations ensure that staffing reviews focus on 3 expectations (found in chart 3) and provide a structured approach to how staffing levels should be triangulated with safety, quality and experience measures to make an evidenced based assessment to whether staffing levels are safe and meet the expectations of patients and service users.

Chart 3: National Quality Board (NQB) expectations



To consider the impact of staffing levels on patient safety, quality and experience, at the Countess of Chester Hospital we use the following measures:

- Actual or potential harms
    - Rate of falls
    - Fall severity of harm
    - Prevalence of hospital acquired pressure ulcers
    - Pressure ulcer severity of harm
- Ward Accreditation System
    - Range of national, regional and local standards (as outlined in the Care Assurance Framework)

Falls

Charts (3-6), table 2 and graphs (8-10) below provide details on the number of falls seen during this reporting period. The analysis for the rate of falls and those that result in harm are presented in SPC graphs, as these have been tracked and the findings considered over a period of time. Falls and fall related injuries are a common and serious problem for older people. People aged 65 and older have the highest risk of falling, with 30% of people older than 65 and 50% of people older than 80 falling at least once a year. The human cost of falling includes distress, pain, injury, loss of confidence, loss of independence and mortality. Falling also affects the family members and carers of people who fall. Falls are estimated to cost the NHS more than 2.3 billion per year. Therefore falling has an impact on quality of life, health, and healthcare costs (NICE Guidance: Falls in older people; assessing the risk and prevention, CG161, 2013).

Chart 3: Number and severity of falls reported (January 2020 – July 2020)

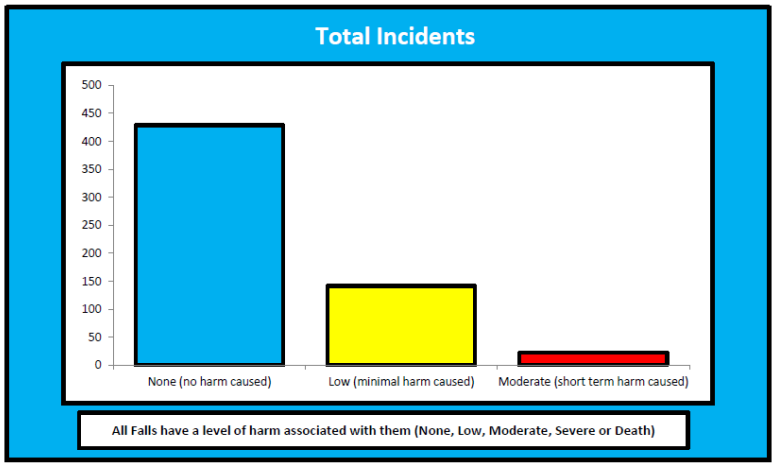
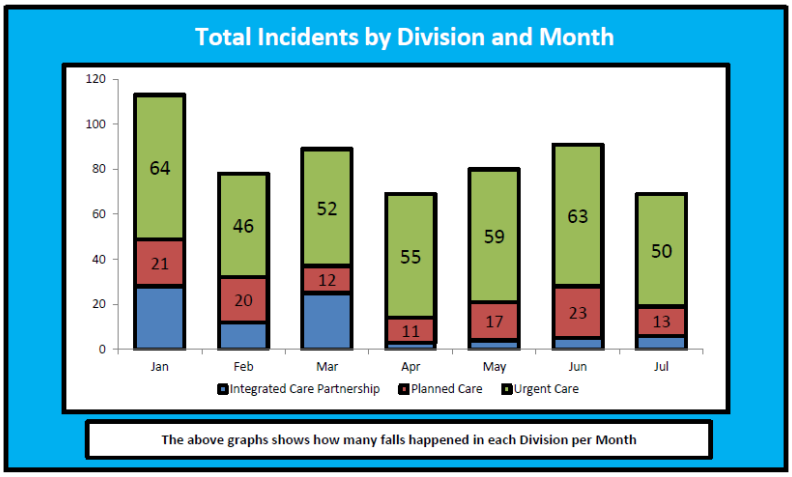


Table 2: Number of falls by month and severity of harm

Category	Metric	Jan 2020	Feb 2020	Mar 2020	Apr 2020	May 2020	Jun 2020
Incidents	Falls Minimal Harm	29	16	23	15	11	32
Incidents	Falls Moderate Harm	4	2	1	1	2	2
Incidents	Falls No Harm	83	55	71	55	63	68
Incidents	Falls Severe Harm	0	0	0	0	1	0

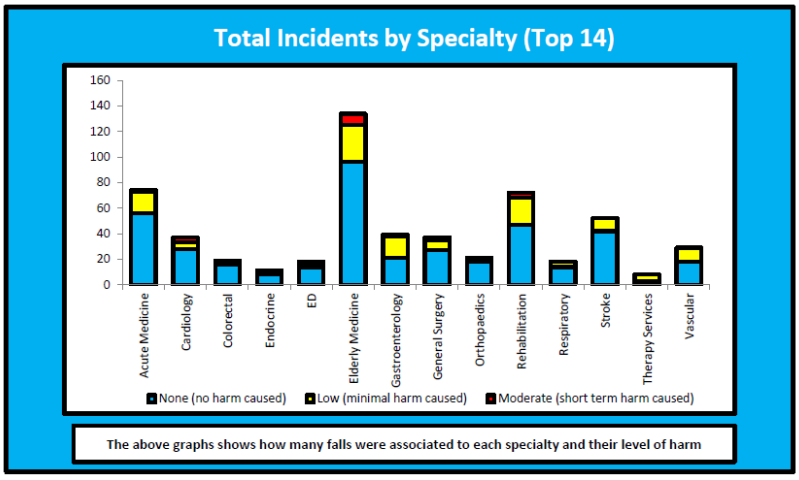
Chart 4: Number of falls by month and Division



The largest proportion of falls are seen in the Urgent Care Division, this is reflective of the number of beds held by the Division and type of patients admitted to the specialties within it. When patients are in hospital it is important to for them to mobilise as soon as their recovery allows. Patients who do get out of bed, get dressed and start moving early are more likely to make a full recovery and return to their usual place of residence. As patients start their rehabilitation they may require additional support from physiotherapy staff and the use of equipment (such as walking aids), this in turn can increase the risk of the person slipping, tripping or falling whilst in hospital. As it is so important not to restrict a person from mobilising it means we need to put measures into place to reduce the risk of the person from falling. We have implemented the national 'FallSafe' programme, which is made up of a number of nationally recognised interventions including:

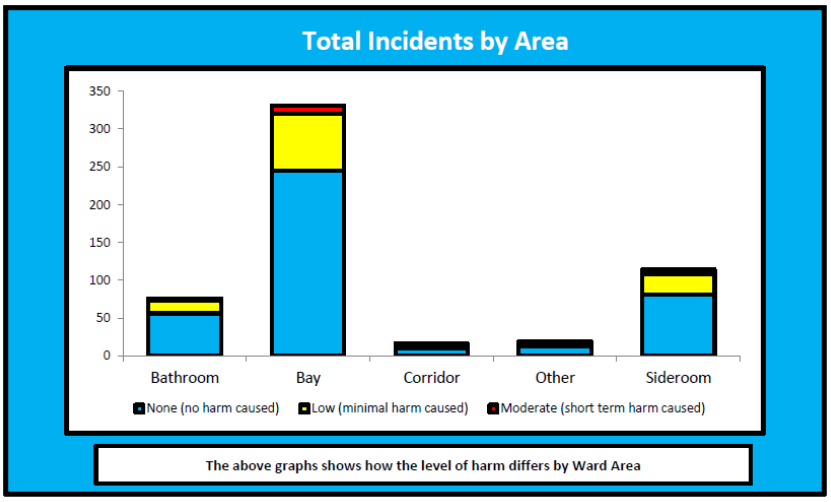
- Assessing if the person has a history of falls and/or has a fear of falling;
- Ensuring patients call bells are within reach;
- Ensuring patients have appropriate footwear whilst in hospital;
- Undertaking a cognitive assessment (to identify confusion);
- Identifying patients at risk of delirium;
- Undertaking a simple visual assessment (none diagnostic);
- Ensuring a lying and standing blood pressure is taken; and
- Ensuring patient medications are reviewed.

Chart 5: Incident by specialty



The areas with the highest incidents of falls (including those that result in harm) are the Acute Medical Unit, Elderly Medicine, Rehabilitation and Stroke. It is estimated that the population in Cheshire West and Chester aged 65 or above will increase by over 50% to 92,100 by 2029, and those aged 85 or above will more than double to 16,300. Although people are living longer, many have to cope with poor health, disability and chronic illness for many years. This inevitably means that access to health care and support services is vital for the growing population of older people and the incidence and risk of patients falling during admission is increased.

Chart 6: Location of fall

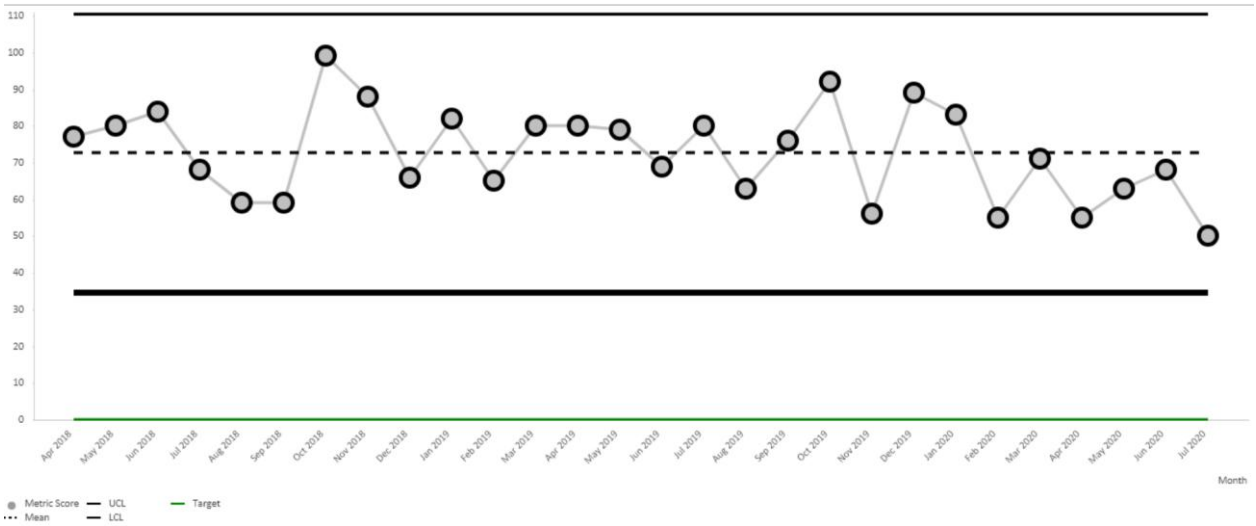


The location of the fall is important to consider, as this can identify areas for improvement. The largest proportion of falls during this reporting period is seen in bays. There may be a number of reasons for this (including but not limited to):

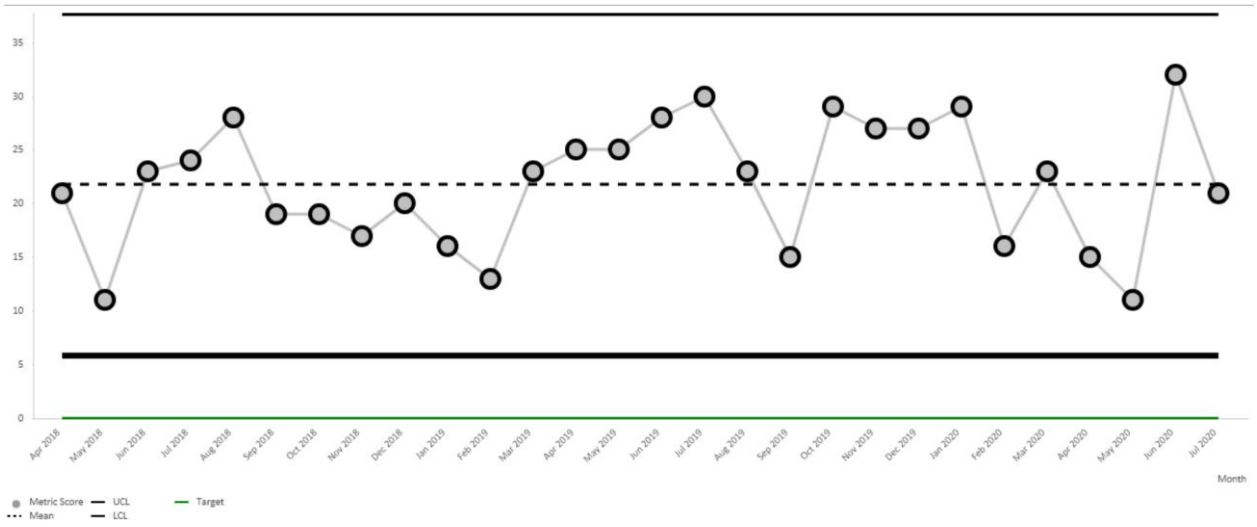
- Reduced observation (closing down of bays as part of COVID -19 transmission avoidance)
- Compliance to initial falls risk assessment (identifying those patients at risk of, or with a fear of falling)
- Compliance with standard and enhanced risk reduction measures (following the 'FallSafe' bundle)
- Adoption and implementation of 'enhanced supervision policy' (for those patients requiring additional measures of observation)

Performance in relation to these are currently being measured and assurance will be available in the next reporting period to establish if there are any gaps in systems and controls which need to be addressed. The following graphs (8- 10) show that the falls rate (with or without harm) is within 'expected variation', with improvement seen in falls with moderate harm but this is not yet statistically relevant. There has also been 1 fall during this reporting period resulting in severe harm.

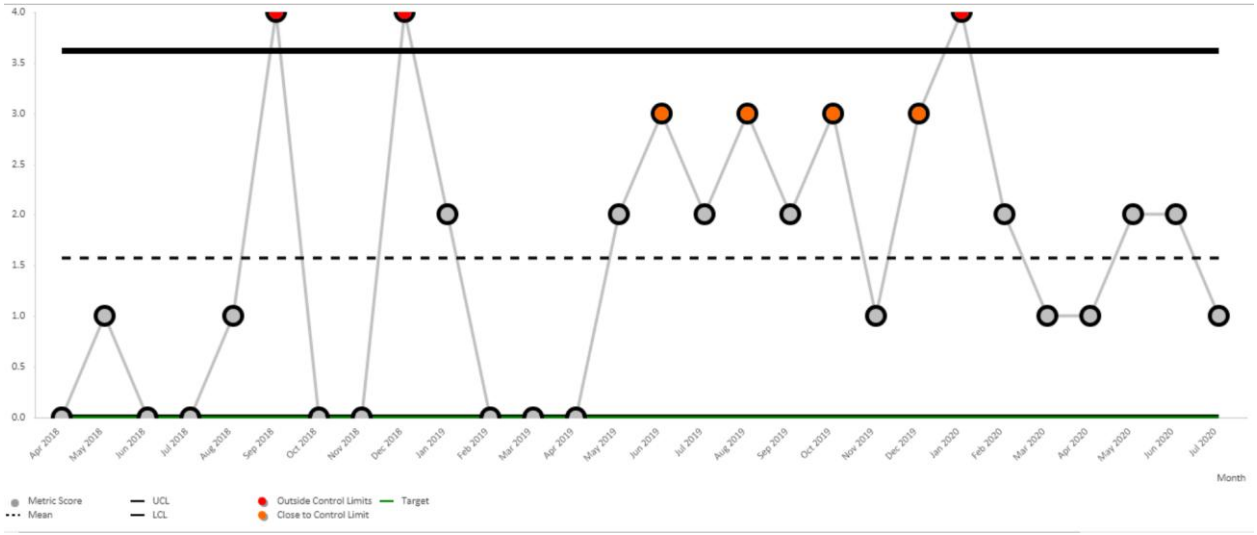
Graph 8: Falls (no harm)



Graph 9: Falls (minimal harm)



Graph 10: Falls (moderate harm)



Pressure Ulcers

The charts (7-9) and graphs (11-14) below provide details on the number of pressure ulcers seen during this reporting period. The analysis for the prevalence of pressure ulcers and those that result in harm are presented in SPC graphs, as these have been tracked and the findings considered over a period of time.

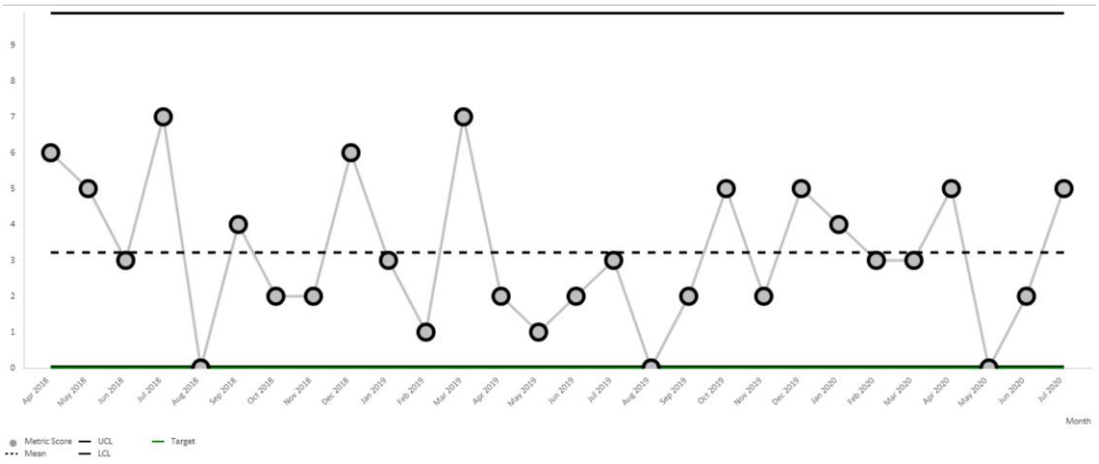
A pressure ulcer is localised damage to the skin and/or underlying tissue, usually over a bony prominence (or related to a medical or other device), resulting from sustained pressure (including pressure associated with shear). The damage can present as intact skin or an open ulcer and may be painful'' (NHS Improvement, 2018a). Pressure damage is common in many healthcare settings affecting all age groups and is costly in terms of both human suffering and use of resources. Pressure ulceration is often preventable and the overarching guidance for pressure ulcer prevention and management is provided nationally within National Institute for Clinical Excellence (NICE 2014) Clinical Guideline and Quality Standard (2015).

All patients at the Countess of Chester Hospital have a risk assessment including skin inspection carried out by a trained healthcare professional within 6 hours of admission or first community contact, using a recognised

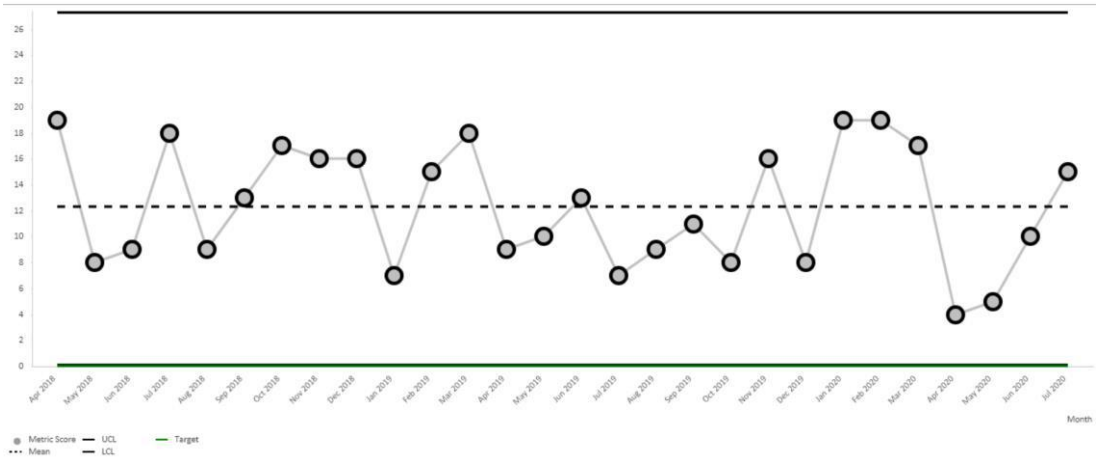
risk assessment tool (BRADEN). Ideally the assessment should be done within one hour of admission, especially if the patient is acutely ill, has existing or previous pressure ulcers or has been on a hard surface (i.e. lying on a floor for a prolonged period) prior to admission. The risk assessment tool does not replace clinical judgement but is used to support it. Results of risk assessment must be recorded within the patient record and patients assessed as 'at risk' have a care plan developed appropriate to their individual needs. The patient and their relatives or carers are involved in the assessment and planning process wherever possible. Pressure ulcer categories should not be linked to a specific pre-set degree of harm but are assessed individually for degree of harm level.

Graphs 11– 14 provide details on the prevalence of pressure ulcers by severity, these demonstrate trends are within 'expected variation' with improvement noted in the reduction of category 3 and 4 ulcers (although these have less statistical value due to very small numbers).

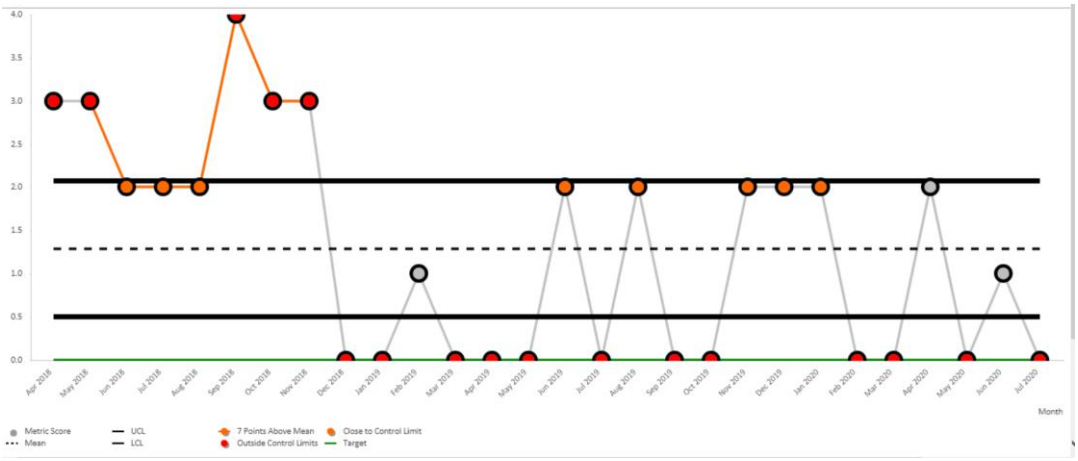
Graph 11: Category 1 pressure ulcers (hospital acquired)



Graph 12 Category 2 pressure ulcers (hospital acquired)



Graph 13: Category 3 pressure ulcers (hospital acquired)



Graph 14: Category 4 pressure ulcers

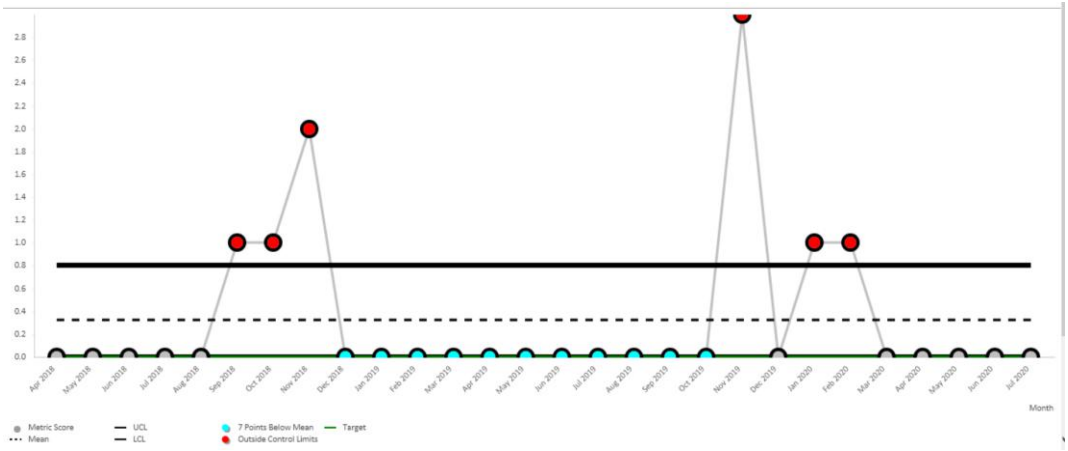
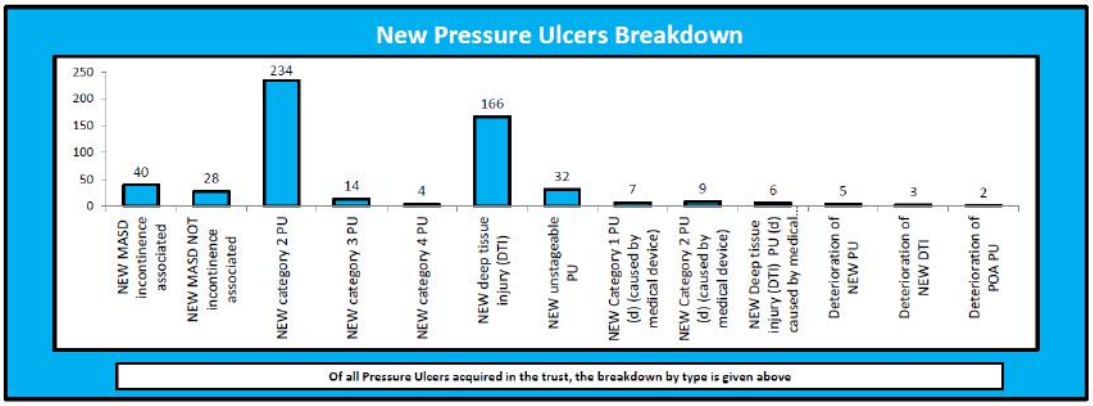


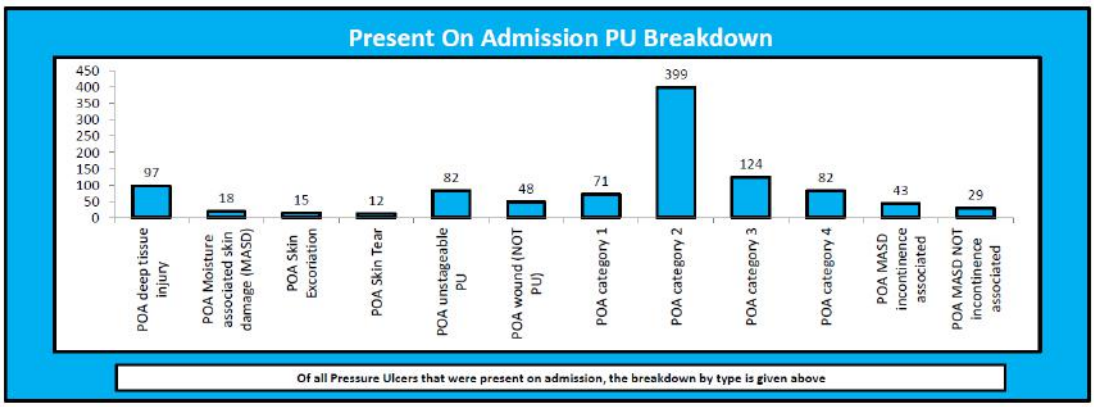
Chart 7: Type and severity of pressure ulcers (hospital acquired)



The majority of pressure ulcers recorded during this reporting period is Category 2 or deep tissue injury. Deep tissue injury is a new reporting field following the implementation of the NHS Improvement standards in 2019; it refers to a pressure related injury to subcutaneous tissues under intact skin. Initially, these lesions have the appearance of a deep bruise. These lesions may develop into a category 3 or 4 pressure ulcer and

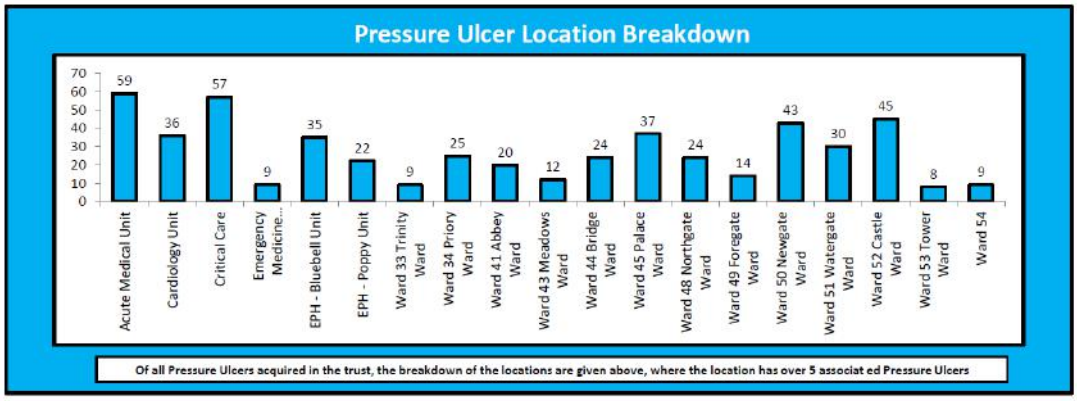
this may be despite optimal prevention and treatment, which is why it is so important to recognised them and act. The category 2 pressure ulcers may be a missed opportunity to recognised and act when the ulcer presents at Category 1 and improvement work moving forward needs to be focused on early identification and preventative action of Category 1 ulcers, this will then reduce the number of Category 2 ulcers developing.

Chart 8: Present on admission (POA) ulcers by type and severity



Working with system partners to prevent avoidable harm has remained a priority during this reporting period. Pressure Ulcers that are POA to hospital continue to be captured in the reporting system and information is shared with the responsible organisation (including where necessary Safeguarding teams). Internally this information is critical to designing and implementing the best care plan to meet the individual patients' needs and to prevent any deterioration of the pressure damage or the development of any new ulcers.

Chart 9: Location of pressure ulcer (ward or department)



Understanding the prevalence of pressure ulcers by ward or department supports targeted improvement work. During this reporting period (and in response to the pressure ulcer deep dive exercise) the following improvement work has been started:

- Policy
    - Cheshire & Merseyside Pressure Ulcer Steering Group guideline implemented
- Pressure ulcer review process at ward level reviewed and education programme designed to
    - Ensure consistent approach to review/documentation
    - Timely and accurate initial reporting in Datix

    - Staff to 'think SSKIN' (Skin Assessment, Support Surface, Keep moving, Incontinence and Nutrition & hydration) a mnemonic to guide appropriate practice and care for patients at risk of pressure ulceration
    - Any corrections uploaded to Datix in a timely manner to support provision of accurate data
- Lessons learnt
    - Improved sharing of lessons learnt following local reviews
    - Development of dashboard

The impact of this improvement work on performance is currently being measured and assurance will be available in the next reporting period to establish if there are any gaps in systems and controls which need to be addressed (i.e. compliance to new policy, staff knowledge and understanding and documentation).

Ward accreditation (Care Assurance Framework)

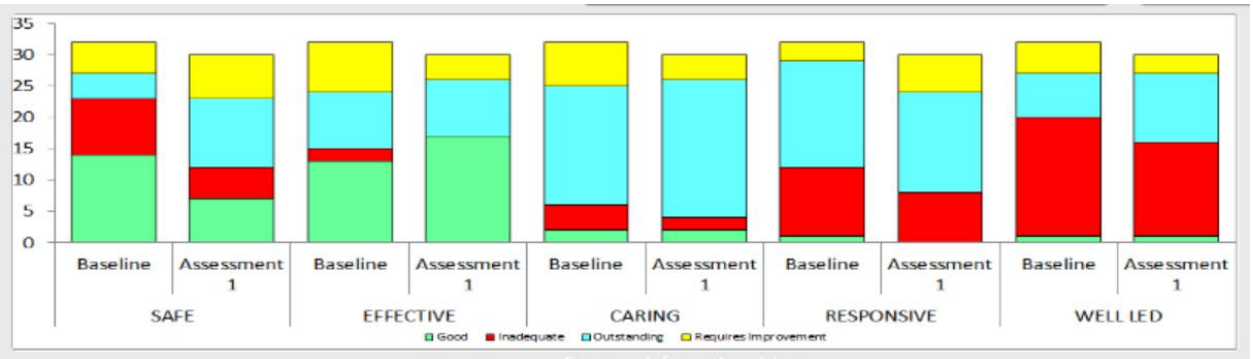
In addition to patient harm, there are a range of safety, quality and experience metrics measured in the Ward Accreditation System (using the Care Assurance Framework). This framework explicitly defines what 'outstanding' care delivery looks like. The measures are set in line with national best practice and regulatory requirements. This system spans adult inpatients, paediatric inpatients, maternity services, adult critical care, neonates, outpatients, theatres and the emergency department. There is a core set of standards that apply to all areas, with additional measures added for relevant services. Each Care Assurance Framework has been designed using the CQC key lines of enquiry (KLOE) and (where relevant) these can be mapped to the 28 regulations set out in the Health and Social Care Act (2008), regulatory activities, Regulations (2010) and the Care Quality Commission (Registration) Regulations (2009).

The Ward Accreditation baseline assessment ran between December 2019 and February 2020 with 32 wards and departments including theatres and outpatients completing. This provided the trust with an overall starting point on which to improve and implement change. During the baseline assessment, anything that was considered to be unsafe was addressed immediately (as the assessment was in progress). This resulted in nine wards accredited at 'outstanding', ten 'required improvement' and 13 were 'inadequate'. Although this was disappointing, it was in keeping with the feedback from the exemplar NHS Improvement sites, who also reported that their initial baseline identified a variety of areas for improvement. Each ward manager had a meeting with the Quality Matron to discuss their results and in order to formulate action and improvement plans, engage teams and commence the continuing improvement journey. In April 2020, despite the global pandemic the Director of Nursing & Quality made the decision to continue with ward accreditation assessments as this would be the tool to provide evidence and assurance of the standard of care being given during the trusts COVID-19 response. In the first formal assessment thirty wards/departments completed; with wards 32 and 35 doing their assessments separately this time as Maternity wards had been accredited as one unit in the baseline assessment. Three wards did not accredit this time, wards 54, Children's outpatients and Poppy as they were closed at the time of this assessment. Several wards had moved location ward 49 had moved to 45, ward 45 to 49, 44 to the modular ward while ward refurbishment could take place on ward 44.

Table 3: Highlights of Ward accreditation findings

OVERALL RESULTS FOR BASELINE (30 WARDS)		
	BASELINE	**IST ASSESSMENT**
Outstanding	9	11
Good	0	0
Requires Improvement	10	13
Inadequate	13	6
TOTAL	**32**	**30**

Chart 10: Breakdown by domain and comparison from baseline and 1st formal assessment



Has there been Improvement from the baseline to the first assessment?

- 12 wards improved their overall accreditation rating with at least one domain being improved;
- 3 wards had a lesser accreditation; and
- 15 wards maintained their previous rating; however one or more domains have improved.

The significant improvement in 'overall ratings' and 'rating in one domain or more' seen in the first formal assessment would indicate that safe staffing levels have been maintained during the reporting period. This is an impressive shift in compliance (from baseline) within a 3 month period, particularly in light of the current national emergency and the ways in which teams and services have been disputed.

Compliance against regulatory and commissioning 'safe staffing' requirements

Table 4 below outlines the Countess of Chester Hospitals compliance against the following regulatory and National Quality Board Standards:

- Emergency Department External Review (2019) using National Quality Board Urgent and Emergency Care Standards (2018) – please see appendix one for full details;
- National Quality Board (2018) An improved resource for adult inpatient wards in acute hospitals[9] – please see appendix two for full details;
- National Quality Board (2017) Safe, sustainable and productive staffing: An improvement resource for maternity services[10]-please see appendix three for full details;
- National Quality Board (2018) Safe, sustainable and productive staffing: An improvement resource for children and young people's inpatient wards in acute hospitals[11]-please refer to appendix four for full details; and
- NHS Improvement (2019) Care Hours per Patient Day (CHPPD): Guidance for inpatient trusts (updated July 2019)[12]-please refer to appendix five for full details.

The National Quality Board (NQB) published these frameworks for provider organisations to use when assessing and reviewing nursing and midwifery safe staffing levels. They are designed to ensure transparency in reporting from 'ward to board' and to ensure the triangulation detailed in the previous section is undertaken consistently and using a standardised framework.

Table 4: Summary of compliance to NQB and NHS Improvement Staffing Standards

NQB/NHSI Framework	(N) Standards	Met (N)	Partially Met (N)	Not Met (N)	Deferred (N)	%
Emergency Department External Review	17	21	4	2	4	91%
NQB (2018) An improved resource for adult inpatient wards in acute hospitals	10	8	1	1	0	80%
NQB (2017) Safe, sustainable and productive staffing: An improvement resource for maternity services	13	13	0	0	0	100%
NQB (2018) Safe, sustainable and productive staffing: An improvement resource for children and young people's inpatient wards in acute hospitals	12	11	1	0	0	91%
NHS Improvement (2019) Care Hours per Patient Day (CHPPD): Guidance for inpatient trusts	16	14	0	1	1	93%

Full details can be found in appendices 1-5.

Summary of Phase 1 Nurse Establishment Review (September 2019 – April 2020)

A nursing and midwifery establishment review was commissioned by the Director of Nursing & Quality and Director of Improvement in September 2019. This was a result of;

- Significant concerns being raised within the Urgent Care Division in relation to registered nurse staffing levels
    - No safe or sustainable approach to roster management and deployment
- Trust recovery programme initiated, early assessment identified high nurse spend compared to peer
- Need to resolve outstanding issues (including CQC compliance in relation to ED staffing)

Early indications from the assessment made into Urgent Care demonstrated that establishments were out of date for the activity and acuity of patients in most areas. The service models where changing in response to the Emergency and Urgent Care pathways; however these pathways had not received appropriate oversight and agreement from the Executive which has compounded the discrepancy between resource and patient requirements. Roster templates did not reflect the needs of any ward or department and short notice deployment of staff had become unsustainable, compounding the higher than expected turnover in 'hot spot' areas, adding to an already difficult vacancy gap. There was also very little effective budgetary control.

Assessment of NHSE/I benchmarking data evidenced high spend on nursing and midwifery staff despite the significant deficit in CHPPD being delivered in adult inpatient wards and departments. This indicated that the

resource was available but not aligned to the activity and acuity to meet patients' needs.

In response the Director of Nursing & Quality and the Director of Improvement asked for a collaborative establishment review of all inpatient areas to be undertaken (in phases) to bring the total nursing and midwifery budgets back in line with 2018/19 spend, whilst ensuring safe staffing levels across all services, wards and/or departments to deliver safe, quality care consistently and to enable redeployment of the resource to resolve. This was achieved by:

- Design of safe roster templates for the acuity and dependency of patients frequently seen;
- Redeployment of resource to invest in under established, high risk areas to mitigate risk and improve patient experience;
- Align the template to the 2018/19 budget (new methodology developed); and
- Identify efficiency savings, nursing establishments and specific areas requiring investment.

The review spanned Nursing and Midwifery (registered and unregistered) in the following services:

- Urgent Care (including ED, GPU and AMU)
- Planned Care (including Outpatients & Theatres)
- ICP (excluding Hospital@Home, Rapid response and Integrated Discharge team)
- Maternity (including inpatients & community)
- Paediatrics (including CAU)

Table 5: Establishments included in the review and saving realised

Area	**Savings (000s)**
General wards	£1,322
GPU (in ED footprint)	£239
SAU (monies held in reserve)	£175
UTC Streamer (band 7 vacancy)	£37
UTC CWP SLA (notice given)	£75
Bluebell (additional band 7 quality post)	£53
Nurse Specials budget	£518
Ward 54 (IMCU) closure	£804
CCU reconfiguration	tbc-Phase 2
Site Management team	tbc-Phase 2
Endoscopy	tbc-Phase 2
UTC closure	tbc-Phase 2
Critical Care Unit (including outreach)	tbc-Phase 2
Specialist Nurse Review	tbc-Phase 2
Total savings	**£3,224**
Ward reinvestments (*see table 2)	£1,116
Net Savings (phase 1)	**£2,107**
Target savings	£1,439
Over achievement	£669

A total saving of £3.2m has been made, this is largely a result aligning the safe staffing template to the budget

(£1.3m) and applying the updated methodology which allows for 80% of shifts to be filled using long days (most commonly seen in wards and departments). Where short shifts are still worked, the times have been changed to reflect up to date working practice, which has resulted in 1.0 hours less 'paid time' per short shift.

£1.1m has been reinvested into the ward budgets (breakdown listed in table 6) which has allowed for an increase in nursing numbers in 5 different ward areas, improving safety, quality and experience for both staff and patients. As staffing templates are now aligned to the acuity and dependency of patients (based on need) it has allowed for the nurse specials budget to be taken as a saving.

Overall Net Saving for phase 1 of the establishment review is £2.1m.

Table 6: Reinvestments in wards to maintain safe staffing levels

Ward	Rationale	Investment (000s)
Ward 44	NA hours (under established)	£27
Ward 33	Increase in beds (RN and NA hours)	£113
Ward 45	Establishment never fully funded and change in dependency of patients (RN and NA hours)	£136
Ward 52	NA hours (under established)	£136
Ward 50	NA hours	£352
Ward 51	NA hours	£352
Total		**£1,116**

During the establishment review a number of investments outside of the ward setting where agreed by the Executive Directors (see table 7), these relate to CQC regulations, safe operating models in the Emergency and Urgent Care pathway and changes in the nursing structure to strengthen oversight and professional leadership.

Table 7: Investments needed- links to 2020/21 investment paper *(those with an * have been prior approved)*

Area	Investment needed (000s)
ED including paediatric	£523*
AMU (5 day model for medical take)	£289*
SAU (5 day model)	£175*
Lead CNS & DDoN post	£27*
Adult Complex Care	£85*
Ward 34 (additional 5 beds)	£283
Rapid Response 6 WTE Band 2 (not recurrently funded)	£tbc
Safeguarding children's (band 6)	£46
Paediatric rotational post (band 6)	£46
ESSU 7 day service	£tbc
Infection Prevention and Control team	£160 -£210 (depending on model)

The total committed through prior Executive agreement is £1.1m, with the remaining items under

consideration. The savings identified have not only allowed for the financial recovery target to be met (£1.439m), full year effect 2020/21 for nursing and midwifery, but has also identified a substantial sum in addition (£669k) to add to the financial recovery plan.

For full details of the Nurse Establishment Review (phase 1 outputs and next steps), please refer to separate Board paper.

Nursing and Midwifery workforce changes in response to COVID -19

The Central Workforce Team became operational on the 6th April 2020 in response to the many challenges that arose in line with the COVID-19 pandemic outbreak. The office is open from 6am to 9pm 7days a week. The formation of the team has allowed workforce planning and deployment to be centralised and has a focus on providing full oversight on staff sickness and absence, this is with a view to providing safe, equitable staffing across the organisation in line with our patient acuity. This service has been established by utilising registered and unregistered nursing staff requiring redeployment due to COVID -19 risks.

Main functions include (not are not limited to):

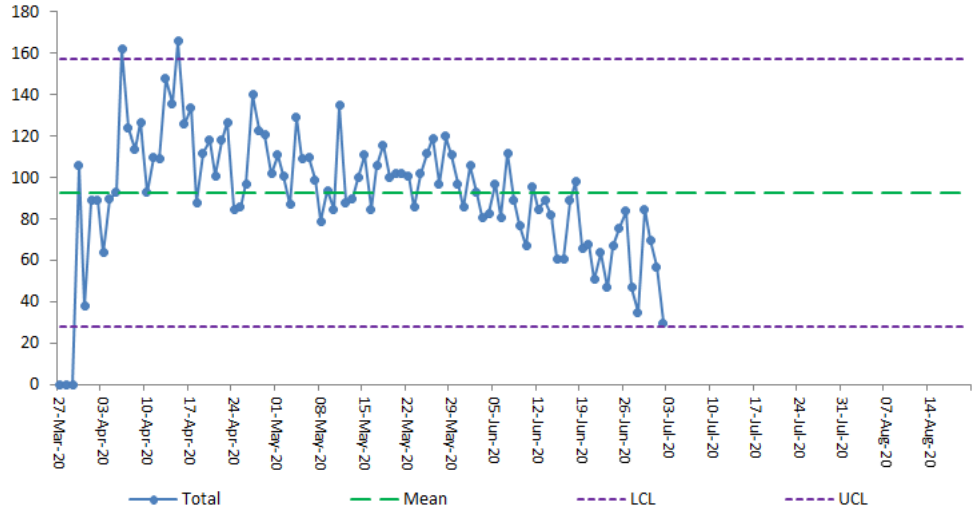
1. **Central workforce Team Function**

Absence Management

Absence reporting- is now centralised through the team call centre, welfare checks are made to staff off sick on day 3 or 4, for those isolating, a call is made on day 7 with further checks taking place every 3-4 days thereafter, these calls or checks are now logged electronically in e-roster in the individuals record. Staff who are symptomatic with COVID are referred immediately to the screening team. This has taken a huge workload off the ward and department managers in hours and the site coordination team out of hours (as shown in graph 15).

Absence recording – any absence, irrespective of reason is now recorded on both the e-roster and on ESR by the call centre; immediately after the call, providing more timely and accurate reporting and analysis. Staff with complex or ongoing absence reasons continue to be overseen by line managers with HR support.

Graph 15: Absence calls received to call centre since established on 6th April 2020



Roster Management

Roster management – all nursing rosters are currently being managed by the team. Although rosters provide staff with 6 weeks of duties, the team focus on a 2 week forward view. Staff moves in relation to short notice

absence are made one week in advance where ever possible. The team are working off the agreed staffing establishments (following the review). However, in response to COVID -19 intensive care and the respiratory unit have bespoke (increased roster templates) due to the number and complexity of patients.

Daily staffing review – takes place throughout the day to address any changes in rosters. Staffing is reviewed in conjunction with SafeCare and tele-tracking. Skill mix of staff, total number on duty and take charge duties is always taken in to account. For nurses who work in departments outside of the ward, who have been deployed to wards to support, their usual area of work and/or specialty has been added to the roster to make this visible.

Temporary redeployment of staff

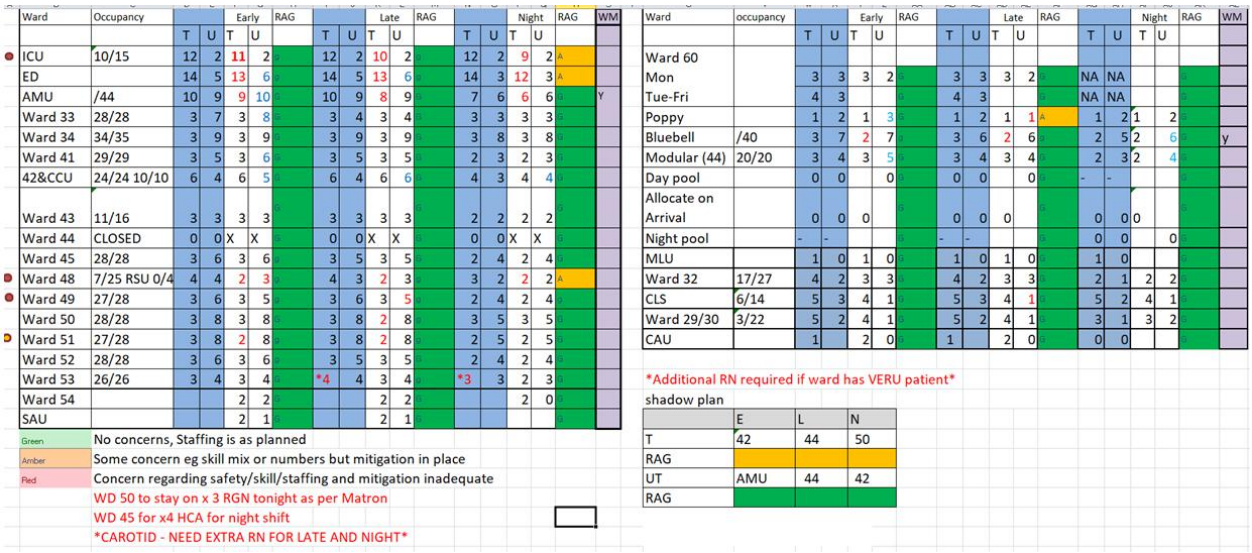
Staffing assurance - a staffing SitRep (see chart 11) is now being produced twice daily at 08.00 and 20.00 to evidence the nurse staffing levels across the organisation. This is rag rated and provides assurance to the Executive Directors and Senior Operational leads.

Aspirant Nurses – are pre-registration nurses in their final 6 months of training (transitioning) who were deployed during this reporting period (alongside other 2nd and 3rd students - see table 8)) into paid placements. These staff were placed on roster in a new role to make them visible in numbers but also to clearly identified this group who remained in training, and who needed support for their programme outcomes and could not be redeployed elsewhere.

Table 8: Students on paid placement during COVID -19 response

Student Deployment	Numbers
3rd year transitional student nurses	50
3rd year student nurses (March '18 cohort)	30
2nd year student nurses	69
Midwifery students	13

Chart 11: Example of twice daily staffing SitRep



Ward	Occupancy	Early T	Early U	Late T	Late U	Night T	Night U
ICU	10/15	12	2	11	2	12	2	10	2	12	2	9	2
ED		14	5	13	6	14	5	13	6	14	3	12	3
AMU	/44	10	9	9	10	10	9	8	9	7	6	6	6
Ward 33	28/28	3	7	3	8	3	4	3	4	3	3	3	3
Ward 34	34/35	3	9	3	9	3	9	3	9	3	8	3	8
Ward 41	29/29	3	5	3	6	3	5	3	5	2	3	2	3
42&CCU	24/24 10/10	6	4	6	5	6	4	6	6	4	3	4	4
Ward 43	11/16	3	3	3	3	3	3	3	3	2	2	2	2
Ward 44	CLOSED	0	0	X	X	0	0	X	X	0	0	X	X
Ward 45	28/28	3	6	3	6	3	5	3	5	2	4	2	4
Ward 48	7/25 RSU 0/4	4	4	2	3	4	3	2	3	3	2	2	2
Ward 49	27/28	3	6	3	5	3	6	3	5	2	4	2	4
Ward 50	28/28	3	8	3	8	3	8	2	8	3	5	3	5
Ward 51	27/28	3	8	2	8	3	8	2	8	2	5	2	5
Ward 52	28/28	3	6	3	6	3	5	3	5	2	4	2	4
Ward 53	26/26	3	4	3	4	*4	4	3	4	*3	3	2	3
Ward 54				2	2			2	2			2	0
SAU				2	1			2	1				

Green	No concerns, Staffing is as planned
Amber	Some concern eg skill mix or numbers but mitigation in place
Red	Concern regarding safety/skill/staffing and mitigation inadequate
	WD 50 to stay on x 3 RGN tonight as per Matron
	WD 45 for x4 HCA for night shift
	CAROTID - NEED EXTRA RN FOR LATE AND NIGHT

Ward	occupancy	Early T	Early U	Late T	Late U	Night T	Night U
Ward 60													
Mon		3	3	3	2	3	3	3	2	NA	NA		
Tue-Fri		4	3			4	3			NA	NA		
Poppy		1	2	1	3	1	2	1	1	1	2	1	2
Bluebell	/40	3	7	2	7	3	6	2	6	2	5	2	6
Modular (44)	20/20	3	4	3	5	3	4	3	4	2	3	2	4
Day pool		0	0		0	0	0		0	-	-		
Allocate on Arrival		0	0	0		0	0	0		0	0	0	
Night pool		-	-			-	-			0	0		0
MLU		1	0	1	0	1	0	1	0	1	0		
Ward 32	17/27	4	2	3	3	4	2	3	3	2	1	2	2
CLS	6/14	5	3	4	1	5	3	4	1	5	2	4	1
Ward 29/30	3/22	5	2	4	1	5	2	4	1	3	1	3	2
CAU		1		2	0	1		2	0	0	0		

Additional RN required if ward has VERU patient

shadow plan

	E	L	N
T	42	44	50
RAG			
UT	AMU	44	42
RAG			

2. Corporate Recruitment Function

To ensure that all registered and unregistered nurse vacancies are appropriately filled at the earliest opportunity and that a robust recruitment plan is in place for anticipated future nurse vacancy. The Recruitment Officer (currently leading the international programme of work), has been based in the centralised team and working closely with ward and department managers to support the move back to ward based recruitment (rather than corporate) and rolling adverts. Student nurse recruitment (early university engagement and offers) remains with the Practice Development Team but supported by the Recruitment Officer. All recruitment plans are based on the revised nurse establishment models and future development plans for clinical areas. This has been very successful with 33 (out of 50) aspirant nurses choosing to stay at the Countess of Chester for their first registered nurse post, many of which have been supported during the past 6 months to undertake their paid placements in the areas which they have a substantive job. The international recruitment has been delayed due to travel and visa applications during the pandemic but is now back on track to have 3 cohorts (total of 55 registered nurses) in posts with their OSCE achieved and NMC PIN issued by April 2021 (cohort 1 by December 2020, cohort 2 by February 2021 and cohort 3 by April 2021).

Table 9: Overview of the international recruitment activity

Number of applicants								
Received	Rejected	Unable to contact for interview	Interviewed	Unsuccessful	Offer made	Withdrawn	On Hold	**Offer accepted**
146	34	4	108	36	72	12	5	**55**

3. Staff Welfare Function

The team provide oversight for all nursing staff risk assessments, including staff that are shielding (or returning) and those who require redeployment for other health related risks.

New services and teams

In addition to the Centralised Nursing Workforce team a number of other services have been established and will need to be maintained as part of the on-going COVID-19 operational plan, these services do not have an established budget or teams and are at present a cost pressure and being supported by registered and unregistered nurses from other areas (having an impact on staffing levels elsewhere). These teams include:

- Screening Service (swabbing and antibody testing)
- Swab tracking team
- Family Support Service
- Jupiter Hood Decontamination team (including 5's)
- Floor walking team
- Centralised Fit Testing team

Furthermore a change in the elective care pathways to manage infection status and risk has resulted in more areas needing to be opened to safely cater for a range of COVID-19 pathways (red, blue and green). Where possible existing staff have been deployed to support the additional areas but this has resulted in the use of temporary staff and backfill has been needed elsewhere.

Conclusion

Considerable work in relation to safe staffing levels has been undertaken during this reporting period and this has been in despite of the national emergency. Although we continue to hold more vacancies that expected (45.55 FTE) this is a reduction (67 FTE) from in the previous reporting period. With the aspirant nurses and the international recruits there are currently 88 FTE in the pipeline which will stabilise the vacancy gap and provide a contingency for any attrition, turnover and the opening of additional capacity/services. However, it is important to note that the lead in time for these staff being deployed with NMC PIN numbers into the clinical area extends to April 2021. Sickness and absence rates (particularly in light of COVID -19) still need to be considered and the redeployment of staff to COVID secure areas or none patient facing role does create a further pressure.

It is clear that the hospitals response to COVID-19 has positively impacted on the number of CHPPD provided to patients, with a significant improvement demonstrated across all adult inpatient areas between April – June 2020. However, with the re-set and restoration programme it is expected that CHPPD will fall back to pre-COVID levels, the work undertaken in the establishment review and the recruitment programme will ensure that the areas previously reported as a concern will continue to be addressed.

When triangulating staffing with key quality and safety measures, falls and pressure ulcers have remained within expected variation, with some improvement noted in the moderate harm categories but this does not have statistical value at present. Significant improvement has been noted in the Ward Accreditation System, with more wards achieving outstanding ratings and improvement seen in one domain or more. 3 wards had a reduced rating and a separate piece of work is currently underway to explore the reasons for this.

Improvement has been noted across all NQB and NHS Improvement safe staffing standards, with the lowest compliance (80%) seen in the adult inpatient measures, this is the smallest data set which includes 10 standards. The 2 outstanding measures have plans in place to address, 1 will be completed by December 2020 taking compliance to 90% and the remaining 1 forms part of phase 2 and 3 of the establishment review which will be concluded by April 2021.

Phase 1 of the nurse establishment review has been concluded during this reporting period and staffing numbers have been increased in 5 ward areas and within the emergency and urgent care pathway (ED and AMU). The savings identified have not only allowed for the financial recovery target to be met (£1.439m), full year effect 2020/21 for nursing and midwifery, but has also identified a substantial sum in addition (£669k) to add to the financial recovery plan.

The COVID-19 surge has created several challenges in managing safe staffing levels across all wards, departments and services (as described) but the formation of the Centralised Nursing Workforce team has been integral in the day to day management of the staffing resource as well as the 2 week forward planning view. This function has also provided oversight and assurance that staffing levels have been maintained and that mitigation is in place for any area not achieving the required levels.

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1. Beech et al (2019) Closing the gap: Key areas for action on the health and care workforce. Available at: https://www.kingsfund.org.uk/sites/default/files/2019-03/closing-the-gap-health-care-workforce-overview_0.pdf

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Date paper written: 14th August 2020

Quality Governance Group is asked to note the content of this paper for assurance.

Appendix One: Emergency Department External Nursing Review (action plan updated July 2020)

Recommendation	Status	Expected date of completion	Comments
Right Staff			
Review the numbers and responsibilities of Band 7 and ENPs	Complete	NA	Roles and responsibilities revised and launched, meeting held with Director of Nursing & Quality to set out expectations and each team leader written to individually.
New roster template, effective from February 2020, should be reviewed and involve Finance to ensure this is aligned to the budget	Complete	NA	Included as part of phase 1 of establishment review.
Further review of staffing requirements is undertaken following completion of the refurbishment of the Department	Complete	NA	Included as part of phase 1 of establishment review.
To assist with the determination of staffing requirements using professional judgement and considering the areas to be staffed, a suggested spreadsheet is attached to this report to assist with this	Deferred	NA	Use of spread sheet considered, however not adopted as establishment review in progress and methodology in place in line with other areas, addressed as part of phase 1 of establishment review.
Consideration should be given to achieving compliance with guidance (NQB 2018b):			
• with an uplift of 25%	Not achieved	April 2021	Will be included in phase 2 and 3 of establishment review.
• skill mix of 85% RN	Not achieved		Day shift: 77% RN to HCA ratio (this includes ENPs and is due to increasing HCA numbers) Night shift: 82%
• staffing requirement of 86.80 WTE is suggested –	Complete		Establishment review carried out and investment

72.80 WTE RN (at least 8.4 WTE of which should have ENP skills) and 14.0 WTE HCAs			made to ensure adequate staffing numbers.
There should be a named practice education lead within the ED to ensure training requirements are identified and met (NQB 2018b)	Complete	NA	1.0 WTE PDN band 6 establishment identified and post recruited to, post holders now in place.
Trust should also consider the employment of housekeepers to provide support to nursing staff and improve the service to patients. It is suggested this service covers the core hours and 1 per 12-hour shift x 7 days (the current uplift would provide adequate cover for this service) would require an establishment of 2.68 WTE	Completed	NA	Housekeepers x2 in post from April 2020 covering 7 day service excluding holidays.
A review of RN and HCA support for the ENP service should be undertaken to maximise the efficiency and patient flow through this service	Complete	NA	Establishment review completed, HCA support allocated by shift to ENP in minors, skills development programme now in place to bring all HCAs to band 3 level with associated competencies.
Right Skill			
Ensure the risk assessment and action plan to mitigate the risks of non-compliance with the RCPCH recommendations is available	Partially complete	September 2020	Action plan progressing – 10 WTE RCN will be recruited to by Sept 2020 which enables 1.7 nurses per shift. The shortfall is mitigated by core ED staff trained in PILS and revised and enhanced pathways to our Paediatric unit. Full gap analysis to RCPCH standards in draft and awaiting ratification.
There is a need for role clarity around team leader/ENP function – consideration should be given to increasing the ENP numbers would increase the knowledge base,	Complete	NA	There is now clarity on how these roles differ. Matrix developed and implemented for what staff progression and career pathways are.

staff flexibility, job satisfaction and improve succession planning			
Clinical Educator should undertake training needs analysis and develop competency training programme to ensure adequate numbers of staff are available with required skill	Partially complete	September 2020	Training needs analysis has been developed, data being collected. Competency based documents have been designed and rolled out to staff to start completing.
Roster rules should reflect the number of staff with the required skills on each shift to ensure any shortfall is visible when the rosters are analysed prior to approval. An example of this would be: • take charge skills are assigned to appropriate staff and there should be one Band 6/7 nurse on duty with this skill on duty each shift and one member of staff with an ATLS skill on duty each shift	Partially complete	October 2020	Take charge shift is incorporated. However with regards to other skills as ATL /APLS and triage skills these need to be incorporated and will run in conjunction with the completion of the TNA.
Right Place Right Time			
Further review of the roster templates, rules and skill requirements for each shift/day of the week following completion of the refurbishment of the Department	Complete	NA	Completed.
Ensure staff are rostered to work in all areas of ED to maintain skills and competence	Complete	NA	Allocation sheet and been devised and clear path way of progression through department written.
When reviewing the roster policy, the governance arrangements and individual responsibilities of the roster creators/approvers should be clarified to ensure ownership and adequate oversight of the rosters	Deferred	NA	Grip and control regained over roster management, build and approval, limited access to create, change and authorise changes, this will not be rolled out again to wider band 7 team for the foreseeable future.
Consideration should be given to retrain senior staff in the use and functionality of the eRoster system to	Deferred	NA	Grip and control regained over roster management, build and approval, limited access to create, change

ensure the efficient and effective deployment of staff in the Department			and authorise changes, this will not be rolled out again to wider band 7 team for the foreseeable future.
Regular check and challenge meetings may be beneficial to monitor compliance with rostering key performance indicators, however if this may need investment to increase the size of the eRoster team	Partially completed	January 2021	ADoN for urgent care checks and challenges rosters each month prior to authorisation. Roster KPI work has been delayed in response to COVID-19, this will now be prioritised during Q3.
Measure & Improve			
Consideration should be given to the development of local quality dashboard specific to ED	Complete	NA	4 hour timeline KPI launched and Qlikview dashboard developed and visible in all areas, ED specific 'Care Assurance Framework' developed as part of the Ward accreditation System initial assessment undertaken as baseline, improvement work started.
Review the ED safety checklist to include the omission regarding notification of and communication with next-of-kin, safeguarding concerns etc. Compliance with the use of this should be audited regularly	Complete	NA	This is audited regularly and results demonstrate consistent compliance.
Regular reviews of the efficiency of roster and the inclusion of the staff metrics available from the eRoster system – this should include compliance with mandatory and job specific training	Complete	NA	Mandatory training is regularly monitored and staff reminded of compliance.
Culture & Leadership			
There appears to be a need to clarify the roles and responsibilities of the senior nursing staff within the ED	Complete	NA	Roles and responsibilities revised and launched, meeting held with Director of Nursing & Quality to set out expectations and each team leader written to individually.
Training in the process of roster approval and analysis is	Deferred	NA	Grip and control regained over roster management,

required			build and approval, limited access to create, change and authorise changes, this will not be rolled out again to wider band 7 team for the foreseeable future.
It is suggested that Department meetings – nursing as well as meetings of the wider team would improve communication	Complete	NA	Monthly meeting are held with staff.
Ensure that team leaders have sufficient management time allocated and any delegated responsibilities are appropriate	Complete	NA	As from August band 7s will be allocated some management time.
Improve recruitment and retention of staff within the ED it may be worth considering setting up a rotation between ED/Medical/Surgical Assessment Units/Critical Care	Complete	NA	Department now fully recruited (last new starter due in September 2020) and no resignations since February.

Appendix Two: National Quality Board (2018) An improved resource for adult inpatient wards in acute hospitals

Recommendation	Compliance	Date	Evidence and/or actions
A systematic approach should be adopted using an evidence-informed decision making tool triangulated with professional judgement and comparison with relevant peers.	Achieved	NA	SafeCare uses NICE recommended 'Shelford Safer nursing care' tool. Acuity census is taken twice daily to measure number of care hours needed. Data collected is used to inform staffing decisions in real-time alongside professional judgement.
A strategic staff review must be undertaken annually or sooner if changes to services are planned.	Achieved	NA	Annual staffing assurance report and 6 monthly progress/update Annex report presented to Board of Executive Directors. Nurse Establishment review undertaken during 2019/20.
Staffing decisions should be taken in the context of the wider registered multi-professional team.	Achieved	NA	Integrated multi-professional staffing models adopted and in place for integrated care partnership and EMU, pharmacy technicians integrated into a number of acute ward teams.
Consideration of safer staffing requirements and workforce productivity should form an integral part of the operational planning.	Achieved	NA	This is being strengthened with a formal governance process to ensure operational plans are implemented with the required staffing model (+/- short, medium and long term plans). This now includes CNS/ANP job planning and training requirements to support delivery of the Trusts Clinical Strategy.
Action plans to address local recruitment and retention prioritises should be in place and subject to regular review.	Achieved	NA	Recruitment & Retention plans in place, supported by comprehensive work programme.
Flexible employment options and efficient deployment of staff should be maximised across the hospital to limit the use of temporary staff.	Achieved	NA	Completed establishment review in 2019/20, roster templates updated to reflect numbers needed, uplift allocated into individual budgets. Centralised Nursing Workforce team established as part of COVID -19 operational response. Twice daily safe staffing SitRep completed. Staff risk assessments determine offers for redeployment.

A local dashboard should be in place to assure stakeholders regarding safe and sustainable staffing. The dashboard should include quality indicators to support decision making.	Achieved	NA	Safe staffing and Quality Measures dashboard developed & in use (Qlikview), visibility on key indicators presented at Transformation Group, CHPPD dashboard being developed to compliment the Board Report and People vs Spend dashboard for Nursing and Midwifery Workforce Group is in draft.
Organisations should ensure they have an appropriate escalation process in cases where staffing is not delivering the outcomes identified.	Partially achieved	December 2020	Safe Staffing Policy and Escalation Cards under review.
All organisations should include a process to determine additional staff uplift requirements based on the needs of patients & staff.	Not achieved	April 2021	Current uplift is not reflective of patient and staff requirements and is not in line with national standard. This will be included in phase 2 and 3 of establishment review.
All organisations should investigate staffing-related incidents and their outcomes on patients and ensure action & feedback.	Achieved	NA	Risk Management system in use is Datix; this system incorporates all aspects of incident management. The online incident reporting form is simple to use and suitable for both clinical and non-clinical incident reporting. Staffing is a category and in addition every submission (regardless of category) has the section 'is this incident related to staffing'? The system allows the reporter to add detail that is specific to the incident. The Risk & Safety team send all low/no harm staffing incidents to the specific ward or departmental manager to review and action, this allows ownership, prompt action and feedback to staff. The Risk & Safety Leads monitor incidents that have caused moderate and above categories of harm, they then produce an SBAR's for the Serious Incident panel who then decide upon the level of action required. Any action plans that form part of a Level 1 or 2 Investigation are monitored by the Divisional Governance Board until completed and are signed off by the CCG.

Appendix Three: National Quality Board (2017) Safe, sustainable and productive staffing: An improvement resource for maternity services

Recommendation	Compliance	Date	Evidence and/or actions
Boards are accountable for assuring themselves that appropriate tools (such as the NICE-recommended Birthrate Plus (BR+) tool for midwifery staffing) are used to assess multi-professional staffing requirements.	Achieved	NA	Birthrate+ establishment review completed during 2018, acuity based tool now in use continuously.
Boards are accountable for assuring themselves that results from using workforce planning tools are cross-checked with professional judgement and benchmarking peers.	Achieved	NA	Annual staffing assurance report and 6 monthly progress/update Annex report presented to Board of Executive Directors. Midwifery Establishment review using Birthrate+ tool undertaken during 2018. Professional judgement using national frameworks to inform the triangulation of evidence provided. Workforce planning is undertaken in conjunction with the Trusts workforce team and local universities (supported by wider HEE work streams). Current projections imply that there will be limited growth in numbers needed over the next 12 months; however changes in skill mix may be required to support new models of care. Benchmarking with peer groups and national providers can be accessed through the NHSi Model Hospital portal and is received at the Nursing and Midwifery Workforce group for discussion/review.
Boards must review midwifery staffing annually, aligned to their operational and strategic planning processes and review of workforce productivity, as well as a midpoint review every six months in line with NICE guideline NG4.	Achieved	NA	Staffing reviewed conducted 6 monthly, this now uses an evidenced based nationally recognised tool (Birthrate+). Reviewed in line with activity, capacity and occupancy both current and potential future service developments.
Boards are accountable for assuring themselves that staffing reviews use the RCOG, RCoA and OAA guidelines on effective maternity staffing resources.	Achieved	NA	
Boards are accountable for assuring themselves that sufficient staff have	Achieved	NA	Midwifery staff undertake an annual appraisal where a detailed discussion takes place in relation to training required to maintain or advance development to support

attended required training and development, and are competent to deliver safe maternity care.			professional and service objectives, this includes all relevant mandatory training. Rotation of staff to support service needs, ensuring a competent and skilled workforce that is transferable across the maternity pathway.
Organisations should have action plans to address local recruitment and retention priorities, which are subject to regular review.	Achieved	NA	Recruitment & Retention plans in place, supported by comprehensive work programme.
Flexible employment options and efficient deployment of trained staff should be maximised across the hospital to limit numbers of temporary staff.	Achieved	NA	Flexible model has been adopted across maternity services, with midwives working across the full range of the maternity pathway, spanning hospital and community, allowing for a flexible and transferable workforce. Flexible working arrangements are available and maternity currently operates an open rostering system allowing for greater staff choice in shift preferences. Only minimum (very occasional) temporary staffing required to support required fill rates (registered and unregistered).
Organisations should have a local dashboard to assure stakeholders about safe and sustainable staffing. The dashboard should include quality indicators to support decision-making.	Achieved	NA	Safe staffing dashboard developed & in use.
Organisations should have clear escalation processes to enable them to respond to unpredicted service needs and concerns about staffing.	Achieved	NA	Escalation process for Midwifery is enacted at times of high activity including deployment of senior midwifery managers and specialist midwives to support the service as required. The policy is currently under review for adult inpatients but this will not affected the escalation process in Maternity Services.
Establishments should include an uplift to allow for the management of planned and unplanned leave to ensure that absences can be managed effectively.	Achieved	NA	Current uplift is not in line with national standard. However, operationally able to manage this effectively with resource available, annual leave rostered evenly throughout the year (in line with key performance indicators), established e-roster principles continue to be monitored and refined.
Organisations must have mandatory training, development and education programmes for the multidisciplinary team, and establishments must allow for staff to be released for training and	Achieved	NA	Robust induction, preceptorship and CPD training programme available, staff rostered to attend.

development.			
Organisations must take an evidence-based approach to supporting efficient and effective team working.	Achieved	NA	All training and guidelines are evidence based. Rotation of staff to support service needs, ensures a competent and skilled workforce, this also allows for integrated team working across the maternity pathway.
Services should regularly review red flag events and feedback from women, regarding them as an early warning system	Achieved	NA	Red flags are reported in line with national requirements, all safety, quality and experience metrics are monitored and actioned (as required) through the Women's and Children's Governance Committee.
Organisations should investigate staffing-related incidents, outcomes on staff and patients, and ensure action, learning and feedback	Achieved	NA	Risk Management system in use is Datix; this system incorporates all aspects of incident management. The online incident reporting form is simple to use and suitable for both clinical and non-clinical incident reporting. Staffing is a category and in addition every submission (regardless of category) has the section 'is this incident related to staffing'? The system allows the reporter to add detail that is specific to the incident. The Risk & Safety team send all low/no harm staffing incidents to the specific ward or departmental manager to review and action, this allows ownership, prompt action and feedback to staff. The Risk & Safety Leads monitor incidents that have caused moderate and above categories of harm, they then produce an SBAR's for the Serious Incident panel who then decide upon the level of action required. Any action plans that form part of a Level 1 or 2 Investigation are monitored by the Divisional Governance Board until completed and are signed off by the CCG.

Appendix Four: National Quality Board (2018) Safe, sustainable and productive staffing: An improvement resource for children and young people's inpatient wards in acute hospitals

Recommendation	Compliance	Date	Evidence and/or actions
Adopt a systematic approach using an evidence-based decision tool, triangulated with professional judgement and comparison with peers.	Achieved	NA	Annual staffing assurance report and 6 monthly progress/update Annex report presented to Board of Executive Directors. Nurse Establishment review undertaken during 2019/20. SafeCare in use utilising the paediatric version of the 'Shelfold' tool to assess acuity in real-time to support decision making alongside professional judgement.
Undertake a strategic staffing review annually or more often if changes to service are planned.	Achieved	NA	Annual staffing assurance report and 6 monthly progress/update Annex report presented to Board of Executive Directors. Nurse Establishment review undertaken during 2019/20.
Staffing decisions should consider the impact of the role and carers.	Achieved	NA	A limitation of the paediatric SafeCare tool is that it does not account for the role of carers with regards to the child's requirements. Professional judgement is applied to staffing allocation on each shift to take this into consideration.
Factor into the establishment the requirement that all children and young people should have access to a registered children's Nurse 24 hours a day – particularly important in the NHS Acute Trusts and DGH's where the children's services are often a small department.	Achieved	NA	Minimum of 2 Registered Children's Nurses on any shift, evidence available on HealthRoster.
Take staffing decisions in the context of the wider registered multi-professional team.	Partially achieved	April 2021	Advanced practitioners are used to support the nursing numbers in the Children's Assessment Unit (currently under established), this leads to limitations in them delivering their usual duties (at an advanced level). A new model with supporting assistant practitioners is currently being explored, this will form part of phase 2 and 3 of the establishment review.
Safe Staffing requirements and workforce productivity should be integral to operational planning.	Achieved	NA	This is being strengthened with a formal governance process to ensure operational plans are implemented with the required staffing model (+/- short, medium and long term plans). This now includes CNS/ANP job planning and training requirements to support delivery of the Trusts Clinical Strategy.

Organisations should have plans to address local recruitment and retention priorities, and review them regularly.	Achieved	NA	Recruitment & Retention plan in place, supported by comprehensive work programme.
Hospitals should offer flexible employment and deploy staff efficiently to limit use of temporary staff, paying particular attention to the younger age profile of registered children's nurses.	Achieved	NA	Flexible working arrangements are available, with some agreements in place, these are reviewed annually. Staff deployment within our speciality area reducing the need for temporary staff (which is minimal).
Organisations should have a local dashboard to assure stakeholders about safe and sustainable staffing. It should include quality indicators to support decision-making.	Achieved	NA	Safe staffing and Quality Measures dashboard developed & in use (Qlikview), visibility on key indicators presented at Transformation Group, CHPPD dashboard being developed to compliment the Board Report and People vs Spend dashboard for Nursing and Midwifery Workforce Group is in draft.
All organisations should have a process to determine additional staffing uplift requirements based on the needs of patients and staff.	Achieved	NA	Currently 20% uplift, although not in line with national recommendation, with occupancy and acuity this can be managed within budgeted establishment.
All organisations should investigate staffing-related incidents and their effect on staff and patients, taking action and giving feedback.	Achieved	NA	Risk Management system in use is Datix; this system incorporates all aspects of incident management. The online incident reporting form is simple to use and suitable for both clinical and non-clinical incident reporting. Staffing is a category and in addition every submission (regardless of category) has the section 'is this incident related to staffing'? The system allows the reporter to add detail that is specific to the incident. The Risk & Safety team send all low/no harm staffing incidents to the specific ward or departmental manager to review and action, this allows ownership, prompt action and feedback to staff. The Risk & Safety Leads monitor incidents that have caused moderate and above categories of harm, they then produce an SBAR's for the Serious Incident panel who then decide upon the level of action required. Any action plans that form part of a Level 1 or 2 Investigation are monitored by the Divisional Governance Board until completed and are signed off by the CCG.
Feedback from children, and young people, families and carers, including complaints, should be an early warning	Achieved	NA	Friends and Family, thank you cards, PALS, Social Media (for example twitter and Facebook), comments are reviewed and actioned appropriately.

to identify service quality concerns and variation.		

Appendix Five: NHS Improvement (2018) Care Hours per Patient Day (CHPPD): Guidance for acute and acute specialist trusts

Recommendation	Compliance	Date	Evidence and/or actions
Do trusts have a clear process for Safe Staffing monthly returns to be quality assured as well as clinically validated within their organisation prior to submission? This will help ensure accuracy, completeness and robustness of reported CHPPD data.	Achieved	NA	Staff staffing data is pulled from the HealthRoster monthly. This is retrospective so all moves/shift changes are reflected in the information pulled. The data pulled is reflective of actual hours worked (day/night and registered/unregistered) by each ward/department. This information is validated by the Centralised Nursing Workforce Team and submitted through the Business Intelligence team to NHS Digital before the reporting window closes. ***NB. The CHPPD calculation used is the NHSi/NHSE definition in line with the Lord Cater metric not SafeCare which uses the Shelford tool.***
Are the ward and speciality names routinely checked for alignment across other national data returns?	Achieved	NA	This now forms part of the clinical validation and approval process undertaken by the Centralised Nursing Workforce Team.
Where there is a legitimate reason for a ward to be renamed, is there a Trust process for validating and updating the Model Hospital in accordance with the revised change form?	Not achieved	December 2020	Newly included standard (July 2019), internal process needed to address, action to be completed by December 2020
Is there a way of exploring the level of variation across the Trust for nationally reported CHPPD in the Model Hospital, and whether this is warranted or unwarranted?	Achieved	NA	Safe staffing and Quality Measures dashboard developed & in use (Qlikview), visibility on key indicators presented at Transformation Group, CHPPD dashboard being developed to compliment the Board Report and People vs Spend dashboard for Nursing and Midwifery Workforce Group is in draft. For CHPPD dashboard, information from the Model Hospital portal is used as a benchmark, any variation internally or against peer is identified.
Is there an understanding of reported CHPPD by ward or specialty compared to national averages and to similar wards at peer Trusts?	Achieved	NA	As above
Are ward establishments set using NICE endorsed evidenced based tools such as	Achieved	NA	Birthrate+ used for Maternity. SafeCare (Shelford tool) used in adults and paediatrics to support real-time decision

the Safer Nursing Care Tool (SNCT) and Birthrate Plus			making. National audit against Shelford tool (twice yearly) commenced in August 2020.
Are these in line with NQB and underpinned by auditable clinical judgement?	Achieved	NA	All reviews undertaken have been in line with the NQB expectations and validated by the Associate Directors of Nursing and Head of Midwifery and Paediatric Nursing.
Are such tools used consistently and exactly as instructed in the implementation guidance in an auditable manner?	Achieved	NA	Nationally validated tool used in SafeCare & fully embedded in line with guidance.
Is the set establishment as signed off at budget setting by finance, workforce, operational and clinical leads being expressed in terms of care hours (and could therefore be convertible to CHPPD) to enable comparisons and triangulation with nationally reported CHPPD?	Deferred	NA	Governance in place to ensure that establishments are now signed off annually at budget setting by finance, workforce, operational and clinical leads. Shelford tool is used to determine number of nurses needed (FTE using multipliers for acuity seen). There is no nationally validated tool that is available to convert CHPPD in establishments (FTE by band) at present.
Do trusts have systems and processes in place to capture the CHPPD that is planned on their daily roster?	Achieved	NA	SafeCare fully embedded and visibility available at ward, divisional and organisation level, with the establishment review and the 'tightening' of roster templates the data quality will improve moving forward.
Can this be reviewed on a shift to shift basis?	Achieved	NA	SafeCare fully embedded and visibility available at ward, divisional and organisation level.
Do trusts have systems and processes in place to capture the CHPPD that is actually delivered on their daily roster?	Achieved	NA	SafeCare fully embedded and visibility available at ward, divisional and organisation level.
Can this be reviewed on a shift to shift basis?	Achieved	NA	SafeCare fully embedded and visibility available at ward, divisional and organisation level.
Can this then be compared and tracked against establishment CHPPD?	Achieved	NA	Reports can be run out of the roster to track and compare CHPPD against establishment (required vs actual). This is visible in the Qlikview app.

Reviewing CHPPD on a daily and shift to shift basis can form a transparent and helpful basis for levelling and redeploying staff between wards.	Achieved	NA	This process takes place on a daily basis by the Centralised Nursing Workforce Team in real-time and in response to changes in staffing level and/or demand.
Daily and shift-to-shift comparisons, auditable, evidence-based methods that are clinically assured and clearly aligned with guidance are required to capture patient acuity and dependency.	Achieved	NA	SafeCare uses the validated Shelford tool; this has been rolled out to all adult and paediatric inpatient wards, using the nationally agreed multipliers to calculate required staffing. In critical care a regional dependency tool has been adopted until a national one is available and the ICS Standards for staffing are applied. In Maternity the Birthrate+ tool is used and in Neonates the BAPM standards are applied in relation to levels of care.

Appendix Six: Midwifery Safe Staffing Report (author Natasha Macdonald, Head of Midwifery)

Purpose: To provide an update to the Trust Board, of the 6 monthly safe staffing for the maternity service, this report informs the board on the midwifery staffing levels and whether they are adequately budgeted to meet the dependency and demand. For continuity and to comply with national recommendations the same methodology has been used; Birth Rate Plus.

Midwifery staffing

Safe Maternity Staffing is recognised in the following documents;

- Birth-rate Plus (the only calculating tool endorsed by NICE)
- Nice Safe Staffing (2016)
- NHS England NQB Safe Staffing documents (2017).

To ensure a safe service the following measures are in place;

- An escalation guideline which is enacted at times of high activity including deployment of senior midwifery managers and specialist midwives to support the service as required
- Rotation of staff to support service needs, ensuring a competent and skilled workforce
- Established e-Roster principles.
- Development of the workforce via the appraisal process to develop a staffing establishment that is competent for the activity/services to be delivered and identifying aspiring leaders
- On-going review of midwifery indicators as per NICE safe staffing guidance for red flag /adverse incidents with an established governance framework.
- Introduction of Birthrate + acuity tool in March 2019

Principles applied to the development of the Midwifery/Nursing Establishment

- Reviewed in line with activity, capacity and occupancy both current and potential future service developments for the financial year 2020/21
- Professional judgement using National frameworks to inform the triangulation of evidence
- Patient acuity and dependency
- Supernumerary Shift Coordinator (Safer Childbirth guidance 2007)
- 20% uplift for sickness absence, maternity leave and training and development

Additional key requirements to support the Midwifery Establishment:

- Ward Managers management time in line with trust guidance
- Supernumerary Midwife in charge of Central Labour Suite
- Screening Midwife
- Fetal Medicine Specialist Midwife
- 1.0 WTE Education Midwives to support mandatory training requirements and developments
- Care Support Workers
- Ward Clerk/Receptionists – to offer clerical support to the ward manager

The Midwife to mother ratio advocated by NICE is 1:29. However determination of an appropriate midwife to mother ratio is complicated by variation in activity and acuity across the service. In March 2019 we have introduced the Birth Rate Plus acuity tool (nationally endorsed) which helps evidence trends in activity.

Midwifery

The calculations are based on the information collected for the period January to December 2018
Methodology; Birthrate Plus (Ball & Washbrook), RCM Staffing Standard Guidance (2009)
Safer Childbirth (2007)

The annual births for the calendar year 2019 were 2376

During the full Birthrate plus review in July 2018, the Countess of Chester Hospital NHS Foundation Trust had over 50% of women in Categories 1V and V ratio

Case Mix Ratio	**No. Hospital Births**	**No. Home Births**	**Exports**	**Imports**
34	2345	31	Equal Imports	Equal Exports

Hospital Midwives

(no of hospital births / differentiated ratio **A = 68.9**
CLS+MLU+BBA births divided by 42 = 2345

Community Care
Total births divided by 98 **B = 23.9**

Home Births and Stand-alone MLU births

No. of births / 35
COCH HB 31 divided by 35 **C = 0.8**

Total Midwife Requirement
(A+B+C) **Total = 93.6**

Assessed Ratio
(Total births / clinical midwives required) 1:29

Management and Specialist roles 10% **8.1**

Issues considered within the review

- The development of continuity team to reach the 51% trajectory
- Increasing complexity/acuity of patients both our induction rate and section rate are steadily climbing (see appendix 1)
- Increasing and changing training and development requirements

- Safeguarding continues to be an increasing challenge and significant use of midwifery resources
- National guidance has impacted on pathways in particular the 'Saving Babies Lives' care bundle which has increased attendance at Triage with reduced fetal movements and increased the demand for serial scans which impacts on midwifery time

Major developments within the last 12 months

- Delivering the national target for continuity of care
- Implemented Saving Babies Lives Version 2
- CTG champion role 0.4 WTE recruited
- Bereavement Midwife 0.2 WTE recruited
- Community midwives providing continuity of care for women undergoing an elective section
- Increased midwifery input into Fetal Medicine unit
- Elective Caesarean section list successfully implemented
- Relaunch of the Midwife led unit
- Reintroduction of aromatherapy services

Main areas of risk

- We have seen a reduction in Welsh births in the last 2 years
- Neonatal unit currently downgraded to a level 1+
- Increasing resources needed to provide safeguarding support particularly in the community
- Implementation of the recommendations from the National Maternity Review (Better Births 2016) within current establishment and resources will be a challenge in particular continuity of carer across the whole pregnancy pathway; community hubs given that there is an growing expectation that maternity services pay for venues and uncertainty regarding the logistics of personalised budgets
- The continued challenge of contributing towards the Trust Cost Improvement Programme

Proposed developments in next 6 months

- Development of Case loading team for low risk women to achieve the 51% continuity target
- Review of escalation capacity
- Developing Perinatal Mental Health services
- Funding a band 6 governance support role for succession planning and to assist with complying with National Safety drivers.

Red flags

3 Unit closures in the last 12 months

Maternity Red Flags

January, February, March	
April, May, June	36
July, August, September	79
October, November, December	35

The maternity unit has seen an increase in midwifery red flags, (see Appendix 2) for what constitutes a maternity red flag), for delay in care but on review of this it is often relating to delay in critical activity which can occur due to no elective list capacity.

In the 9 month period from April 2019 147 red flags were reported, with 79 of these between July and September when activity was higher.

A significant amount of work has recently been undertaken in improving the midwifery red flags incident reporting. Maternity is a high reporting service.

The acuity and red flags are reviewed at the Women and Children's Governance Committee and all staffing red flags have a datix submitted and are reviewed by the Midwifery Matron.

This is a national working ratio used to benchmark the midwife to birth ratio and the recommended number is 1 midwife to 29.5 births (Birthrate Plus and RCM).

Midwifery services at the COCH midwife to birth ratio tends to be around 1:29 (Chart 1). This can fluctuate due to the number of deliveries divided by the funded establishment of midwives

Midwife to birth ratio January – December 2019 29 (Chart 1)

January	1:28
February	1:29
March	1:29
April	1:29
May	1:29
June	1:29
July	1:29
August	1:29
September	1:29
October	1:29
November	1:28
December	1:27

One to One Care in Labour

An increase in the induction of labour rates has affected the complexity of care women require. The local induction of labour rate is approximately 40% with the national being approximately 31.6% in 2017-2018 (NHS Digital 2018). Work is ongoing with Data collection to ensure we can capture the 1:1 care in labour.

Conclusion

This paper has demonstrated that the Trust has complied with the requirements to review Midwifery staffing level and report to the board on a 6 monthly basis. Using the birthrate plus methodology based on 2019-2020 births we require 93.6 WTE and we have 85.81 in post and budget for 87.1. It also recommends 10% for

management and specialist roles which equates to 8.1 and we have 7.9. Currently work is being undertaken at a corporate level and maternity services have been identified as an area requiring investment.

The Board is reminded that we have a rise in complexity of cases and a requirement to deliver maternity care in a different way where a minimum of 35% of women received care through a continuity model for all aspects of maternity care by 2020 and 51% by 2021. This is mandated by the Better Birth Maternity review and is also described in the NHS Contractual guidance 2020-21.

Appendix 1 – current staffing profile; Midwifery January 2019

Clinical Midwifery Staffing Profile

BAND	**WTE IN POST**	**WTE BUDGETED**	**VACANCY**	**OVER ESTABLISHMENT**
7	6.98	6.98	0	0
6	66.82	72.25	5.43	0
5	12.91	7.87	-5.03	0
	86.71	87.1	Total 0.4	

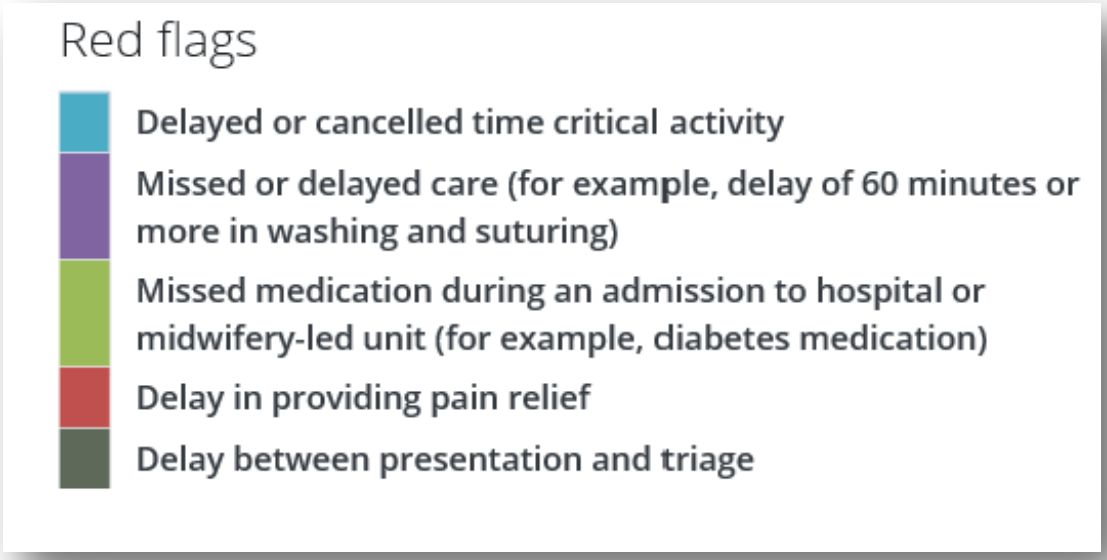
Clinical Midwifery Specialists
Current Staffing

BAND	**WTE IN POST**	**WTE BUDGETED**	**VACANCY**	**OVER ESTABLISHMENT**
8a Fetal Med	0.8	0.8	0	0
7 Screening	0.5	0.5	0	0
7 Feeding MW	1	1	0	
6 Smoking cessation	0.6	0.6	0	
Total	2.9	2.9		

Midwifery Managerial Profile

BAND	WTE IN POST	WTE BUDGETED	VACANCY	OVER ESTABLISHMENT
8a	1	1	0	0
7	4	4	0	0

Appendix 2


Red flags
Delayed or cancelled time critical activity
Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing)
Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication)
Delay in providing pain relief
Delay between presentation and triage

Countess of Chester Hospital NHS Foundation Trust

Meeting	**1st December 2020**		**Board of Directors**					
Report	**Agenda item 17.b**		**Director of Infection Prevention and Control Annual Report 2019/20**					
Purpose of the Report	Decision		Ratification	X	Assurance	X	Information	
Accountable Executive	Alison Kelly				Director of Nursing and Quality/ Director of Infection Prevention and Control (DIPC)			
Author(s)	Sam Walker				Lead Nurse – Infection Prevention and Control			
Board Assurance Framework	Q2	Quality						
Strategic Aims	Interim strategic objective: People are protected from abuse and avoidable harm							
CQC Domains	Safe, Effective, Caring, Responsive, Well Led							
Previous Considerations	Infection Prevention and Control Strategy Group, 25th August 2020 Quality & Safety Committee, 15 September 2020							
Summary	The 2019/20 DIPC annual report is a comprehensive overview of all elements of the Trust's infection prevention and control (IPC) programme of work. This provides an overall assessment of Trust compliance with the Health and Social Care Act 2008: code of practice on the prevention and control of infections, through a review of the systems, processes, developments and initiatives to support IPC compliance, in conjunction with a range of associated outcome and performance measures. These measures include surveillance, antimicrobial stewardship, policy review and development, audit, investigation and training and education. The emergence of SARS-CoV-2 and the developing global COVID-19 infection pandemic within year is also referenced. The Committee/Board is asked to note that although the Trust was able to demonstrate that systems and processes to support infection prevention and control are in place, it was not possible to demonstrate full compliance with these systems and processes at all times, in all areas, within year. A number of areas have been identified for inclusion within the Trust's HCAI/IPC improvement programme including compliance with policy for MRSA screening and hand hygiene, antimicrobial stewardship, challenges with the environment requiring refurbishment in multiple areas plus capacity for patient isolation, the release of revised national standards for healthcare cleanliness and the continued development/review of the corporate infection prevention and control assurance framework.								

	The report also identifies that although national HCAI reduction objectives have not been released for 2020/21, the delivery of high quality, safe and effective healthcare services, ensuring that avoidable healthcare associated infections do not occur, remains a key priority for the Trust, with particular reference to COVID-19 infection and the requirement for continuous improvement in healthcare associated infection risk reduction measures.
Recommendation(s)	The Board is asked to: • note the Trust's infection prevention and control objectives for 2020/21; • ratify the Director of Infection Prevention and Control Annual Report 2020
Corporate Impact Assessment	
Statutory Requirements	Meets NHSE/I and Public Health England guidance Supports compliance with the Health and Social Care Act (2008) Code of Practice on the prevention and control of infections and related guidance
Quality & Safety	Supports delivery of safe care, CQC and Public Health England requirements
NHS Constitution	Contributes to safety standards
Patient Involvement	Patient input not obtained for this report
Risk	Trust COVID-19 infection risk register in place, with specific IPC risk escalated through Divisions
Financial impact	Financial impact being monitored, especially regarding Capital improvements
Equality & Diversity	N/A
Communication	Document to be published on the website and intranet

NHS
Countess of Chester Hospital
NHS Foundation Trust

Director of Infection Prevention and Control Annual Report

1st April 2019 – 31st March 2020

1. Executive Summary

Infection prevention and control (IPC) is an essential aspect of quality healthcare provision. Making certain that we have robust systems and processes embedded at all levels of the organisation to ensure that avoidable infections do not occur, is crucial to routinely delivering safe, kind and effective care to patients.

In addition, antimicrobial resistance is recognised as an international threat, with the UK government being determined to ensure that access to working antimicrobials is sustainable into the future. This places an even greater focus on infection prevention as resistance to the drugs that we use to treat infections increases, rendering them ineffective.

The Trust is committed to maintaining the intensity of both infection prevention and control and antimicrobial stewardship, to ensure that risks associated with all healthcare associated infections are minimised, including infections such as C. difficile infection, MRSA bacteraemia and Gram-negative bloodstream infections, in support of the national objective to reduce the incidence of these infections. Monitoring and evaluation of the systems and processes aimed at reducing the risks associated with healthcare associated infection are essential to ensuring that high quality care is delivered in a safe and appropriate environment. Communication strategies play a key part in this, ensuring that resources are targeted appropriately and that the workforce remains informed, with learning and actions for improvement disseminated in real time.

During 2019/20, the Trust undertook a collaborative assessment with NHS Improvement as part of a healthcare associated infection review. This review provided a positive opportunity to identify what the Trust does well, as well as identifying areas where improvements in infection prevention and control could be achieved, in support of a continuous improvement programme.

The outcome of this assessment was a healthcare associated infection improvement plan that has been the focus of infection prevention and control activity and good progress was made towards achieving the objectives within this improvement plan within year. Some examples of the activity that has been undertaken include:

- Benchmarking local practice with other organisations to share ideas for improvement
- A review of the infection prevention and control assurance framework in alignment with the Health and Social Care Act (2008) Code of Practice on the prevention and control of infections and related guidance
- A review of the Infection Prevention Committee structure and associated governance processes
- Strengthening the role of the Matron in support of IPC activity at an operational level through collaborative working and a scheduled programme of walk rounds with the IPC Team, supported by delivery of a Matron workshop within year
- Work to strengthen antimicrobial stewardship systems and processes
- Strengthening links between infection prevention and control and delivering the fundamentals of care

- A review of the link practitioner programme and how this role can support improvements in practice
- Improving methods for sharing learning from healthcare associated infection investigations
- Programmes of work to support environmental improvements, including maintenance and environmental cleaning
- Developing local processes to support improvements in compliance with MRSA screening policy

The emergence of SARS-CoV-2 within year and the rapidly evolving COVID-19 infection pandemic also emphasises the requirement for infection prevention and control to be central to the delivery of healthcare, to minimise risks for patients, healthcare workers, visitors and the wider health economy.

The goal of infection prevention and control activity in response to the COVID-19 pandemic is to support the maintenance of essential healthcare services, by reducing the risk of transmission of this infection among patients and healthcare workers.

The aim is for:

- Rapid identification of cases through assessment and surveillance
- Early isolation (or cohorting if isolation is not possible) and referral for testing
- Clinical management to support recovery
- Adherence to standard infection prevention and control precautions plus transmission based precautions, to reduce the risks associated with transmission
- Early identification and sharing of any learning for continuous improvement

This approach to the management and control of COVID-19 infection is based on the fundamental principles of infection prevention and control and it is planned that the learning from this pandemic will be utilised to inform future infection prevention and control improvement plans for the Trust.

2. Infection Prevention and Control Arrangements

The substantive team structure within year was:

- 3wte Consultant Microbiologists, reducing to 2wte due to a post becoming vacant in 2020
- 1.4wte administrative support for Consultant Microbiologists
- 1wte Lead Nurse – Infection Prevention and Control
- 2wte Infection Prevention and Control Nurses
- 1wte Infection Prevention and Control Support Nurse – vacant post during April/May 2019
- 1wte administrative support for the Infection Prevention and Control Nurse Team

Dr Ken Mutton continued to provide locum Consultant Microbiologist cover on a reduced number of hours to support the Consultant Microbiologist service provision.

The role of Director of Infection Prevention and Control transferred to the Director of Nursing and Quality within year, providing regular reports to the Board of Directors on progress with key performance indicators and improvement plans.

Work to re-structure the Infection Prevention Committee commenced within year, as part of the collaborative work with NHS Improvement, with the aim being to ensure that the future of this

meeting aligns with revised organisational governance structure. Meetings continued to be held bi-monthly to progress infection prevention and control activity within the organisation.

3. Infection Prevention and Control Budget

There is Board approval to financially support infection prevention and control activity, including any identified outbreak of infection to ensure appropriate management and control.

Staffing budgets fall within Pathology/Corporate Nursing budgets, with finance also identified to support the ongoing training and development of the team.

4. Corporate Infection Prevention and Control Assurance Framework

During 2019/20, the Trust undertook a collaborative piece of work with NHS Improvement to undertake a review of the HCAI agenda, for a six month period commencing 1st April 2019.

Following initial discussions with the Trust relating to the CDI and MRSA position and a change in the DIPC leadership role, the Trust requested support to review the HCAI programme in a wider context with a focus on continuous improvement.

The review focused on helping the organisation to be assured that current processes for delivery against the Health and Social Care Act 2008: Code of practice on the prevention and control of infections and related guidance are robust and to assist in the development of an improvement programme that may include wider stakeholders.

The process concentrated on the 10 criteria in the Health and Social Care Act 2008 and the related key lines of enquiry, with the initial review including:

- Trust visits and walkabouts
- Attendance at key meetings
- Review of policy and documents
- Collaboration with Trust staff as part of the improvement offer
- Collaboration with external stakeholders to support the process e.g. Public Health England

The key output from this review was the development of a HCAI improvement plan that was the driver for Trust-wide IPC activity within year, including:

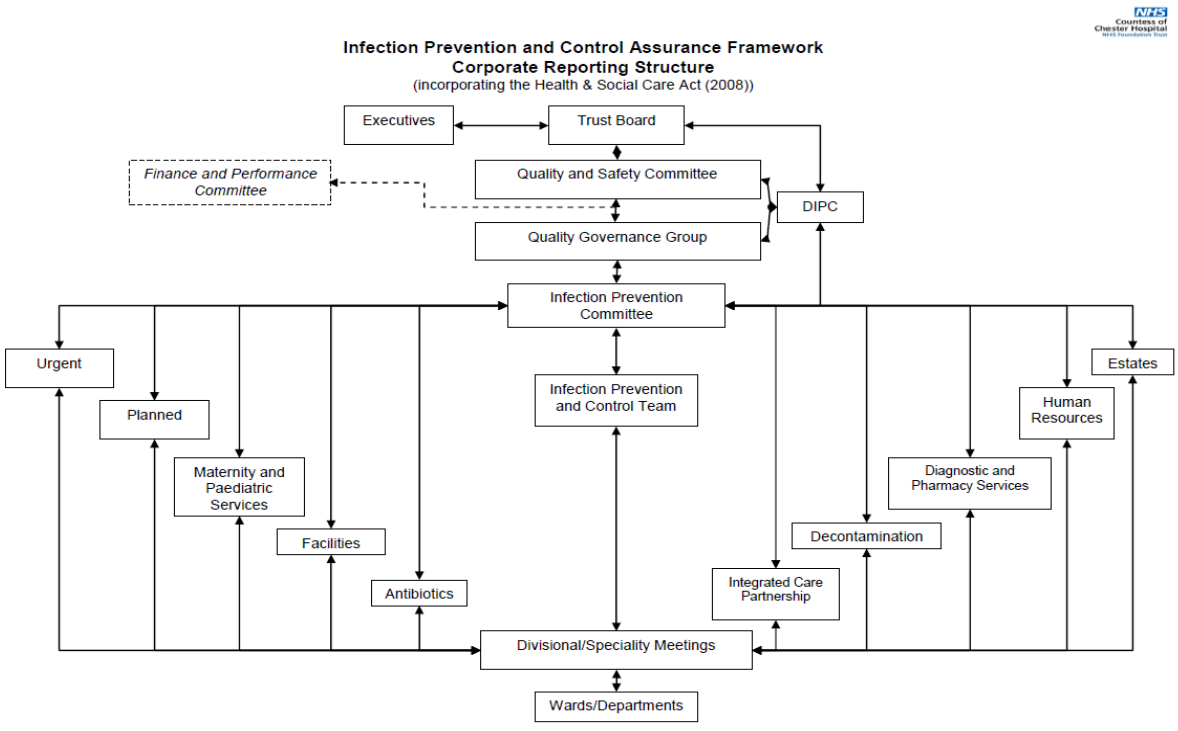
- Benchmarking local practice with other organisations to share ideas for improvement.
- A review of the infection prevention and control assurance framework in alignment with the Health and Social Care Act (2008) Code of Practice on the prevention and control of infections and related guidance.
- Strengthening the role of the Director of Infection Prevention and Control, including job plans and job description.
- A review of the Infection Prevention Committee structure and associated governance processes.
- Raising the profile and visibility of the Infection Prevention and Control Team.
- Ensure rapid shared learning from root cause analysis investigations.

- Strengthening the role of the Matron in support of IPC activity at an operational level through collaborative working and a scheduled programme of walk rounds with the IPC Team. This was supported by delivery of a Matron workshop within year.
- Work to strengthen antimicrobial stewardship systems and processes.
- Strengthening links between infection prevention and control and delivering the fundamentals of care.
- A review of the link practitioner programme and how this role can support improvements in practice.
- Improving methods for sharing learning from healthcare associated infection investigations
- Programmes of work to support environmental improvements, including maintenance and environmental cleaning.
- Introduction of 'bare below the elbows' policy for all staff entering into a clinical area, whether staff have a clinical or non-clinical role.
- Reviewing the infection prevention and control audit programme, including hand hygiene compliance monitoring and high impact interventions.
- Developing local processes to support improvements in compliance with MRSA screening policy.
- Developing an IPC communications strategy with the Communications Team.
- Refreshing all IPC related information leaflets.

In particular, the review of the infection prevention and control assurance framework remained an ongoing project throughout the year and further development of this has progressed into 2020/21.

The corporate infection prevention and control assurance framework within the Trust remains structured to ensure engagement and ownership at all levels of the organisation from Board to ward, with the operational process supporting the overarching Trust strategy of zero tolerance to avoidable healthcare associated infections.

Figure 1 Corporate Infection Prevention and Control Assurance Reporting Framework



4.1 Systems assurance

The Health and Social Care Act 2008: Code of practice on the prevention and control of infections and related guidance (July 2015) applies to all registered providers of healthcare and sets out the 10 criteria against which the Care Quality Commission (CQC) will assess registered providers on compliance with the infection prevention and control requirements, set out in regulation.

CQC regulation for infection prevention and control takes the following into account:

- Regulation 12(2h): Assessing the risk of, and preventing, detecting and controlling the spread of infections, including those that are health care associated
- Regulation 15 (2): The registered provider must, in relation to such premises and equipment, maintain standards of hygiene appropriate for the purposes for which they are being used

These 10 compliance criteria provide assurance that Trust-wide systems and processes are in place to support those practices that minimise risks associated with healthcare associated infection, including policy, training, audit, surveillance, cleaning, decontamination, governance, occupational health, laboratory services etc.

4.2 Outcome measures

Outcome measures can be used as a benchmark of standardised compliance with the systems and processes that are designed to reduce risks associated with infection prevention and control. Effective systems and processes to support infection prevention and control can be established within an organisation; however it is a combination of these systems and processes, plus routine compliance with these in practice that has the most significant positive impact on a reduction in the risk associated with healthcare associated infection.

It is important to note that measuring the number or rates of an infection as a performance outcome is not always an indicator of non-compliance with required system and process, as unavoidable infections do occur. This is measured through root cause analysis investigation for certain bloodstream infections and C. difficile infection.

There are a number of national and local outcome measures that the Trust uses to measure compliance with systems and processes to support continuous improvement and risk reduction, as detailed throughout this annual report.

4.3 Compliance self-assessment

The following table was developed as a method of providing a synopsis of the Trust's self-assessment of compliance with the systems and processes that are requirements within the Health and Social Care Act 2008: Code of practice on the prevention and control of infections and related guidance. This now includes the associated outcome measures as a more comprehensive snapshot of overall compliance.

Figure 2 Compliance with the Health and Social Care Act (2008): Code of practice on the prevention and control of infections and related guidance

Compliance criterion	What registered providers need to demonstrate	System	Outcome
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.		
Criterion 2	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.		
Criterion 3	Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.		
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.		
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.		
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.		
Criterion 7	Provide or secure adequate isolation facilities.		
Criterion 8	Secure adequate access to laboratory support as appropriate.		
Criterion 9	Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections.		
Criterion 10	Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection.		

It is evident from this self-assessment that the Trust has developed multiple system-wide systems and processes to support infection prevention and control at all levels of the organisation. Continuous improvement in infection prevention and control remains a key priority and working collaboratively with NHS Improvement within year has focussed on re-enforcing and developing existing infection prevention and control risk reduction measures including:

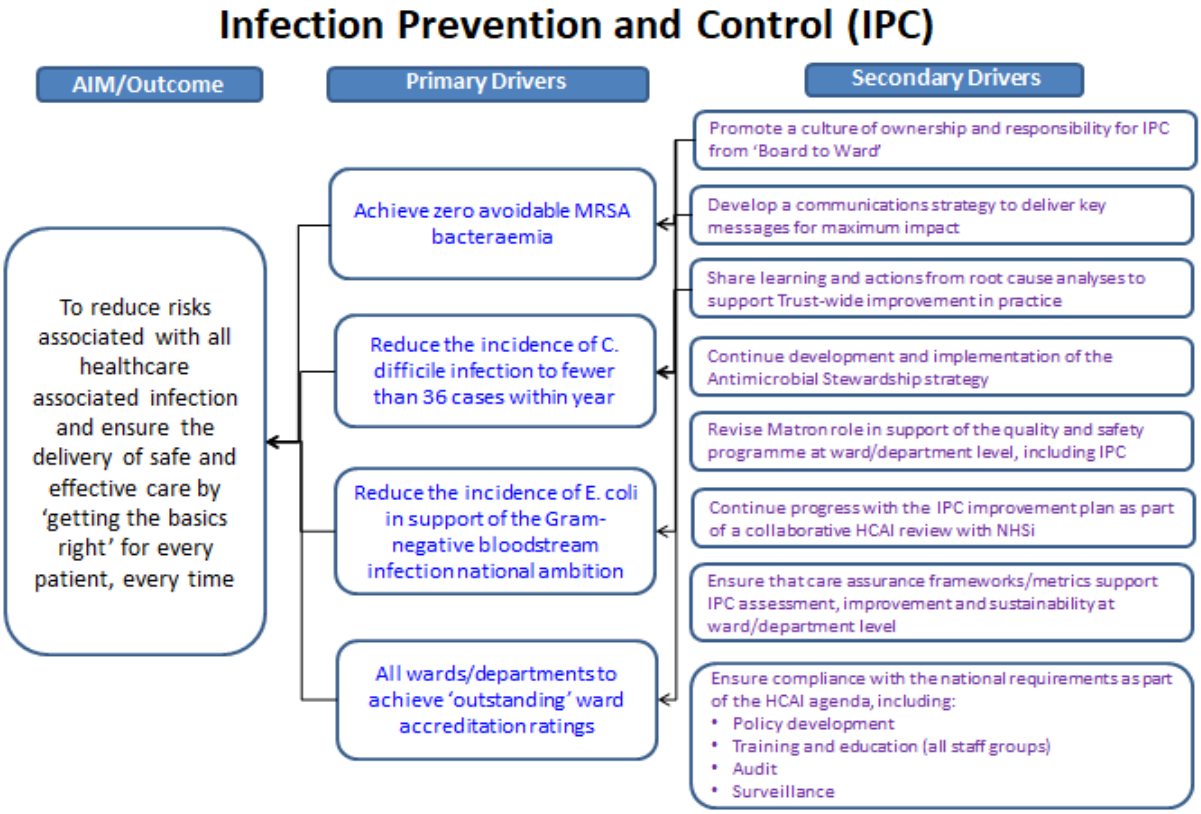
- Antimicrobial stewardship;
- Infection prevention and control policy supported by training and education;

- Robust programmes for audit, surveillance and investigation for early risk identification and action;
- A clean and appropriate environment for healthcare delivery, including appropriate decontamination of equipment; and
- Sharing learning through effective communication to support real-time improvement.

In addition, investigation for certain infections can provide valuable learning for focussed improvement, including process redesign and consideration of doing things differently. Rapid sharing of any learning from investigations has been a core theme within year and varied methods of communicating information have been used, to maintain awareness.

The HCAI improvement plan was developed to support continuous improvement for those criteria that outcome measures identify as priority areas for consideration, planning and action and good progress was made within year against the set objectives. The Trust aim for providing full assurance of compliance, is to be able to clearly evidence that we are getting everything right first time (and every time) for our patients.

Figure 3 Infection prevention and control – key Trust priority



Moving forwards into 2020/21 this improvement plan will be refreshed to incorporate the learning and improvements that have been identified through the Trust's response to the COVID-19 pandemic, including further development and review of the:

- COVID-19 infection prevention and control board assurance framework
- Infection prevention and control assurance framework in alignment with the Health and Social Care Act (2008) Code of Practice on the prevention and control of infections and related guidance

- Infection Prevention and Control Strategy Group
- Systems and processes for antimicrobial stewardship
- Programmes of work to support environmental improvements, including maintenance and environmental cleaning
- Methods for sharing learning from healthcare associated infection investigations

This will continue to drive infection prevention and control improvement at all levels of the organisation, with regular monitoring and oversight on progress taking place through the Infection Prevention and Control Strategy Group and established governance systems through to Trust Board.

5. Surveillance and Reporting of Health Care Associated Infection

Ensuring that avoidable healthcare associated infections (HCAI) do not occur is an essential aspect of quality healthcare provision. Infection prevention and control practices are fundamental to protecting patients, visitors and staff and routinely following standard infection prevention and control precautions can help to prevent the transmission (spread) of infection. These precautions include:

- Hand hygiene;
- Personal protective equipment (PPE);
- Environmental cleaning;
- Decontamination of equipment;
- Preventing sharps injury; and
- Waste disposal and linen management.

These standard precautions apply in all areas and situations across the hospital and it is important to remember that we are committed to reducing risks associated with all infections, not just those infections that are included within national reduction strategies. This standard application of prevention measures in combination with additional transmission based precautions for specific infections e.g. diarrhoeal or respiratory illness, works in combination to minimise the risk of infection spreading.

Establishing robust HCAI surveillance systems is important to continually support a zero tolerance culture within health care organisations. Surveillance is essential for many reasons including quality assurance, early outbreak identification, benchmarking between organisations and the provision of accurate information on progress to healthcare workers. Surveillance data can also provide evidence to guide how improvements in clinical practice assist in reducing the incidence of HCAI.

The Infection Prevention and Control Team has developed robust HCAI surveillance systems to ensure that all data is collected, collated and disseminated through established communication routes in real time, and that national mandatory surveillance data reporting requirements are met within the required timeframes.

National mandatory surveillance data reporting requirements are regularly reviewed by NHS England, NHS Improvement and Public Health England, and are used as a quality measure by other monitoring bodies including the Care Quality Commission.

National mandatory HCAI surveillance requirements include:

- Methicillin resistant *Staphylococcus aureus* bacteraemia (MRSA)

- *Staphylococcus aureus* bacteraemia (MSSA)
- Gram-negative bloodstream infection
    - *Escherichia coli* bacteraemia (E. coli)
    - *Klebsiella species* bacteraemia
    - *Pseudomonas aeruginosa* bacteraemia
- *Clostridium difficile*
- Infections associated with surgical orthopaedic procedures

For 2019/20, it is disappointing that the Trust reported:

- 3 avoidable cases of MRSA bloodstream infections against an objective of zero avoidable cases within year;

- 41 cases of Clostridium difficile infection, against an objective of no more than 36 cases within year

The Trust has also continued to support the Clinical Commissioning Group with whole health economy improvements to reduce risks associated with Gram-negative bloodstream infections, as part of the national improvement programme for these infections.

5.1 MRSA Bacteraemia

The national objective for MRSA bacteraemia reduction for 2019/20 remained unchanged at zero avoidable infections for all healthcare providers.

The Trust continued to undertake post-infection review (PIR) on a case by case basis, with emphasis remaining on this review process supporting organisational learning; identifying how a MRSA bacteraemia occurred and any associated actions that will prevent recurrence. This investigative approach to MRSA bacteraemia to identify and share learning in real time, supports commissioners and providers to deliver zero tolerance on MRSA bacteraemia.

Within 2019/20, the Trust reported three cases of MRSA bacteraemia, with all three cases identified as avoidable infections following investigation. The focus for continuous improvement was aimed at maintaining established systems of infection prevention, evidence based best practice and key clinical procedures, including:

- Compliance with MRSA screening policy, including swabbing technique
- Compliance with MRSA decolonisation
- Insertion and ongoing management of invasive devices, including review and documentation
- Comprehensive and inclusive admission assessment
- Standard communication between clinical teams
- Antimicrobial stewardship

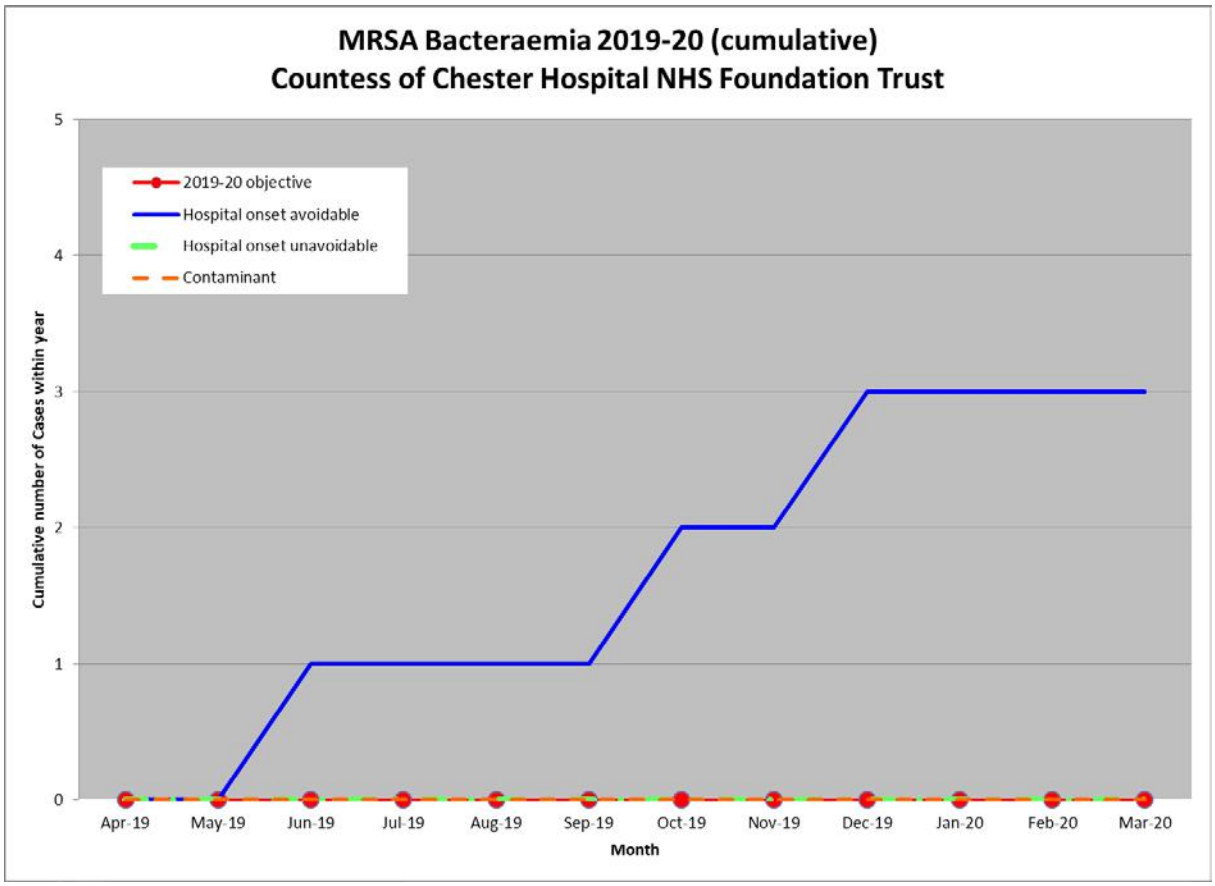
It is essential that the Trust takes every opportunity to share the learning identified by investigations such as these within clinical teams and with the wider organisation. Various methods for shared learning were utilised within year including a revised communication strategy for sharing learning identified through incident investigation, training, education, escalation through divisional and corporate meetings and other Trust-wide communications strategies, including screensavers etc.

A number of initiatives were implemented within year to support compliance and demonstrate sustained improvement. These included the development of information systems within the

electronic patient record, plus the development and introduction of a cannula history chart following a successful pilot.

MRSA bacteraemia data submission is via the national HCAI data capture system. The data includes MRSA detected in blood cultures only and does not include MRSA carriage on, or within other body sites. MRSA bacteraemia are also reported externally through the Strategic Executive Information System (StEIS) and to the Clinical Commissioning Group via the Trust's serious incident review process.

Figure 4 Trust assigned MRSA bacteraemia cases 2019/20



5.2 *Clostridium difficile* Infection (CDI)

2019/20 saw a national change in how cases of CDI are assigned to acute organisations. From 1st April 2019, four case assignment definitions were introduced into the national programme for CDI surveillance and reduction. These changes to the reporting methodology are:

Trust assigned cases of CDI now include all infections that meet the following definitions:

- **Hospital onset healthcare associated** – positive stool specimen taken after the first 2 days of any admission episode (date of admission = day 1)

- **Community onset healthcare associated** – positive stool specimen taken within the first 2 days of any admission episode, or GP specimens, if the patient has been discharged from an inpatient episode at COCH within the preceding 28 days.

All other cases of CDI will be **Non-Trust assigned** and fall within the C. difficile objective for the health economy as a whole, with CCGs having responsibility and accountability for delivery of reductions in the total number of CCG assigned cases. These include two additional definitions for case assignment, as follows:

- **Community onset indeterminate association** – positive stool specimen taken within the first 2 days of any admission episode, or GP specimens, if the patient has been discharged from an inpatient episode at COCH within the preceding 29 – 84 days.

- **Community onset community associated** – positive stool specimen taken within the first 2 days of any admission episode, or GP specimens, if the patient has not been discharged from an inpatient episode at COCH within the preceding 84 days.

NHS Improvement identified that this change in the assignment of CDI cases is to support a more system-wide approach to learning and improvements in patient safety. Lapses in care related to the care and treatment of patients, in or out of the hospital setting, are to be identified through the investigation of individual cases of infection, to identify any patient safety issues or learning, with any case of CDI deemed to be a serious incident. It remained possible within year for Commissioners to impose financial sanctions on acute Trusts of up to £10,000 for each case of CDI in excess of the Trust's objective, if lapses in care are identified.

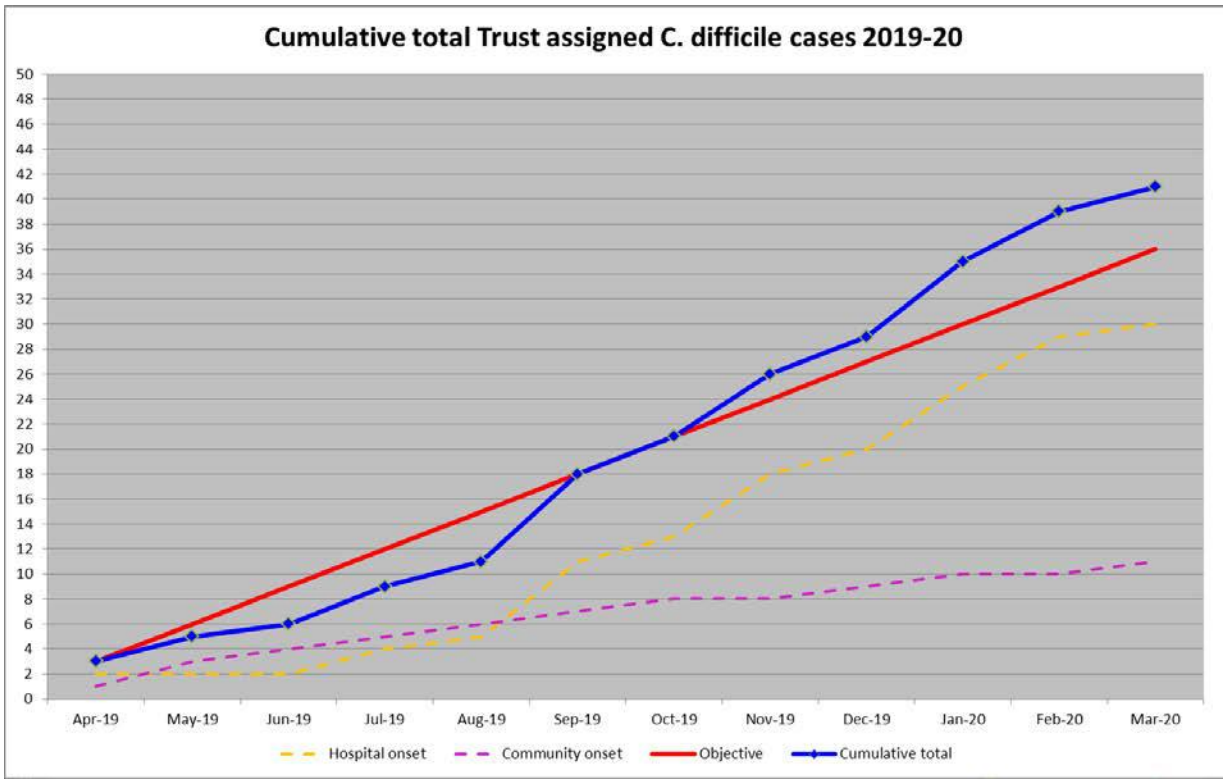
The CDI reduction objective for the Trust for 2019/20 was set at no more than 36 Trust assigned cases within year. Objectives were adjusted nationally for 2019/20 to take account of the change in case assignment that was introduced. Overall, the Trust reported 41 cases of C. difficile infection, exceeding this objective by 5 cases of infection.

The requirement to ensure that robust measures to reduce the risks associated with developing CDI are sustained throughout the Trust remained a key priority. The focus for CDI reduction continued to be supported by evidence based practice and learning from local root cause analysis investigations into each case of infection, plus regional and national learning for improvement.

The CDI risk reduction strategy within year included:

- Maintaining the case by case C. difficile surveillance with robust feedback methodology, including the early identification of any period of increased incidence
- Maintaining weekly multidisciplinary C. difficile wards rounds
- Reinforcement of the antibiotic stewardship policy
- Further development of the Antimicrobial Stewardship Committee
- Daily Consultant Microbiologist antimicrobial ward rounds within Critical Care
- Maintaining combined antimicrobial stewardship ward rounds within other specialities
- Maintaining robust infection prevention and control practices Trust-wide, including hand hygiene, patient isolation and environmental/equipment hygiene
- Further consideration and development of methods to provide antimicrobial data to support Divisions and Consultant teams with antimicrobial stewardship
- Strengthen an open and honest root cause analysis process for each CDI case, emphasising ownership and responsibility of this investigation process for clinical teams – compliance with this objective was a particular challenge within year
- Robust communication systems to ensure that the workforce remains informed on progress and that learning is widely disseminated, including the promotion of best practice.

Figure 5 CDI Cases against objective 2019/20



Learning from investigation has also indicated a number of themes to inform shared learning and continuous improvement to target risks associated with CDI, including:

- Continuation of infection prevention and control and antimicrobial stewardship strategies
- Work to reduce unnecessary antibiotic exposure including Trust wide dissemination of "to dip or not to dip" advice in relation to antimicrobial prescribing without a positive urine culture
- Timely isolation for patients with suspected infective diarrhoea
- Reducing the length of time that patients spend in hospital
- Providing education on the importance of correct documentation of bowel habit using the stool chart both at local ward level and through the Skills Update for Nurses course.

Understanding the CDI trajectory within year is also important, as the case distribution identifies where a single period of increased incidence (Pii) of infection during September 2019 resulted in the Trust exceeding trajectory. Case by case surveillance was able to link this Pii to a single ward, with associated ribotyping and enhanced fingerprinting linking two cases of infection, suggesting that transmission of infection had occurred on this occasion. It is standard for focussed infection prevention and control measures to be immediately implemented on any suspicion of an increased incidence in infection, to reduce risks associated with CDI and limit further impact. This occurred with good effect and no further cases of CDI were reported within the enhanced surveillance period for this ward. In addition to this, it is thought that a second increase in incidence of CDI, reported in January 2020, was likely secondary to an atypical seasonal influenza season, with the majority of seasonal influenza activity taking place over a few short weeks in December 2019.

5.3 Antimicrobial stewardship

Antimicrobial stewardship programmes have been implemented widely as an effective approach to address the worldwide problem of increasing antibiotic resistance. This is a multi-disciplinary response with aims to optimise clinical outcomes while minimising unintended consequences of antimicrobial use, including toxicity, selection of pathogenic organisms (such as *Clostridium difficile*), and the emergence of antibiotic resistance. Thus, the careful and responsible use of antimicrobials is an essential part of patient safety.

The AMS (Antimicrobial Stewardship) Committee was set up within the Trust during November 2011 following the publication of Department of Health Advisory Committee Guidance on Antimicrobial Resistance and Healthcare Associated Infection (ARHAI) on antimicrobial stewardship in hospitals (England).

The AMS Committee is chaired by a Consultant Microbiologist and follows an inter-professional strategy. The committee is multidisciplinary with clinician representation from a cross-section of specialities (including Consultants and junior doctors), together with senior Pharmacy and Infection Prevention and Control Team input. The Committee reports to the DIPC/Infection Prevention Committee and works closely with the Drugs & Therapeutic Committee.

During 2019/20 the main activities of the AMS Committee and the AMS programme were focussed on achieving the **Antibiotic CQUIN targets**.

5.3.1 CQUIN indicators for 2019-20:

CCG1a: Lower Urinary Tract Infection in older people

- Diagnosis of lower UTI based on documented clinical signs or symptoms as per PHE UTI diagnostic guidance
- Diagnosis excludes use of urine dip stick
- Empirical antibiotic prescribed following NICE Guideline (NG109)
- Urine sample sent to microbiology

100 cases per quarter will be sampled, and will include patients aged 65 years and older.

CCG1b: Antibiotic prophylaxis in colorectal surgery

The number of prophylactic single dose antibiotic prescriptions that meet the NICE CG74 guidance regarding the choice of antibiotic.

Both CCG1a and CCG1b require 90% compliance to achieve the CQUIN, and a minimum of 60% to achieve any payment.

5.3.2 CQUIN achievements during 2019-20

CCG1a: Lower Urinary Tract Infection in older people

CQUIN objective	Q1 Result	Q2 Result	Q3 Result
Diagnosis of lower UTI based on documented clinical signs or symptoms as per PHE UTI diagnostic guidance	36%	58%	76%
Diagnosis excludes use of urine dip stick	60%	82%	78%
Empirical antibiotic prescribed following NICE Guideline (NG109)	70%	86%	86%
Urine sample sent to microbiology	62%	76%	58%
Overall compliance	16%	28%	38%

The Antimicrobial Stewardship Committee implemented the following actions in order to improve compliance with the CQUIN, including:

- Development and promotion of a flowchart to guide clinical teams (and nursing teams) in how to diagnose and treat a UTI.
    - This is within the antibiotic guidelines
    - Laminated copies have been placed on every ward (1 in sight of the clinical teams on each ward and another by the urinalysis machines)
    - We conducted a whole hospital walk round in August to promote this to all staff, and we sent a medicines in a minute bulletin to all staff

- A quiz was developed suitable for clinical staff, nurses and healthcare assistants for World Antibiotic Awareness Week (18-24 November) focussed on the UTI CQUIN. During this week the Antimicrobial Specialist Pharmacist and IPC nurse conducted a whole hospital walk-round to promote the CQUIN targets to all staff

CCG1b: Antibiotic prophylaxis in colorectal surgery

- Q1: 92.73% compliance
- Q2: 82.5% compliance
- Q3: 75% compliance

Please note Q4 was not completed due to the COVID19 pandemic.

5.3.3 AMS activity

Several audits have taken place over the last 12 months, involving various members of the group:

- Antibiotic point prevalence audits (quarterly)
- Auto Stop date audit
- Hospital at Home Teicoplanin dosing and review of levels audit
- High dose Teicoplanin dosing and review of levels audit
- Start Smart then Focus audits for wards 33 and 43
- Regional gentamicin audit
- Clinical audit of treatment of C. difficile infections July 2019

Teaching has been provided across the trust by various members of the group, in subjects relevant to antimicrobial use:

- Junior doctor teaching on antibiotics
- Junior doctor teaching on Therapeutic Drug Monitoring
- New pharmacists antibiotic induction and Therapeutic Drug Monitoring training
- Pre-registration pharmacist teaching: antimicrobials
- Junior doctor teaching: re-audit of treatment of C. difficile infection

Antimicrobial Guidelines and Formulary - the following antimicrobial guidelines have been updated within the last 12 months:

- Gentamicin policy switched to using adjusted body weight for dosing following audit results
- Antibiotic policy – Teicoplanin for Outpatient Parenteral Antibiotic Therapy for moderate and severe infections (OPAT)
- Policy for self-administration of IV antibiotics for Hospital at Home
- Competency and risk assessment for self-administration
- Self-administration of Teicoplanin
- Antibiotic Policy update – bronchiectasis
- Antibiotic policy update – chronic obstructive pulmonary disease
- Antibiotic Policy update – genitourinary

Ward rounds

- Regular ward rounds by Consultant Medical Microbiologists continued on a daily basis on critical care area, with representation from clinicians and pharmacists.
- Weekly multidisciplinary meetings with Haematology Consultants/ junior doctors/ pharmacist continued
- Weekly orthopaedic ward rounds
- Multidisciplinary *C. difficile* ward rounds (weekly)

Ward rounds not only provide an opportunity for antimicrobial review but also a chance to teach junior doctors about prudent antibiotic usage.

Clinical advice

- The written referral system allows timely and effective consultation about antibiotic usage in selected cases between Medical microbiology Consultants and clinicians.
- The service allows optimising antimicrobial prescribing, and also teaching on an informal basis.

Meetings and professional development

- Members of the Antimicrobial stewardship team attended several meetings, courses and conferences to update their knowledge and understand the national/ international/ local challenges and opportunities of antimicrobial stewardship.

- Antibiotic Pharmacists are members of the North West antimicrobial pharmacists group and attend regular meetings.
- Regular participation at Medical Unit Meetings, Grand Rounds and Laboratory Lunchtime Meetings.
- Training day for the use of 'Refine and Define' for antibiotic consumption figures – June 2019.
- CPPE Leading for change course completed May – December 2019.
- UKCPA Infection Network Masterclass – October 2019.
- BSAC OPAT conference – December 2019.
- Participation in Shionogi advisory board for Cefiderocol.
- BSAC Educational workshop: The partnership of AMS and IPC – stewarding new antimicrobials and IPC practices – November 2019.
- On line course: TARGET ANTIBIOTICS – PRESCRIBING IN PRIMARY CARE.
- Attendance at medical education meeting: MEETING THE CHALLENGES OF GRAM-NEGATIVE INFECTIONS IN THE UK Manchester – November 2019.

5.3.4 AMS strategy

Further aims and strategies of the Antimicrobial Stewardship Program include:

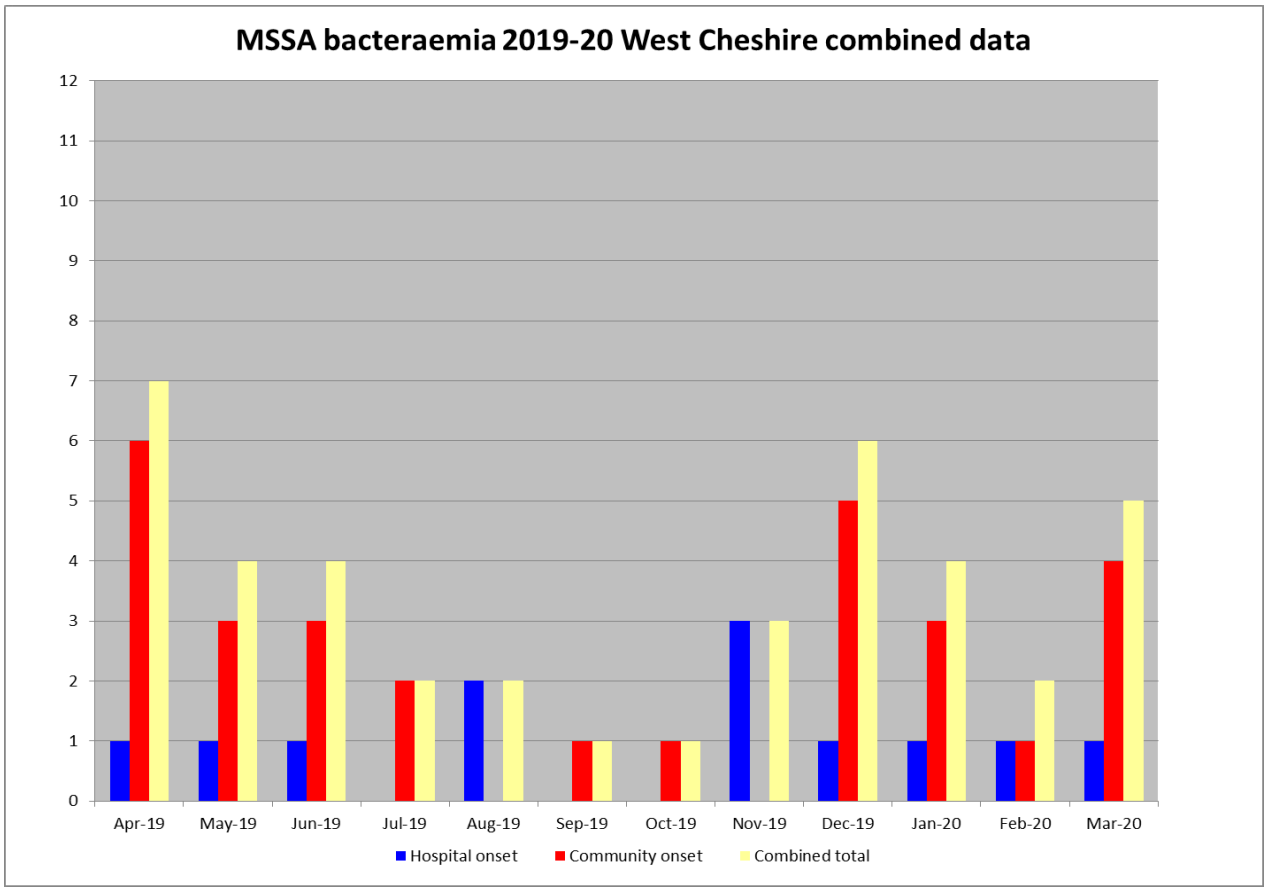
- Ensure proper clinical engagement in antimicrobial stewardship efforts and achieving CQUIN targets
- Possible continuation of Antibiotic Review Kit (ARK) Trial following review of resource required to set this up across the hospital
- Regular review of the local Antibiotic Formulary in view of national requirements, antimicrobial shortages and local resistance figures
- Harmonise Trust and Primary Care Formularies to ensure joint healthcare approach
- Finalise a COCH version of the regional paediatric antibiotic guidelines
- Horizon scanning for new antimicrobials to ensure potential antibiotic treatment for patients with multi-resistant infections
- Development of AMS/antibiotic treatment educational methods/strategies to increase AMS understanding/awareness of junior doctors
- Antifungal stewardship programme will take a significant part of the AMS plans next year, with completion of a gap analysis on diagnosis of fungal infections. Furthermore development of Trust-wide antifungal treatment guidance is planned including management of most frequent superficial and deep Candida and Aspergillus infections, available antifungal agents, potential side effects and restricted antifungal agents.

5.4 *Staphylococcus aureus* bacteraemia *(MSSA)*

Mandatory surveillance for MSSA bacteraemia continued through 2019/20, as part of the national surveillance programme. Data collection is via the national HCAI data capture system (see figure 5 below), with robust surveillance systems in place.

Objectives for the reduction of MSSA bacteraemia have not been set and it is not planned that these will be introduced for 2020/21. However, local understanding from the surveillance data is that this infection continues to develop predominantly within the community setting.

Figure 6 MSSA bacteraemia cases 2019/20



5.5 Gram-negative bloodstream infection (GNBSI)

The timescale to achieve the national ambition to reduce GNBSI by 50% was adjusted with publication of *Tackling antimicrobial resistance 2019-2024: The UK's five-year national action plan,* with the ambition for this to now be achieved by 2024. This national ambition has been set as a quality premium for Clinical Commissioning Groups.

The GNBSI mandatory surveillance programme includes:

- Gram-negative bacteraemia surveillance for *E. coli, Klebsiella* species and *Pseudomonas aeruginosa*.
- Assignment of *E. coli* bacteraemia using the national two day algorithm to identify if the onset of infection occurred in the community or hospital.
- Additional data collection to record risk factors for GNBSI as part of an enhanced surveillance programme.

This enhanced surveillance programme for GNBSI involved surveillance data sourced from secondary care, with data entry responsibilities for community and hospital onset cases sitting with the acute organisation. As for MSSA bacteraemia, local surveillance data identifies that GNBSI predominantly develop within the community setting.

Figure 7 Gram-negative bacteraemia 2019/20 – inclusive of *E. coli, Klebsiella* species and *Pseudomonas aeruginosa*

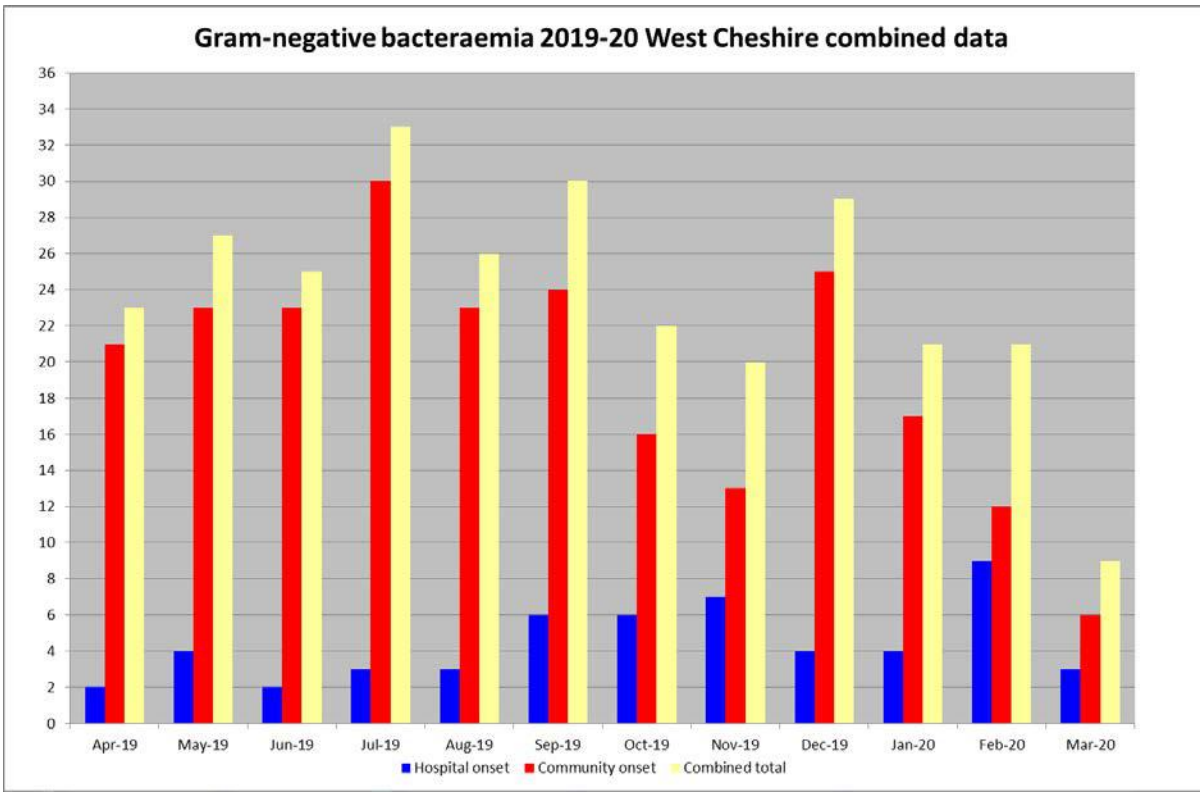


Figure 7.1 *E. coli* bacteraemia cases 2019/20

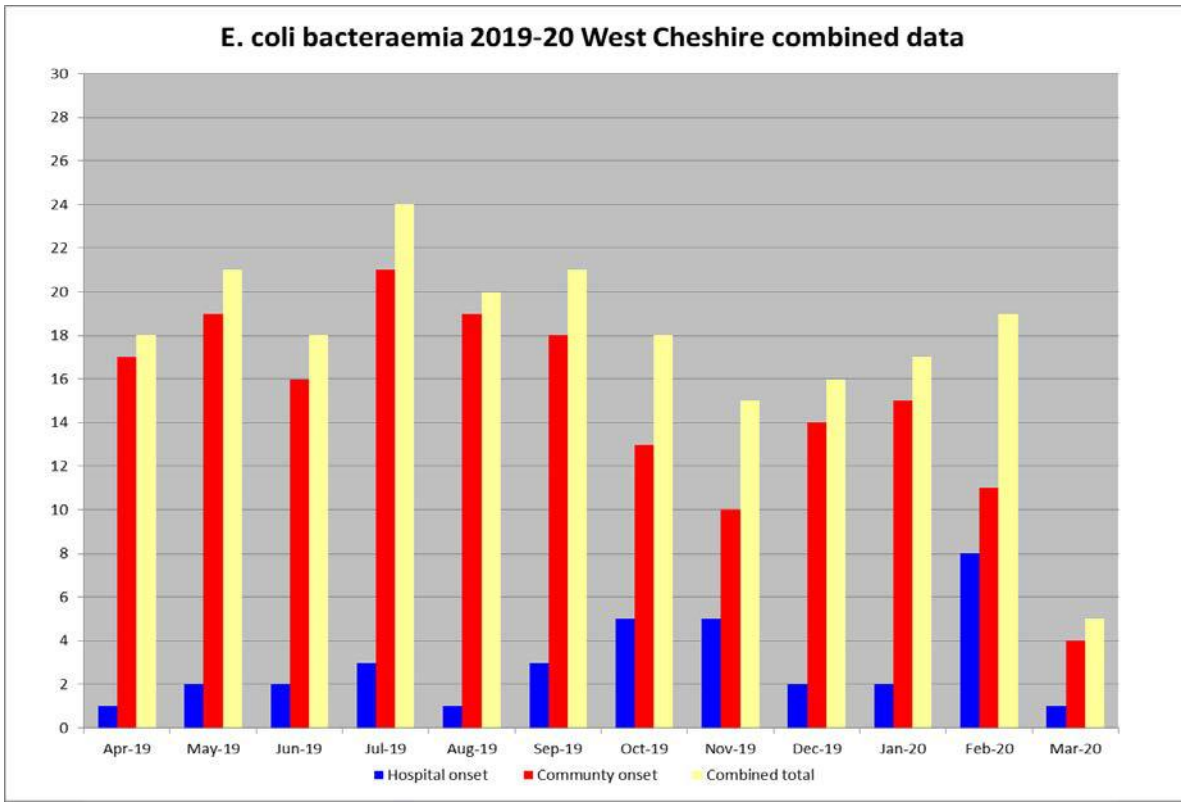


Figure 7.2 ***Klebsiella*** **species bacteraemia cases 2019/20**

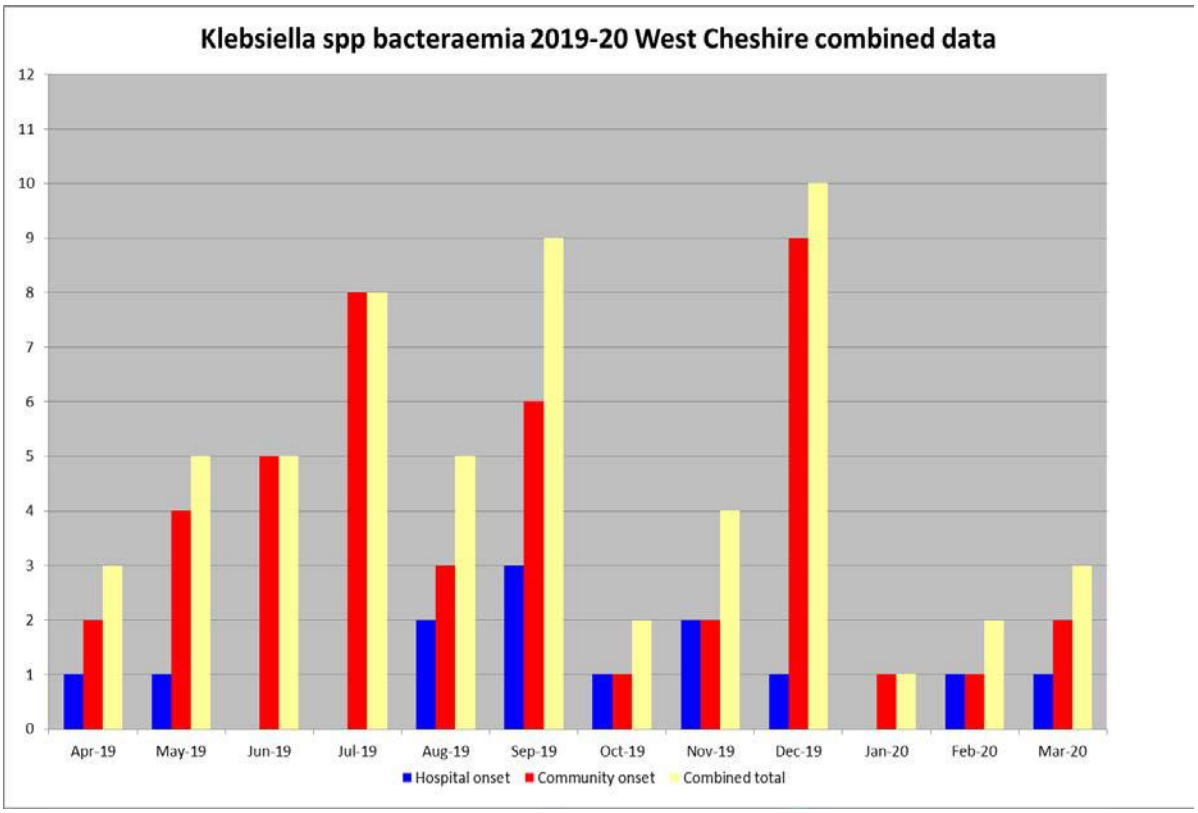
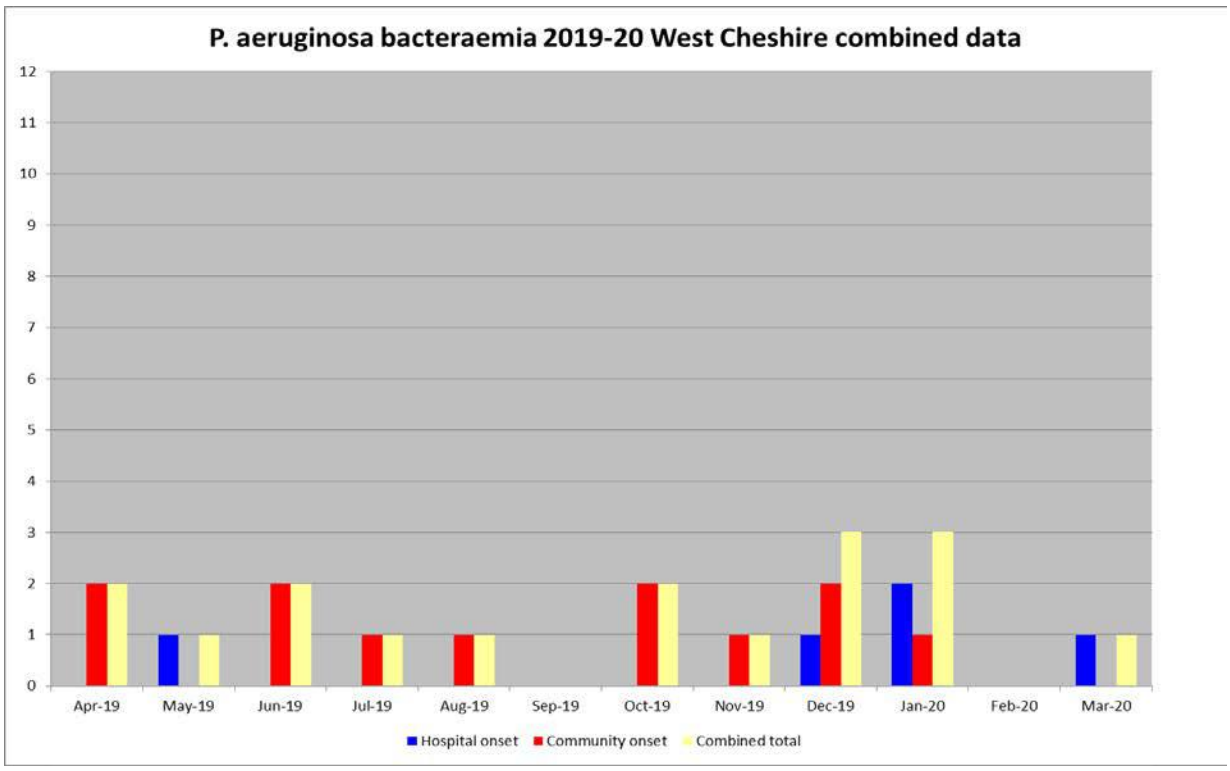


Figure 7.3 ***Pseudomonas aeruginosa*** **bacteraemia cases 2019/20**



West Cheshire CCG/Local Authority have adopted a collaborative approach towards GNBSI reduction that is inclusive of the whole health economy. A West Cheshire GNBSI Group has been formed that is led by the community infection prevention and control service, with acute Trust representation. This group has developed a GNBSI improvement plan that is focussed on the identified risk factors which contribute to the development of GNBSI, incorporating the national evidence base for risk reduction for these infections. In addition, a local communication strategy has been developed to support sharing key messages across identified groups and populations, for continuous improvement.

This includes a continued focus on:

- Antimicrobial stewardship, with particular reference to urinary tract infection
- Urinary catheter management and practice, including development and implementation of a standardised urinary catheter passport – this piece of work expanded within year to incorporate development of a Cheshire and Merseyside – wide urinary catheter passport, working in partnership with NHS England/Improvement
- Implementation of the 2019/20 CQUIN for lower urinary tract infections in older people and the 'to dip or not to dip' initiatives
- Hydration

5.6 Surgical Site Infection Surveillance

The Trust's surgical site infection (SSI) surveillance programme continues to be co-ordinated and facilitated by the Infection Prevention and Control Team, with surveillance at an operational level being undertaken by appropriately trained ward/departmental staff.

During 2019/20, the Trust maintained the planned surgical site infection surveillance programme throughout the year. This programme is undertaken as part of the national surveillance system, co-ordinated via Public Health England. There is a robust data dissemination process established, where reports produced centrally by Public Health England are disseminated to the corresponding clinical teams. Surgical site infection surveillance data is also made widely available for staff to access via the S-drive.

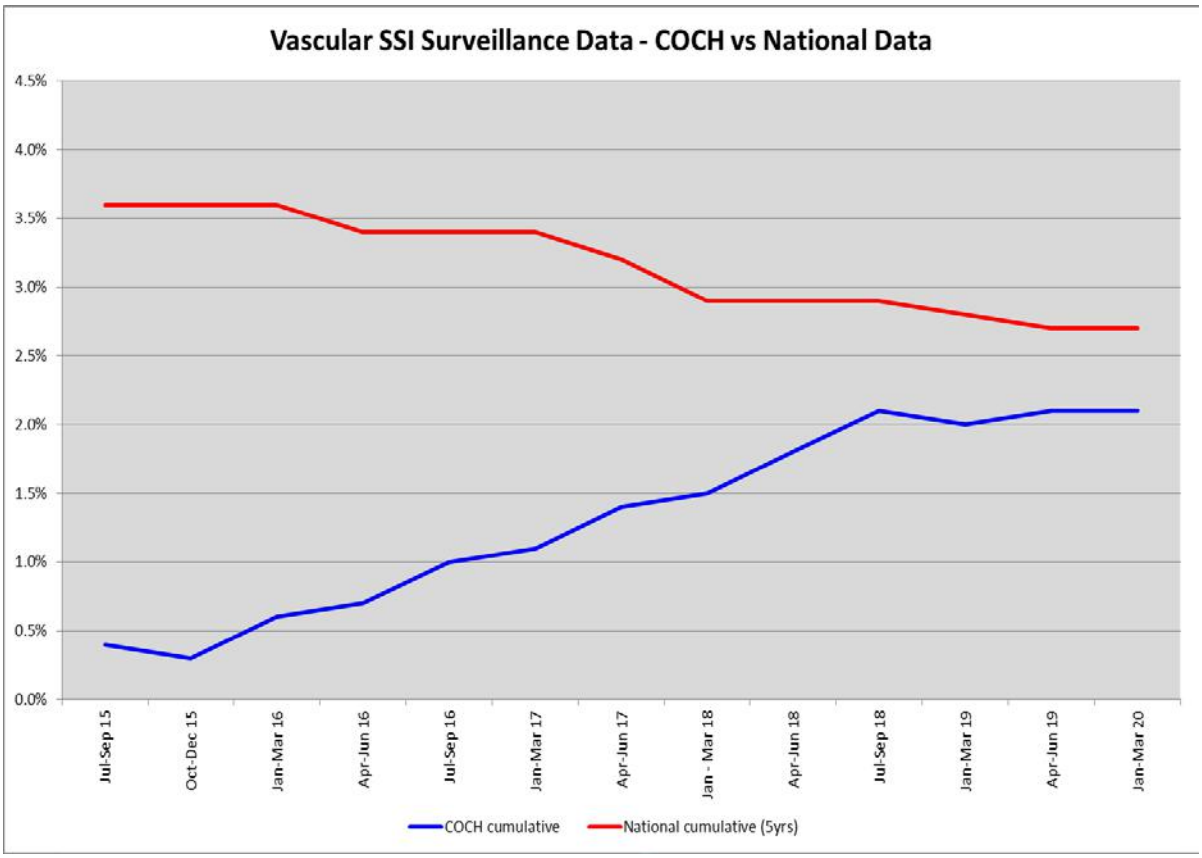
An SSI Surveillance Group was formed within year as an informal forum to discuss the SSI surveillance programme, identify any issues or training needs within the group and to maintain oversight of progress with data collection and submission.

Trust cumulative data for surgical site infection is calculated locally to provide an accurate benchmark against the national distribution of surgical site infection incidence, by category of surgical procedure, for the last 5 years (inpatient and re-admission).

Surgical site infection surveillance was undertaken for the following surveillance categories within year:

- Vascular procedures
- Hip replacement procedures
- Knee replacement procedures
- Repair of neck of femur procedures

Figure 8 Vascular Procedures



In context, there is a 2.1% incidence of vascular surgical site infection as of the January – March 2020 surveillance period. This is below the national incidence for this type of infection.

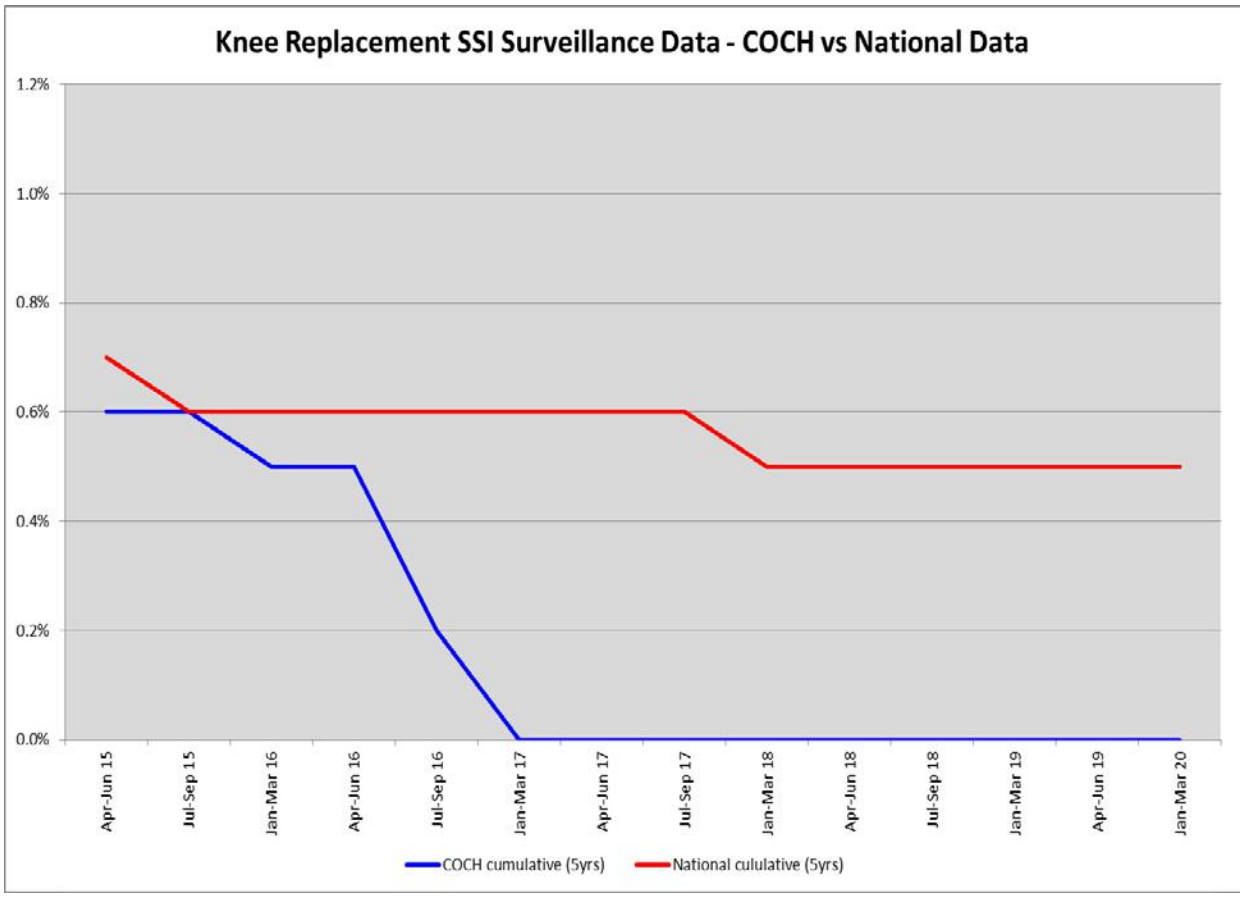
Due to the increasing incidence in vascular surgical site infections, the Vascular Team undertook a retrospective audit to benchmark local pre-, peri- and post-operative practices against the evidence base for best practice to reduce the risk associated with surgical procedures. Changes in practice that have been implemented include:

- Update of peri-operative antibiotic prophylaxis policy
- Update of pre-operative showering policy, including patient information and staff education
- Development of a prospective audit to continue monitoring

Vascular SSI Identification April 2015 – March 2020

	Number of SSI identified
During Admission	**9**
On Re-admission	**13**
Total	**22**

Figure 8.1 Knee replacement procedures

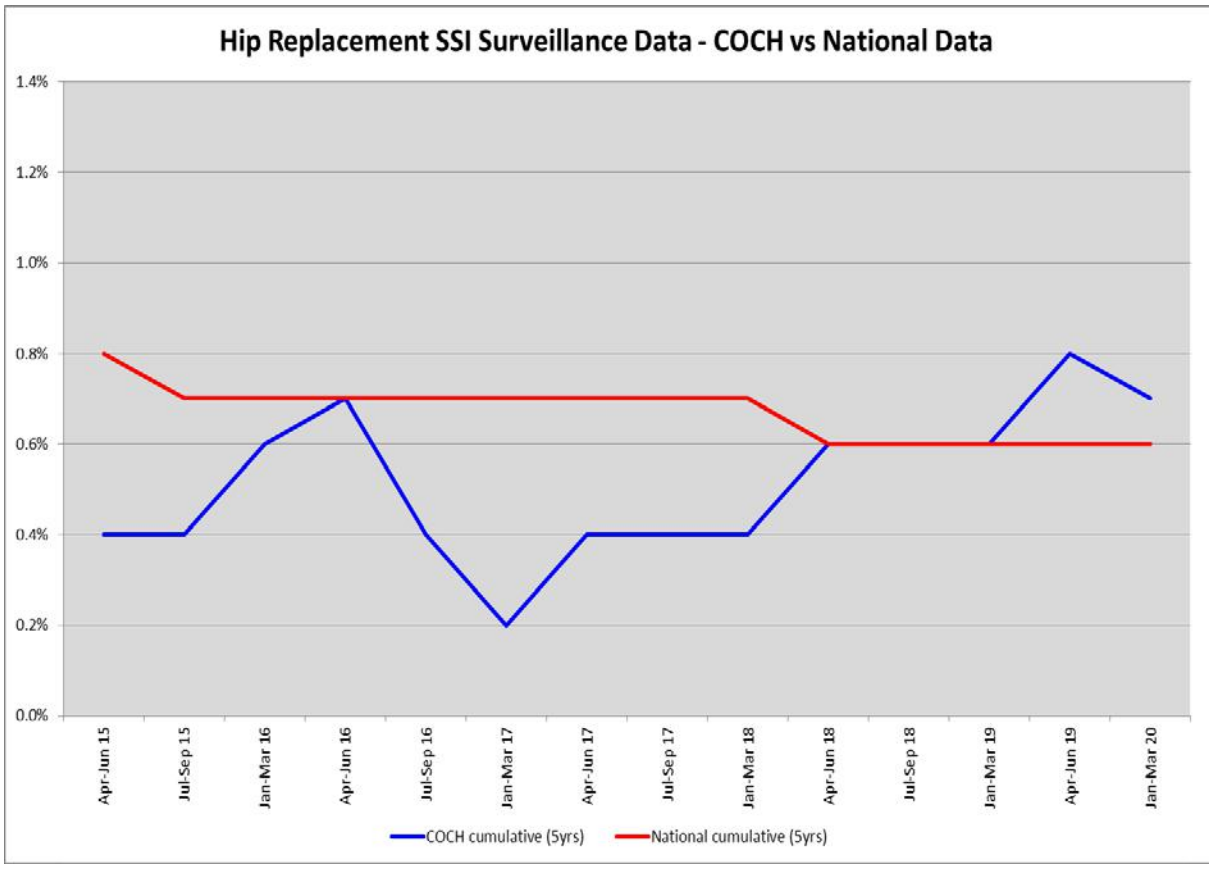


In context, there is a 0% incidence of knee replacement surgical site infection as of the January – March 2020 surveillance period. This is below the national incidence for this type of infection.

Knee Replacement SSI Identification April 2015 – March 2020

	Number of SSI identified
During Admission	**0**
On Re-admission	**0**
Total	**0**

Figure 8.2 Hip Replacement Procedures



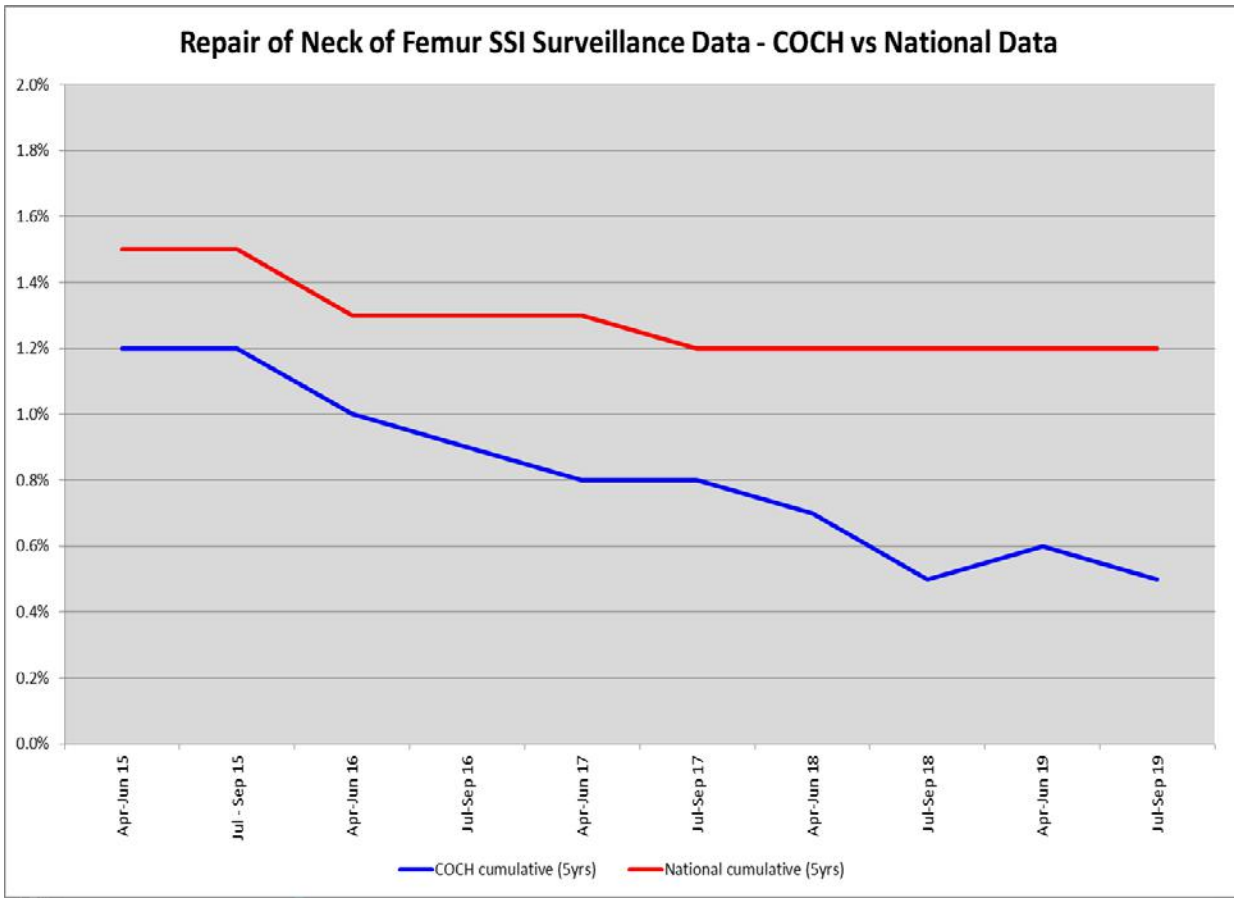
In context, there is a 0.7% incidence of hip replacement surgical site infection as of the January – March 2020 surveillance period. This is above the national incidence for this type of infection; however, a decrease in the incidence of infection is noted within the January – March 2020 surveillance period.

The Trust received notification in October 2019 that the surgical site infection surveillance data for hip replacement procedures identified the Trust as a high outlier amongst other participating hospitals. In response to this, the Orthopaedic Team developed a best practice audit utilising NICE guidelines and planned a retrospective case review in consideration of twelve modifiable risk factors for the prevention of infection. The results of both pieces of work are pending.

Hip Replacement SSI Identification April 2015 – March 2020

	Number of SSI identified
During Admission	**2**
On Re-admission	**2**
Total	**4**

Figure 8.3 Repair of Neck of Femur Procedures



In context, there is a 0.5% incidence of repair of neck of femur surgical site infection as of the July – September 2019 surveillance period. This remains below the national incidence for this type of infection. (Note: repair of neck of femur surgical site infection surveillance undertaken for six months April – September 2019).

Repair of Neck of Femur SSI Identification April 2015 – March 2020

	Number of SSI identified
During Admission	**2**
On Re-admission	**2**
Total	**4**

5.7 COVID-19 infection

January 2020 saw the emergence of an outbreak of a novel Coronavirus in Wuhan, China, with worldwide reports escalating, as cases were seen to become more widespread.

This Trust identified a potential case of this infection in mid-January, with the patient being transferred from the Emergency Department to the local infectious diseases unit, following escalation and advice from the national investigation team. Guidance that the Trust had received was followed locally and a debrief was held to identify learning. This learning was taken forward in

to planning for the Trust response to what was becoming an internationally escalating event at that time.

A national alert was circulated from the Chief Medical Officer on 23/01/2020 in relation to "Wuhan novel coronavirus" and the steps which needed to be put in place to rapidly identify and manage any cases appearing in the UK. Regular Cheshire and Merseyside stakeholder briefings commenced and the Trust's first Wuhan novel coronavirus planning meeting was held on 29/01/20, led by the Infection Prevention and Control Team. A subsequent action plan was developed from this meeting, in line with the national guidance.

Daily planning meetings involving the Trust's Senior Team, clinical and Divisional teams, plus microbiology and IPC commenced on 05/02/2020 and training in the correct use of personal protective equipment (PPE), plus escalated fit testing for FFP3 respirators commenced Trust wide.

All Trusts were mandated to provide a Coronavirus testing pod which was separate from the Emergency Department. The Trust was able to rapidly identify an appropriate area for this pod and with some minor adjustment to the infrastructure, the Coronavirus Support Centre opened on 14/02/2020. Staff within this area all received training in the safe clinical practices required to deliver this swabbing service, in collaboration with NHS111.

COVID-19 infection activity remained community focussed during the initial weeks of the national escalation of this pandemic, with the Trust screening the first inpatient for SARS-CoV-2 on 09/03/2020. The first SARS-CoV-2 positive result from an inpatient was from a specimen collected on 10/03/2020 on admission to the hospital.

The emergency planning and preparedness in response to the emerging pandemic was extensive and rapid, in response to the frequently changing guidance from national teams, as more was learned about this infection and this continued into 2020-21.

5.8 Other Alert Organism Surveillance

Other 'alert' organisms are included within the Trust surveillance programme, including all MRSA positive cases (non-bacteraemia related), Haemolytic *Streptococcus* (Group A), Norovirus, Adenovirus, Rotavirus, Shigella, Salmonella, Campylobacter, E. coli 0157, Listeria, *Neisseria meningitides*, *Mycobacterium tuberculosis*, extended-spectrum beta-lactamase (ESBL) producing organisms, Acinetobacter, *Pseudomonas aeruginosa*, Vancomycin Resistant *Enterococcus* (VRE), carbapenemase-producing *Enterobacteriaceae* (CPE), plus others as appropriate. Data is disseminated to identified staff groups on a monthly basis for information/action, as applicable.

6 MRSA Screening Programme

MRSA screening for all elective cases and emergency admissions has been established within Trust policy for a number of years. 2019/20 involved a continuation of the work to ensure that MRSA screening becomes embedded within day to day clinical practice, with a particular emphasis on this following MRSA bacteraemia post-infection review analyses.

Trust wide communications and education were implemented to raise awareness of the importance of compliance with MRSA screening policy, with additional initiatives developed at ward/department level to promote compliance with MRSA screening requirements for both emergency and elective

admissions. Education in relation to MRSA screening is included within the Trust's mandatory training programme.

Monitoring compliance with MRSA screening remains part of internal reporting to divisional Associate Directors of Nursing on a monthly basis, this is to inform and improve on practice. Learning from post-infection review of MRSA bacteraemia cases identified non-compliance with MRSA screening, with learning from these cases shared with Commissioners

Compliance with MRSA screening fluctuated throughout the year, with screening compliance for elective admissions routinely outperforming screening compliance for emergency admissions. Programmes aimed at demonstrating sustainable improvement will continue through 2020/21.

7. Untoward Incidents Including Outbreak Management

7.1 Norovirus Outbreak Synopsis

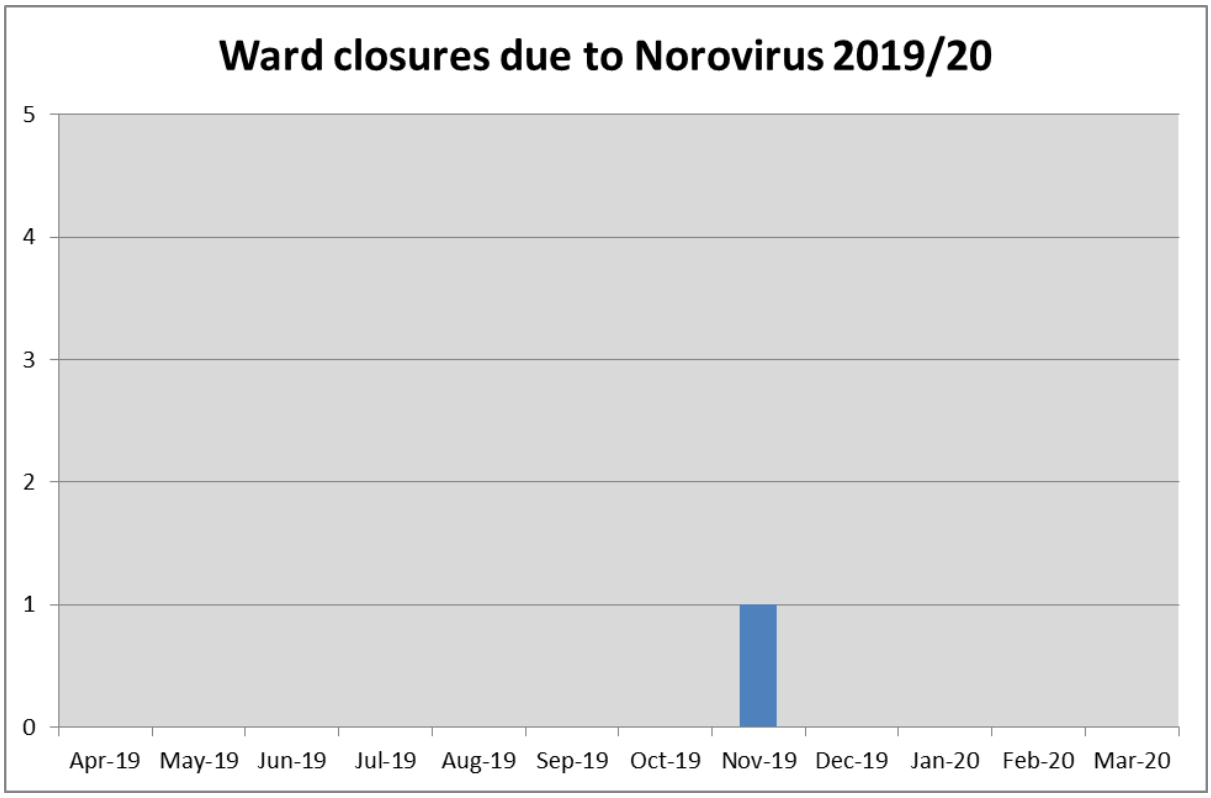
Viral gastroenteritis outbreaks impact on patient well-being (sometimes significantly), operational capacity and service management. Therefore, it is essential that effective outbreak prevention, management and control systems are in place to limit the impact of these outbreaks. The effectiveness of locally developed infection prevention and control measures was demonstrated during 2019/20, with a single ward closure due to gastroenteritis within year.

- The need for this ward closure was identified through established surveillance systems
- The ward was closed for a total of 9 days
- Norovirus was confirmed as the cause of the outbreak.

Prompt implementation of established outbreak management and control measures are essential and contributed to limit the effect that this infection has within our organisation. Management and control measures included:

- Prompt isolation of all diarrhoeal cases assists in limiting the transmission of all enteric pathogens, including Norovirus.
- Ensuring that any ward remains closed for the duration of an outbreak is the most important measure to limit the overall impact that Norovirus outbreaks have on an organisation.
- Immediately informing clinician teams once an outbreak has been identified, ensuring that patient discharges are expedited.
- Daily clinical rounds by the Infection Prevention and Control Team, once an outbreak is suspected, to ensure that ward staff feel supported and to promote adherence to the required infection prevention and control measures.
- Ongoing surveillance of cases, with accurate monitoring of symptoms, ensures that the length of any outbreak is kept to a minimum.
- Regular outbreak meetings between the Infection Prevention and Control Team and relevant managers (including bed managers), to ensure that all symptomatic patients are promptly recognised and appropriately isolated in single rooms or cohort areas wherever possible.
- Information dissemination to all appropriate staff groups including outbreak updates and policy requirements, ensuring that the workforce remains informed.

Figure 9 Norovirus Outbreak Data 2019/20



Signage within public areas also continued throughout 2019/20, improving communication with the wider population about how visitors to the hospital can help to prevent Norovirus outbreaks occurring.

All outbreaks are reported to Public Health England plus Commissioners and the Community Infection Prevention and Control Team, with an outbreak synopsis report tabled for each outbreak at subsequent Infection Prevention Committee meetings. This reporting process aids communication with wider healthcare provision and identifies any learning that may improve on future outbreak management and control.

7.2 Vancomycin Resistant *Enterococcus* (VRE)

Enterococci are bacteria that are commonly found in the bowels of most humans. Vancomycin Resistant *enterococci* (VRE) are enterococci that are resistant to the glycopeptide group of antibiotics (Vancomycin and Teicoplanin). VRE commonly cause wound infections, bacteraemia and infections of the abdomen and pelvis, with the highest risk patients being those that are immunocompromised, receive treatment in specialist units such as Critical Care, have a prolonged hospital stay or have had previous treatment with certain other antibiotics. Established case by case surveillance systems for VRE have been maintained through 2019/20 to facilitate the rapid recognition of any potential outbreak, ensuring the early implementation of interventions for prevention, management and control. No VRE outbreaks were identified during 2019/20.

The VRE policy was also reviewed within year, with plans to adopt a focused, risk assessed approach to VRE management and control in support of patient safety and operational activity. Roll-out of this

revised policy was paused due to the Trust response to the emerging COVID-19 pandemic and will progress into 2020/21.

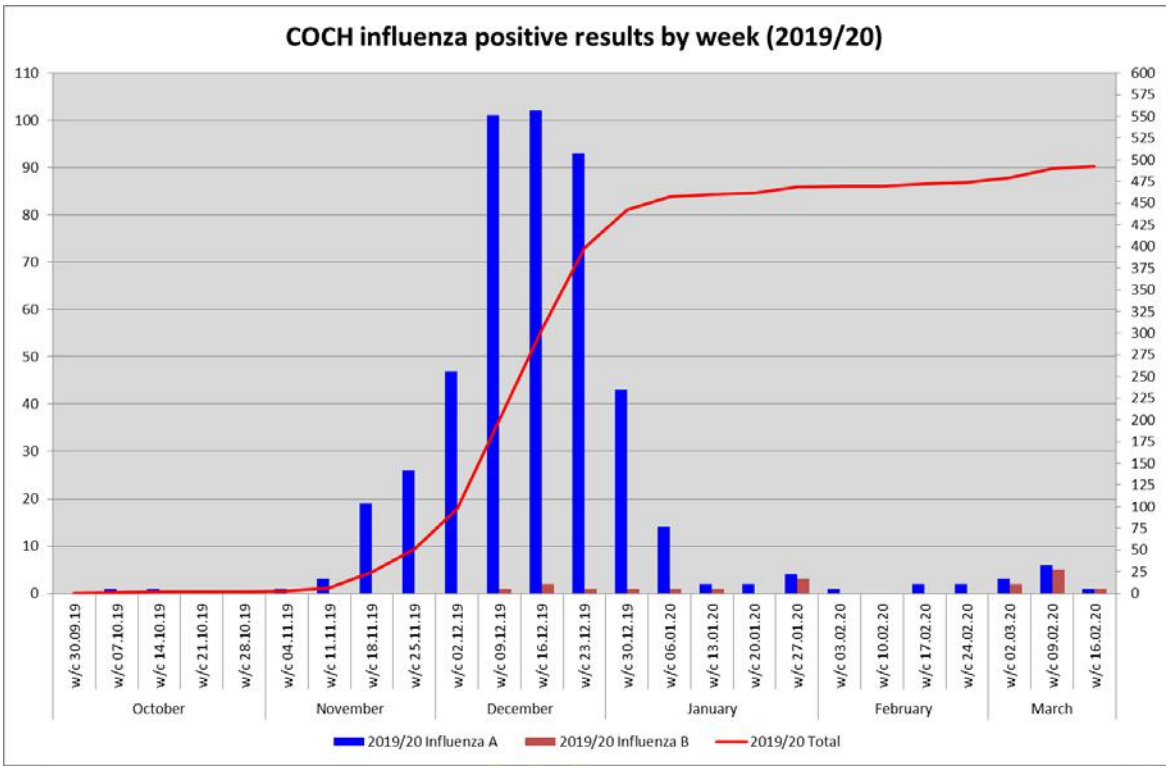
7.3 Carbapenemase Producing *Enterobacteriaceae* (CPE)

Enterobacteriaceae are bacteria that usually live harmlessly in the gut of humans. Carbapenemase-producing Enterobacteriaceae (CPE) are Enterobacteriaceae that are resistant to carbapenem antibiotics (Meropenem, Ertapenem and Imipenem). CPE can cause wound infections, bacteraemia and infections of the urinary tract, with the highest risk patients being those that are immunocompromised, receive treatment in specialist units such as Critical Care, have a prolonged hospital stay or have had previous treatment with certain other antibiotics. As for VRE, established case by case surveillance systems for CPE have been maintained through 2019/20 to facilitate the rapid recognition of any potential outbreak, ensuring the early implementation of interventions for prevention, management and control. No CPE outbreaks were identified during 2019/20.

7.4 Seasonal Influenza - Winter 2019/20

Winter 2019/20 saw high levels of influenza activity being reported within the acute Trust, which impacted on operational activity within the organisation. A variation from the usual pattern was observed during 2019/20 with an earlier onset and more sudden peak of shorter duration than in previous influenza seasons. This resulted in an atypical influenza season with the largest number of cases being identified during December 2019.

Figure 10 Local influenza surveillance data by week for winter 2019/20



Two separate outbreaks of influenza were identified on different medical wards during November and December 2019 respectively. Outbreak control meetings were implemented together with specific management and control actions (including ward closures), these were integral in limiting the impact of these outbreaks. Duration of the influenza outbreaks were for 5 and 7 days respectively.

Local influenza surveillance was concurrent with the regional and national surveillance data with influenza A being the predominant circulating strain. A total of 492 positive influenza results were reported from specimens collected within the acute Trust during the winter months, with approximately 71% of cases identified over 4 weeks during December 2019. This concentrated seasonal presentation placed significant pressure on organisational resources during this period of time and during the following weeks leading into January 2020.

Influenza testing via PCR during the influenza season continued to demonstrate the benefit of having access to rapid test results.

National influenza surveillance programme was maintained with weekly reporting of confirmed influenza cases within critical care.

Extensive planning took place to prepare for seasonal influenza prior to the influenza season commencing, with Occupational Health continuing to lead on an excellent staff influenza vaccination campaign, exceeding the national objective of more than 80% of frontline staff to receive an influenza vaccination.

8. Infection Prevention and Control Audit Activity

8.1 Audit Programme

The infection prevention and control audit programme is undertaken by the Infection Prevention and Control Nurse Team, utilising a nationally recognised, evidence based audit tool developed by the Infection Prevention Society in conjunction with the Department of Health. The audit tool encompasses the full range of standard principles of infection prevention and control.

Work took place within year with the Business intelligence team, to locally develop this audit tool into an electronic version that is more compatible with available technology. This currently remains a work in progress at year end and will continue into 2020/21.

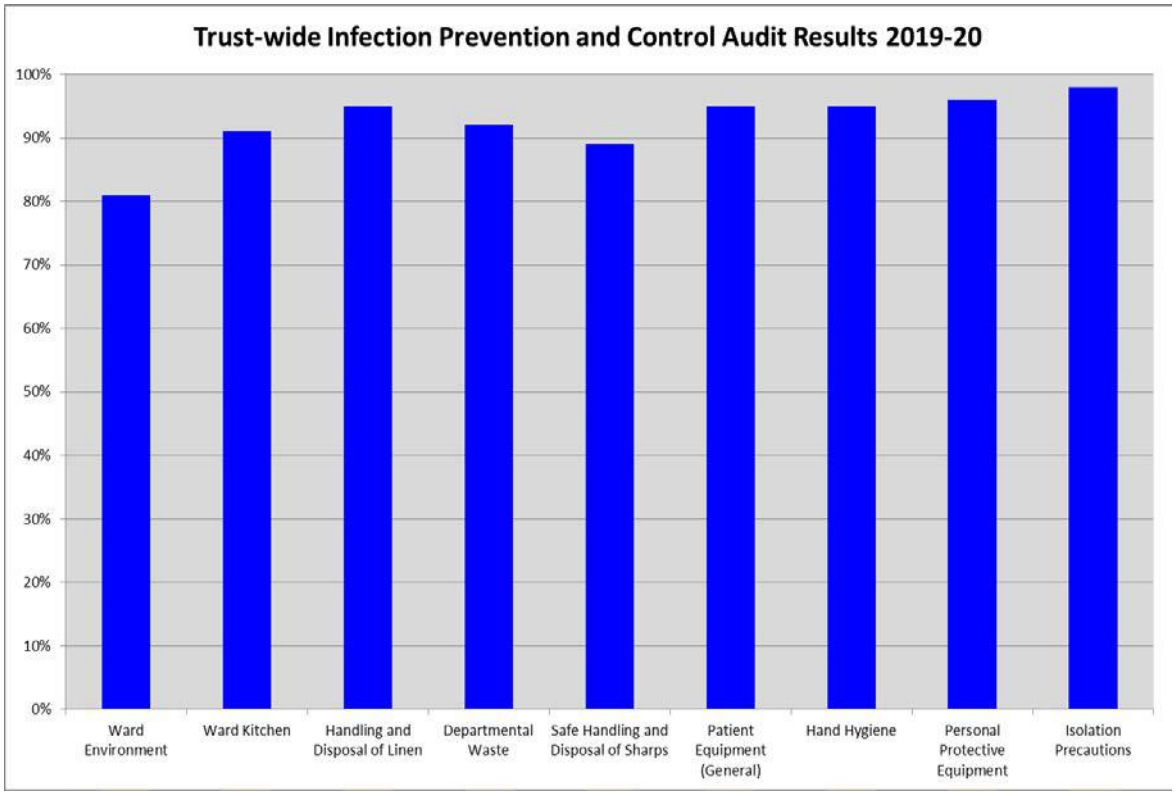
A summary of the 2019/20 infection prevention and control audit programme is as follows:

- A total of 23 audits were undertaken, including inpatient and outpatient areas of the Trust. This is a lower number than in previous years due to an atypical early onset influenza season, closely followed by the evolving COVID-19 pandemic. Therefore audits were focused and prioritised inpatient areas within year.
- Verbal feedback was provided at the time of each audit.
- Formal feedback on audit findings includes a chart detailing the compliance score for each audit criteria, plus an action plan template for the ward/department to complete to address any identified areas for improvement.
- Results are fed back for action to Ward/Department Manager, Matron, Associate Directors of Nursing, Consultant Microbiologists, Facilities Manager, and Estates Manager plus identified others as relevant.

- Action plans are detailed for return to Infection Prevention and Control within a specified timescale.

Levels of compliance remained similar to previous data although there was a noticeable decline in compliance in the Ward Environment section. On closer inspection of the data this fall in compliance was noted to be mainly due to deterioration in infrastructure due to the age of the building. In order to rectify this issue, a capital programme is planned to focus on improvements in infrastructure for 2020/21.

Figure 11 Trust-wide Infection Prevention and Control Audit Results 2019/20



Other Trust-wide audits have been undertaken as part of the annual infection prevention and control audit programme, with appropriate dissemination of results across the organisation. These include:

- Hand hygiene compliance, including the availability of hand hygiene facilities
- Safe handling and disposal of sharps
- Commode audit

Although a fewer number of infection prevention and control audits were undertaken within year, due to gaps in service, operational pressures and the emergence of SARS-CoV-19, it is thought that the introduction of the Matron/IPC walk round programme had a positive impact. These walk rounds support clinical areas with the identification of good practice and any areas for improvement, with required actions identified and undertaken in real time. These walk rounds are supplemental to the Trust IPC audit programme and provide an ongoing review, in support of sustainable improvement.

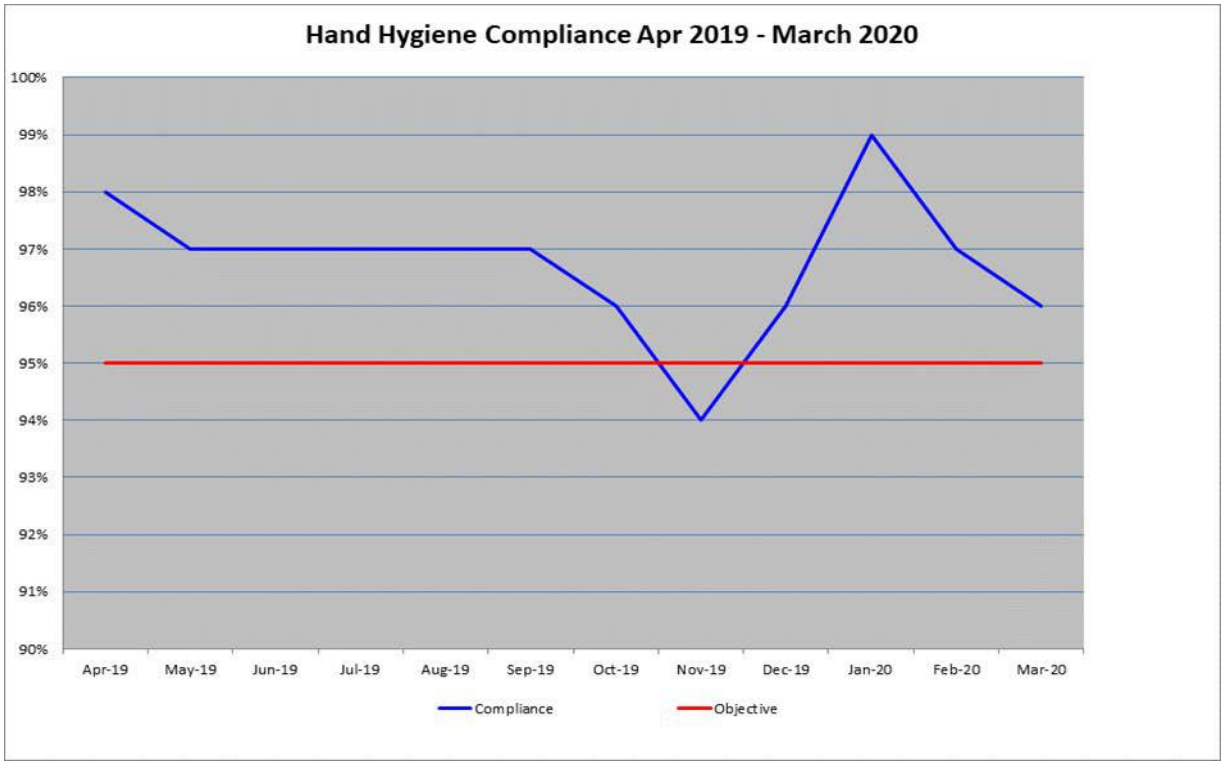
8.2 Hand Hygiene Compliance Monitoring

The corporate hand hygiene compliance monitoring process is established within both inpatient and outpatient areas. The chart below outlines Trust performance during 2019/20, with the Trust aim of achieving 95% compliance as minimum sustained throughout the year, except for a dip in compliance during November 2019. From January 2020 there was a change in the number of hand hygiene episodes required, going from 60 per month to 40 and the partial compliance (a minimum of 30 episodes per month) possibility was removed. This was to standardise the process so that all areas are submitting the same number of hand hygiene audits. The audit tool was also simplified to facilitate staff to collect the data more easily.

Hand hygiene compliance monitoring data is disseminated to all staff on a monthly basis, to ensure that staff remain aware of how the organisation is performing, highlighting areas for improvement in conjunction with policy requirements.

As routine adherence to required hand hygiene practice is key to ensuring that avoidable infections do not occur, the promotion of hand hygiene remains a high priority and is embedded within all infection prevention and control training. It has also been included as part of the ward accreditation scheme.

Figure 12 Trust-wide Hand Hygiene Compliance 2019/20



8.3 High Impact Interventions

High impact interventions are a suite of evidence-based, peer assessment tools that have been developed to provide assurance that key aspects of high risk clinical procedures or care processes are performed safely and effectively, reducing risks associated with healthcare associated infection.

The Trust has a robust rolling programme for high impact intervention monitoring embedded within the care provider divisions, including:

- Central line insertion
- Ongoing care of central lines
- Peripheral cannulation
- Ongoing care of peripheral cannula
- Urinary catheterisation
- Ongoing care of urinary catheters
- Renal dialysis catheter insertion
- Ongoing care of renal dialysis catheters
- Regular observation for ventilated patients or patients with a tracheostomy
- *Clostridium difficile*
- Enteral feeding
- Chronic wound management

These assessment tools provide a measure to indicate whether all required stages of any process have been completed correctly for every patient, on every occasion. The Divisional Facilitator analyses compliance data on a monthly basis, developing performance reports for dissemination and learning for relevant wards/departments. Outcome monitoring is also discussed at identified divisional forums and is part of the Infection Prevention Committee assurance reporting process for care providing Divisions.

Work continued within year to redesign and re-launch the High Impact Intervention programme, following publication of the revised High Impact Intervention evidence-based approach at a national level. A gap analysis was completed and local data collection resources were revised in support of identified improvements, discussion at the Nursing and Midwifery Board previously identifying that this programme will supplement the wider piece of work that is being undertaken to review how care metrics are routinely measured.

Unfortunately, the planned roll-out for the revised High Impact Intervention programme was paused due to a delay in co-ordinating the S-drive requirements for data collection and the emergence of COVID-19 infection increasing workloads for clinical teams. Roll-out of this revised programme will now take place in 2020/21.

9. Training and Education Programme

The Infection Prevention and Control Team delivers a well-established infection prevention and control training and education programme at all levels of the organisation that includes all healthcare workers, in clinical and non-clinical roles. This is aimed at ensuring that the workforce has the necessary knowledge and understanding to deliver services safely and effectively.

A synopsis of the infection prevention and control training and education programme is:

- Trust Welcome Event – To ensure that all new starters are informed of Trust expectation in relation to infection prevention and control, including the importance of routine adherence to policies and procedure. Key aspects of infection prevention and control are also included within the local induction packs that new starters receive and is further re-enforced during local induction requirements.

- Mandatory training – Staff groups across all areas and specialities of the organisation attend risk management mandatory training including senior clinicians and executives. Attendance requirements are as specified within the Trust Training Needs Analysis.

- Scheduled training and education programmes for Nurse Cadets, Nursing Assistants, Porters, Student Nurses and newly qualified Staff Nurses are established.

- Additional infection prevention and control training is routinely provided for all medical students and junior doctors.

- All training and educational materials are compliant with Health and Social Care Act (2008) criteria and are updated if national recommendations or evidence base alters. They also focus on key areas for improvements in practice, identified during any root cause analysis or audit process, and highlight Trust policy and procedure in relation to healthcare associated infection reduction.

- A rolling programme of practical hand hygiene training is established Trust-wide. The required equipment and training pack are stationed in designated areas around the Trust and moved to a different area each month on a rolling programme. A database is kept of all staff members that participate in this activity.

- Other ad hoc training and education takes place whenever the requirement for this is identified and can be related to any aspect of infection prevention and control. An established system is in place to facilitate this via the Trust's Training Directory.

- All methods of communication available to the Trust are utilised by the Infection Prevention and Control Team to ensure that information is distributed through all levels of the organisation in a varied manner, dependant on the content, with the team working closely with the Communications and Engagement Team. This may include poster development, training videos, on-line power point presentations, screensavers, emails, contributions to the Fortnightly Round-Up/Friday Feedback etc.

- Infection Prevention and Control Link Practitioners received enhanced training from the Infection Prevention and Control Team and external speakers via 2 dedicated study days during the year. A further study day planned for February 2020 was cancelled due to pressures Trust wide from the evolving COVID-19 situation.

Professional development of the Infection Prevention and Control Team also remains ongoing, with team members accessing training courses/national updates as relevant.

In response to emergency planning and preparedness for the escalating COVID-19 situation, the Trust took a novel approach to rapidly delivering the essential training and education to multiple staff, across all areas of the Trust. The development of the 'Floorwalker' role to support training and education in clinical practice took shape during 2019/20 and continued into 2020/21.

10. Policy Review and Development Programme

The Trust has a robust infection prevention and control policy review and development programme, co-ordinated through the Trust's document management system (SharePoint). Infection prevention and control policies are evidence based and available for any member of staff to access at all times,

with the availability and importance of routine adherence to policy being consistently re-enforced during staff training and education.

Policies may also be revised, re-written or developed if the available evidence base changes or novel practices or micro-organisms are identified. This may be ad hoc, but also forms part of the policy review and development programme. Any changes to policy are ratified through the Infection Prevention Committee and these changes are communicated to staff via established systems.

The Infection Prevention and Control Team also support the organisation in the development of non-speciality specific policies that may have an aspect of infection prevention and control within their content.

The following lists the available infection prevention and control policies that are routinely included within the policy review and development programme:

- Infection Prevention and Control Operational Policy
- Hand Hygiene Policy
- Infection Control Standard Precautions Policy
- MRSA Policy
- Clostridium difficile Infection (CDI) Policy
- Vancomycin Resistant Enterococcus (VRE) Policy
- Creutzfeldt-Jakob Disease and other Transmissible Spongiform Encephalopathies
- Carbapenemase-producing Enterobacteriaceae (CPE) Policy
- Norovirus Policy
- Patient Isolation Policy
- Linen Handling Policy
- Outbreak Control Policy (including ward/bay closure)
- Control of Blood Borne Pathogens Policy
- Management of Blood/Body Fluids Spillages
- Scabies – the diagnosis and management of inpatients
- Head Lice Management
- Toy Cleaning Policy
- Ice Making Machines – use and maintenance
- Birthing Pool Decontamination
- Faecal Management Systems
- Viral Haemorrhagic Fevers (VHF) Policy
- Invasive Group A Streptococcal (IGAS) Infection Policy
- Extended Spectrum Beta-Lactamase (ESBL) Producing Bacteria Policy
- Quick reference guide to influenza management 2019/20
- Middle East respiratory Syndrome Coronavirus (MERS-CoV) Policy
- Quick Reference Guide to Measles

Nationally, it has been agreed that England will universally adopt Scottish infection prevention and control policy and the route to achieving this commenced during 2019/20. The first guidance to be rolled out for national implementation related to hand hygiene and standard precautions. Local policy was cross-referenced with this national policy and revised accordingly. The long-term plan will be to adopt Scottish policy in its entirety; however, interim adjustment to local policy is required until this full adoption is achieved.

With the emergence of SARS-CoV-2 and COVID-19 infection within year, the Infection Prevention and Control Team also supported the organisation in the assessment and implementation of national policy, in response to the emerging pandemic.

11. Decontamination

The Trust has an identified Decontamination Lead who has responsibility for providing assurance via representation on the Infection Prevention Committee. This incorporates both sterilisation services (HSDU) and decontamination of endoscopes, as per national requirements and supports the corporate infection prevention and control assurance framework.

There are robust systems and processes in place for both the management of medical devices and decontamination of these, including a Medical Devices Group that is chaired by the Medical Director. A revised Decontamination Policy was approved and published within year.

Key personnel concentrate expertise around this area of practice within the organisation and aim to provide a corporate approach to all aspects of medical device and decontamination management. Any non-compliance with decontamination procedures are reported via the Trust incident management system to ensure that issues are escalated/addressed at the earliest opportunity.

The Equipment Library and Decontamination Unit (ELDU) has responsibility for decontaminating items of equipment that are generically used across the organisation, but have no requirement to be sterilised and reports directly to the Electrical and Biomedical Engineering (EMBE) service. This maintains the improved standards of cleaning/disinfection for items of equipment that would otherwise be decontaminated at ward/departmental level.

12 Other Infection Prevention and Control Activities

12.1 Procurement

Equipment purchased by the Trust is subject to a structured assessment process prior to purchase, as detailed within the policy for the purchase of medical devices. Infection prevention and control is included within this process, ensuring that any item of equipment is fit for purpose and can be appropriately decontaminated.

The Infection Prevention and Control Team continue to work with procurement and commodities to facilitate procurement, also providing expertise for any relevant tendering process, whether for equipment or external service provision.

12.2 Service Development

Ensuring infection prevention and control involvement within any service development is included within the corporate infection prevention and control assurance framework and devolved to individual Divisions within assurance plans.

Estates have established processes for involving the Infection Prevention and Control Team within all new build, refurbishment or remodelling projects undertaken within the organisation. Collaborative working occurs from the earliest opportunity, through the planning/design stage, undertaking risk assessments prior to any works commencing, with a final infection prevention and control

assessment of the completed work prior to clinical activity commencing. This ensures that the risks associated with building/refurbishment work within any health care environment are controlled and that the resulting facility achieves infection prevention and control standards, as detailed within the associated evidence base.

12.3 Water Safety

Work took place within year to strengthen the Trust's Water Safety Group and the group were delighted to welcome Dr Tom Makin as the Authorising Engineer for water. The Water Safety Group is chaired by the Head of Estates and includes Consultant Microbiologist and Infection Prevention and Control Nurse membership, with the group reporting to the Infection Prevention Committee and the Estates and Facilities Divisional Board.

The focus of the Water Safety Group is to assess and maintain Trust compliance with current relevant guidelines and legislation relating to the safe management of water systems, including the control of waterborne pathogens such as *Pseudomonas aeruginosa* and *Legionella*.

This work includes design, installation, commissioning, testing, monitoring and operation of the water systems within the Trust. This is to enable prompt action if issues are identified, promoting good practice and protecting vulnerable patients.

12.4 Patient Flow and Bed Management

The Infection Prevention and Control Team regularly liaise with clinical site co-ordinators through established processes. Information sharing includes availability of single rooms within the organisation, to aid appropriate isolation at the earliest opportunity, management and control of any identified infection related bed closures to facilitate patient flow, plus the management and control of outbreaks.

The Infection Prevention and Control Nurse Team routinely undertake risk assessments to assist in maintaining operational capacity, while maintaining patient safety. This is facilitated by the team's clinical caseload, ensuring that all relevant microbiological results are reported in real time and that individual cases are regularly reviewed, to ensure that patient management is appropriate and that patient isolation is not unnecessarily prolonged.

It has been recognised corporately that the emergence of antimicrobial resistant organisms continues to put increasing pressure on the organisation's capacity to isolate patients, due to insufficient single rooms within the existing footprint. Work remains ongoing to identify methods to address this.

This collaborative approach to patient flow and bed management supported early planning for the Trust response to COVID-19 infection, including assessment of how the Trust would achieve compliance with national guidance for patient placement, to reduce risks associated with transmission of SARS-CoV-2.

12.5 Occupational Health

The Infection Prevention and Control Team maintains a close working relationship with Occupational Health, assisting with various workforce related activities including risk assessments for individual staff members, policy and guideline reviews and staff vaccination campaigns.

12.6 Infection Prevention and Control Link Practitioner Programme

The Trust has an active Infection Prevention and Control Link Practitioner programme (IPCLP) including members of staff from varying areas of service delivery, including allied health professions.

Link practitioners are a valuable asset to the Trust's infection prevention and control programme, acting as role models for their colleagues, demonstrating good practice and raising infection prevention and control awareness within their clinical area, having a positive influence on practice.

IPCLP study days occur twice per year and are a useful resource for disseminating infection prevention and control related information in more detail, providing enhanced knowledge and training for the IPCLP to take back to their individual areas. There is also a quarterly newsletter to share good practice and identify areas of practice for local consideration and improvement.

During 2019/20, the Infection Prevention and Control Team continued to develop a central electronic reporting system in support of the locally developed Link Practitioner audit programme. This audit programme was launched within year; however, work to strengthen implementation was paused due to the emergence of SARS-CoV-2 and the associated operational pressures that staff were experiencing at ward/department level. There are plans to re-launch this audit in programme during 2020/21.

12.7 Domestic Services

Meetings between Domestic Services managers and the Infection Prevention and Control Nurse Team occur on a bi-monthly basis and more frequently if required, to problem-solve and develop improvements in practice, monitoring any projects that are in progress. Domestic Services have an essential role within strategic planning for the infection prevention and control programme, including environmental cleaning, the Bed Turnaround Team, waste handling and disposal and linen services.

Domestic Services Managers work in close partnership with the Infection Prevention and Control Nurse Team on all aspects of cleanliness and the environment, including regular attendance at PLACE meetings (Patient-Led Assessments of the Care Environment).

PLACE, a national programme, is service user focussed and patient-led, with multiple patient representatives being involved within the assessment process, reviewing cleanliness, buildings and facilities, food, hydration, privacy, dignity and well-being. The organisation is able to demonstrate good standards of cleanliness overall via the regular programme of cleanliness monitoring that is conducted in-house, supported by PLACE assessment reports. In addition, Domestic services carry out monthly audits on all Ward areas to ensure standards of cleanliness are maintained and have systems and processes in place to provide a rapid response if standards of cleanliness require attention in any area of the Trust.

As the New National Standards of healthcare cleanliness, are due to be ratified post their draft status imminently, Domestic Services have taken the opportunity to begin a review of their current service to 'future proof' the function and meet the new demands. The New National Standards of Healthcare Cleanliness allocates each area within the Trust a Functional Risk rating which mandates how often audits have to be completed for each area. These range from:

- Weekly for Functional Risk 1

- Monthly for Function Risk 2
- Bi-monthly for Function Risk 3
- Quarterly for Function Risk 4
- Six monthly for Function Risk 5
- Annually for Function Risk 6

Each audit has a corresponding % score that needs to be achieved as a pass rate with an emphasis on action plans being produced if these scores are not achieved. The % scores are to be published, as a star rating, outside each area. To achieve these new standards, Domestic Services (within the scope of the review) have identified that a team of Supervisors will act as the auditors, using a new audit tool as the current provider does not meet the requirements of the new standards. The initial service review in response to the publication of these standards had to be suspended due to COVID-19 and will be re-launched during 2020/21.

Unique challenges were presented to the Trust with the emergence of COVID-19 and saw a 'dynamic' approach in delivering Domestic Services across the Trust as a consequence of national recommendations and local changes in being able to control and prevent infection spread. However, although cleaning standards have been maintained, this approach is not sustainable into 2020/21 and the Domestic Services operation will need to be adjusted to meet the new requirements moving forwards. The re-launched service review is aimed at ensuring that Facilities Services have created an environment that supports patient centred care and supports nursing colleagues in being able to take time to care.

13 Infection Prevention and Control Objectives for 2020/21

With the emergence of SARS-CoV-2, infection prevention and control remains essential to the delivery of high quality, safe and effective healthcare services, ensuring that avoidable healthcare associated infections do not occur and will continue to be a key priority for the Trust throughout 2020/21.

MRSA bacteraemia and C. difficile infection reduction as key performance indicators continue to be a significant national and local challenge. Due to the emergence of the COVID-19 pandemic, the national reduction objectives for MRSA bacteraemia and CDI have been not been released for 2020/21. There was also the expectation that national GNBSI reduction objectives would be introduced from 1st April 2020, with this also being delayed at the time of writing this report. Pending release of any revised national HACI objectives, the Trust continues to work towards a zero tolerance approach to all HCAI, including:

- Zero avoidable MRSA bacteraemia cases within year
- Fewer than 36 cases of C. difficile infection within year

Infection prevention and control activity will continue to focus on the following objectives:

1. To maintain a focus on evidence-based risk reduction measures for COVID-19 infection, supported by the infection prevention and control COVID-19 board assurance framework.
2. To integrate the infection prevention and control COVID-19 management checklist into the ward accreditation programme, for quarterly compliance review – Trust-wide objective to achieve 95% compliance for all standards by April 2021.

3. To develop the HCAI improvement plan and incorporate the areas for improvement that were identified following the infection prevention and control COVID-19 management checklist baseline assessment audit.
4. To continue collaborative working towards a reduction in the number of Gram-negative bloodstream infections within the local health economy.
5. To continue development of the corporate infection prevention and control assurance programme, including:
    - Revised quarterly IPC/HCAI Board reporting
    - Further development of the Infection Prevention and Control Strategy Group
    - Development of an infection prevention and control dashboard to maintain oversight of identified outcome measures
    - Further development of a robust process for self-assessment of compliance with the Health and Social Care Act (2008) Code of Practice on the prevention and control of infections and related guidance, or adoption of a national compliance matrix if this is developed
6. To maintain established systems for promoting best practice to reduce the number of bacteraemia cases due to antibiotic resistant organisms, including MRSA, CPE and VRE, via learning from root cause analyses and national evidence base.
7. To complete the Domestic Service Review to support compliance with the National standards of healthcare cleanliness, plus enhanced cleaning frequencies as part of the local response to COVID-19 infection.
8. Make progress against the capital planning programme to support environmental improvements, including backlog maintenance and ventilation.
9. To maintain focus on antimicrobial stewardship strategies, incorporating the 'Start Smart Then Focus' approach, to support a reduction in clinically inappropriate antibiotic prescription and consumption.
10. To consistently achieve 95% compliance or above with hand hygiene practices
11. To demonstrate sustained improvement in compliance with MRSA screening practices.
12. To maintain local surveillance systems, ensuring that Trust responsibilities are met, as part of the national mandatory HCAI surveillance programme.
13. To maintain training and education programmes for all staff groups, consistently reinforcing the routine implementation of infection prevention and control standards and antimicrobial stewardship for all patients, all of the time.
14. To maintain systems of information dissemination to ensure that the workforce remains informed and engaged on performance against agreed aims for healthcare associated infection reduction, adapting these as circumstances dictate.

This activity is not exhaustive and is routinely monitored via the corporate infection prevention and control assurance framework, adapting systems and processes to the needs of the population and service provision as required.

Infection Prevention and Control Team
August 2020

Meeting	**1st December 2020**		**Board of Directors**					
Report	**Agenda item 17.c**		**Continuous Improvement Strategy**					
Purpose of the Report	Decision	✓	Ratification		Assurance		Information	
Accountable Executive	Susan Gilby				Chief Executive Officer			
Author(s)	Ian Bett Hollie Salisbury				Director of Transformation Head of Continuous Improvement			
Board Assurance Framework	P2, Q1, E1, E2, E3, P1							
Strategic Aims	Delivers towards safe and effective care							
CQC Domains	Safe, Effective, Caring, Responsive and Well Led							
Previous Considerations	Informal Engagement Sessions at: • Staff engagement sessions • Executive Away Day, 13th July 2020 • Non-Executive Directors Briefing, 20th July 2020 • Transformation Group, 3rd September 2020 • Quality & Safety Committee, 15th September 2020							
Summary	The purpose of this report is: • To present the proposed new Continuous Improvement Strategy for the Trust • to seek approval of the Continuous Improvement Strategy							
Recommendation(s)	The Board is asked to**:-** • Ratify the Continuous Improvement Strategy							
Corporate Impact Assessment								
Statutory Requirements	CQC Standards							
Quality & Safety	Improved Quality and Patient Safety							
NHS Constitution	Aid improvement in performance standards							
Patient Involvement	Improved Patient Involvement (Lived Experience Panel)							
Risk								
Financial impact	Improve efficiency and reduce waste							
Equality & Diversity								
Communication	Communication to staff across the Trust							

Continuous Improvement Strategy 2020 - 2025

BACKGROUND

1. Over the past 18 months research has taken place by visiting different organisations with a strong continuous improvement culture, both within and outside of healthcare. From our learning and with the help of our people we have developed a Continuous Improvement Strategy which aims to create a culture of continuous improvement at the Countess. A number of factors went into understanding the need and benefits in the need for a new approach into Continuous Improvement. They include:

    - Improved quality and improvement of services for patients
    - Improved staff engagement, experience and retention
    - It is recognised as a key enabler by regulators, such as the CQC, that a strong Continuous Improvement methodology and strategy improves care and outcomes for patients
    - It develops an organisational culture of learning and improving
    - It is a standardised approach to improvement

PURPOSE

2. The purpose of this paper is to seek approval of the new Continuous Improvement Strategy for the coming 5 years. The strategy details a number of key areas:

    - The importance and what Continuous Improvement is
    - Ambitions of the Trust
    - Where we are now and the planned benefits of the strategy
    - The proposed methodology
    - Our aims of the Strategy (including details of our proposed six primary drivers)

CURRENT POSITION

3. A draft strategy has been created in conjunction with our staff. Engagement sessions have been delivered over the past 10 months via various routes and we have directly engaged with over 1,200 staff. Staff who attended a face to face (or virtual) session was asked to provide feedback on the draft strategy via survey monkey, this has been considered in the final edit which is reflected in this draft strategy. Engagement has also been sought with our senior clinical and managerial leaders within the Trust as well as the executive team and non-executive directors. We are now seeking approval from the committee to formally launch the strategy.

RECOMMENDATION

4. The Board is asked to:-

- Ratify the Continuous Improvement Strategy

NHS
Countess of Chester Hospital
NHS Foundation Trust

Continuous Improvement Strategy

2020/2025

Contents

"I am delighted to see the development of a Continuous Improvement Strategy for the Countess. Myself and the Non-Executive Directors believe that this is the right approach to ensure that we are continually improving all that we do for our patients. We look forward to hearing about progress of the strategy and sharing our improvement experiences, both from within and outside of the NHS to support its delivery."

CHRIS HANNAH
CHAIR

Foreword

I am pleased to share with you our five year strategy for Continuous Improvement (CI). This document marks an important step forward for our Trust as CI will become an integral part of everyone's daily work.

This places our people at the forefront of improving care as they are best placed to identify and solve the problems they face. This approach will help to make a real difference for our patients and support our staff to continue to deliver the highest standards of care - whatever your role, you all have the power to influence and improve the services you deliver.

Within this document you will read more about our chosen methodology for improvement - Lean. I have seen first-hand the benefits that this methodology can achieve. The application and commitment of adopting this methodology is what will set us apart in the years ahead. Please rest assured Lean is not about cutting costs and reducing the workforce, Lean helps us focus on the processes to support the people to do the best that they can do. Lean will help us to redesign our pathways and processes to ensure that all that we do is adding value. We are a clinically led organisation which means putting the needs of the patient first.

The CI strategy will be a key enabler for delivering other strategies such as the Clinical Strategy which describes the shape and direction of our clinical services over the next five years. Whatever we do our services need to be safe and effective, a message which you will have heard me say many times before.

It is well known that the safest and most effective hospitals are ones where they have a formal CI methodology which is recognised and adopted across the Trust. Our strategy provides a clear statement of intent to CI and provides clear and concise stages of our aim, which I believe, will support our progression towards becoming an outstanding Trust.

To deliver the strategy successfully I recognise that you may require support from me and the Board of Directors. The Trust Board will undertake training in Continuous Improvement to ensure we understand the approaches and are best placed to support you. The Trust Board will play a key role in guiding teams to success. We will ensure, where we can, we will remove the

blockers to enable our staff to make improvements happen. Our CI strategy reiterates the Trust Board's commitment to delivering safe and effective care to our patients.

I ask of you all, encourage and support each other to make continuous improvement happen.

Dr Susan Gilby,
Chief Executive Officer

You may be more familiar with the term Quality Improvement (QI) rather than Continuous Improvement (CI).

Whilst they both aim to achieve the same outcome, our people told us that they felt CI was a better phase to use as it reflects that we are all continually building on the great care that we already provide.

As a partner within the West Cheshire Integrated Care Partnership (ICP) we recognise the importance of working with others in the wider healthcare system, working in partnership to develop innovative and integrated ways of working that drive CI. We know services will need to adapt and transform to meet the changing needs of our population.

The CI Strategy demonstrates our commitment to improve the quality of care for our patients. It sets out our clear aim and priorities and, most importantly, how all staff can be supported and encouraged where they see an opportunity to make improvements. To create a culture of CI we promise to ensure our staff are equipped with the skills they need to get through challenges they face. We will continue to strengthen and support our leaders by proving them with the skills to motivate and empower staff to lead and deliver improvements themselves. This strategy should be a living document which supports all of our staff to bring to life our ambition

Ian Bett,
Director of Transformation

Introduction

As a Trust we are committed to continually improve the experience and outcomes in all that we do.

Continuous improvement is a way of working which delivers improvements by the everyday use of improvement tools and techniques.

An important success factor for continuous improvement is the way in which change is introduced and implemented. Taking a consistent approach and ensuring that all staff understand their role is essential if we are to continually improve the quality and safety of care we provide for our patients.

Our ultimate ambition is for the Countess of Chester Hospital to build and embed a culture of continuous improvement across the Trust. This means that we make improvement a daily routine activity and use improvement tools and techniques to solve the problems we face. Paul Batalden, Senior Fellow at the Institute for Healthcare Improvement and teacher at the Jönköping Academy in Sweden states, "everyone in healthcare really has two jobs when they come to work every day: to do their work and to improve it"[1].

Building a continuous improvement culture will not happen overnight and we recognise that this is a journey which will require commitment and determination from all.

This document sets out our five year strategy for continuous improvement, however this will be reviewed and updated every two years. The strategy, and the plans which underpin it, will be closely linked with the Care Quality Commission's (CQC) domains of safe, effective, caring, responsive and well-led.

> "Continuous improvement is a systematic, sustainable approach to enhancing the quality of care and outcomes for patients."
>
> **KPMG[2]**

> "I am very happy to endorse our refreshed approach to continuous improvement within the organisation. We have a strong track record in delivering across a range of quality improvement (QI) projects and have taken a conscious decision to reframe our success into a wider and more challenging phrase –continuous improvement. By making this change, we are reflecting how we embed a culture of improvement into business as usual and away from project-based approaches. This is a change which I am sure will be welcomed by our people. We have an incredibly enthusiastic and high performing CI support team and I look forwards to facilitating further success in the months and years ahead."
>
> **DR DARREN KILROY, MEDICAL DIRECTOR**

Developing
the strategy

We have developed this strategy through a series of workshops in which we have talked to and listened to our colleagues and users of our services.

The workshops were carefully designed to gain an understanding of what is important to our people and how we can work together to build a continuous improvement culture.

The feedback and recommendations that have been captured have been collated and throughout this strategy you will see how we have turned these into our drivers for embedding a continuous improvement culture at the Countess of Chester Hospital.

Throughout the strategy we have included key learning points from experts in improvement.

Learning from Others

We recognise the value of learning from others, especially those who have already started on their continuous improvement journey. Learning from outstanding organisations, both within and outside of the NHS, we have found 6 consistent learning points in which we have considered when developing our strategy.

1. Staff engagement is a vital driver for change
2. Small change is just as important as large scale change
3. A standardised and disciplined approach is essential for success
4. It is a marathon, not a sprint
5. Leadership is key to success
6. Cultural change is needed ‘the way we do things around here’. It is not a programme of work.

Word cloud created at one of our workshops.

The image is composed of words used within the workshop, the size of each word indicates the frequency that is was used.

> “This strategy cannot be created in isolation, engaging our patients, doctors in training and staff in the development is vital for its success. I believe the strategy should be patient focused and promote a straightforward approach which should be adopted by everyone working here”
>
> **IAN BENTON**

Strategic Overview

and Trust Priorities

Our Corporate Strategy describes the shape and direction of our Trust over the next five years with a focus on a number of key themes including the development of our workforce, our digital ambitions and how we see our estate will look in the future, just to name a few.

Continuous Improvement is recognised by the Trust as the key enabler and support to our staff in delivery of our Trust ambitions contained within the Corporate and Clinical Strategy and future enabling Trust strategies and plans .

Where are we now?

Care Quality Commission (CQC) inspection

Our hospital works closely with regulators and commissioners to ensure we continuously strive for excellence and monitor our progress against local, regional and national standards of care. The Trust underwent a CQC inspection in 2018. We were disappointed to report that the CQC could not be assured that our current systems and processes were effective. The Trust was rated as 'Requires Improvement' overall: we will change that.

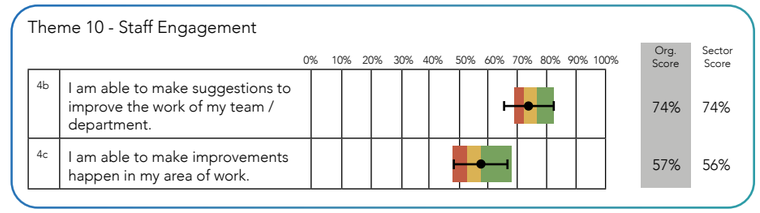
Overall rating for this trust	Requires improvement
Are services safe?	Requires improvement
Are services effective?	Requires improvement
Are services caring?	Good
Are services responsive?	Requires improvement
Are services well-led?	Requires improvement

Our continuous improvement strategy aims to see us strive towards becoming an 'Outstanding' organisation, which is no less than our patients and staff deserve. All improvements will be assessed against the five key questions the CQC considers during an inspection:

- Safe? You are protected from abuse and avoidable harm.
- Safe and Effective? Your care, treatment and support achieves good outcomes, helps you to maintain quality of life and is based on the best available evidence.
- Caring? Staff involve and treat you with compassion, kindness, dignity and respect.
- Responsive? Services are organised so that they meet your needs.
- Well-led? The leadership, management and governance of the organisation make sure it's providing high-quality care that's based around your individual needs, that it encourages learning and innovation, and that it promotes an open and fair culture.

Staff Survey

We know that staff engagement is vital for success in our continuous improvement journey. Our latest staff survey results tell us that 26% of our staff, who completed the survey, do not feel able to make suggestions to improve the work of their team or department.
Also, only 57% of staff who completed the survey feel able to make improvements happen in their area of work. The CQC also reported in their latest inspection that staff working here did not always feel actively engaged or empowered.



To embed a continuous improvement culture our staff must feel empowered and skilled to make improvements happen. Our staff are the experts in their field of work and therefore in conjunction with patients, are best placed to identify, create and deliver the improvements that need to be made. It is essential that they feel empowered and confident to make improvements happen.
With the successful implementation of the continuous improvement strategy we aim to improve our staff survey results for questions 4b and 4d, and place best in peer.

> "The key attributes for improvement are good leadership, effective staff engagement and a strong organisational culture that embraces learning."
>
> **PROFESSOR TED BAKER, CHIEF INSPECTOR OF HOSPITALS, CQC[3]**

Friends and Family Test

The Friends and Family Test (FFT) is a way that patients can provide feedback on their experience and asks if they would recommend the services they have used. Listening to the views of patients helps us identify what is working well, what can be improved and how.

In 2019 we reported that 86.7% of patients that have used our services would be likely to recommend them to friends and family. Our strategy aims to seek the views of our patients and include them in our improvements. We aim to improve our FFT score to be best in peer.

Quality Champions

To date we have trained approximately 200 staff in the basics of improvement methodology. We are proud of the improvements our staff have made but recognise the need to widen the capability. Our Quality Champions will be key individuals in the successful delivery of our new continuous improvement strategy.

JO BATEMAN,
PHARMACIST AND QUALITY CHAMPION

"I attended an improvement programme where I learnt about improvement methodology and the tools and techniques that sit within it. As part of the programme I undertook an improvement project which aimed to develop the pharmacy technician role to provide a medicine administration service on the intermediate care unit.

Traditionally, nurses administer medication to patients in hospital and audit work shows that they spend over 40% of their time handling medicines; successful completion of my project would enable nursing staff to focus their skills on delivering patient care. I created a driver diagram which helped me plan my improvements, and then tested my ideas using a PDSA cycle. A go see exercise was undertaken which timed the pharmacy technicians administering medications.

The pharmacy technician providing medicines administration saved on average 132 mins per day of nurse time administering medicines each morning and lunch. Subsequently, this has now become standard practice in many areas across the Trust with additional funding provided to recruit more technician medicine administration roles. Within Pharmacy, I circulated the improvement methodology to all staff members undertaking improvement projects and requested that all projects should follow this as I had found it a useful tool to ensure projects were written up concisely and appropriately.

I have also applied the knowledge and tools to all further projects and have recently completed an innovative project looking at integrated working for medicine optimisation reviews for patients on direct-acting oral anticoagulants in Primary Care, which has been written up using the improvement skills and techniques which I think has made the process more robust and efficient."

PERRY MASKELL,
JUNIOR DOCTOR

I had the idea of a Quality Improvement Project (QIP) to "Improve e-Discharge summary timeliness in surgery" after working in the colorectal department during year one of my foundation programme and feeling frustrated by being given the responsibility of completing the backlog of those that had not been done. I was guided by the QI team to explore the issue utilising the tools and techniques I had learnt during a teaching session.

I started by researching the standard of what we should be doing, I found a national target of completing every e-Discharge summary (EDS) within 24 hours of the patient leaving the hospital. I knew from my experience, that the surgery department couldn't be reaching this target, so I sought how the department was doing in terms of an exact percentage. Once I had these figures, I could confirm there was an improvement to be made. From there I enlisted the help of two of the clinical fellows in general surgery, as well as gaining a consultant supervisor to oversee the project. It was really important to create a project team to support and drive the QIP forward.

We kicked off the first intervention, beginning PDSA cycle one, where we tried to get Surgical Assessment Unit staff to print the outstanding e-Discharge list daily, to prompt the doctors to be aware of the backlog, and hopefully facilitate their completion. Adding to this, the second PDSA cycle initiated the role of "e-Discharge co-ordinator" within the surgical team, to keep better track of the backlog, and organise the junior doctors to address it. The first two PDSA cycles were not successful towards improving the issue however, the purpose of the PDSA allows us to learn as quickly as possible whether an intervention works. I have made adjustments accordingly to increase the chances of delivering and sustaining the desired improvement and I am now amidst a new PDSA cycle, with the intervention being a formal arrangement in the morning and evening handover policy, whereby the outstanding EDS list will be printed and discussed.

We are in the process of reviewing this by keeping track of the intervention uptake, hopefully enabling us to correlate the intervention with a change in EDS completion timeliness. I recognise that there is still work to be done but using QI methodology has helped me structure the process and I feel that it has helped and hopefully the sustainment of the improvement".

''We should be using improvement methodology to help achieve sustained improvements''

DEBBIE BROWN, CONTINUOUS IMPROVEMENT MANAGER

Methodology

If we are to embed a continuous improvement culture we need to adopt and apply a methodology for change that is recognised by all staff

Øvretveit, a leading expert on quality in healthcare, describes improvement as better patient experiences and outcomes achieved through changing provider behaviour and organisation through using a systematic change method and strategies[4]. The key elements in this definition are the combination of a 'change' (improvement) and a 'method' (an approach with appropriate tools)[5].

"Lean management tools empower staff to support patient-centered care by improving their daily work processes, eliminating waste and non-value added activities, and ultimately, becoming more efficient and innovative at problem-solving"

VIRGINIA MASON INSTITUTE, SEATTLE, USA[6]

Lean

Our principal method for change will be Lean. Put simply Lean is about ensuring we are maximizing value whilst minimizing waste. Lean helps us to identify the least wasteful way to provide better, safer healthcare to your patients - with no delays[7]. Lean is not about cutting costs.

Lean has been developed from the Toyota Production System and has been used successfully in manufacturing and other industries such as Amazon and Tesco for many years. It is increasingly being applied to health services in the UK and overseas to improve the quality of clinical care, improve patient safety and experience, eliminate delays, and improve productivity and financial health. There are many examples across the NHS showing that even relatively small-scale quality improvement initiatives can lead to significant benefits for patients and staff, while also delivering better value[8]. You may be familiar with 'Releasing Time to Care, The NHS Productive Series' which evidenced success in the in the NHS by using Lean to reduce

time spent on tasks that don't add value and to put this time back into patient care.

One of the key themes of Lean is 'respect for people'. In the context of Lean this means the people closest to the work should be empowered to assess current conditions and create solutions to problems they find to make improvements happen - which we know from our staff survey results our people want to do. There are many Lean tools such as Go See, Value Stream Mapping, Plan-Do-Study-Act (PDSA) and A3 Thinking which will support our people to make improvements happen.

Go See

We use Go See to solve problems and improve processes by going to the source and personally observing and verifying. If a problem exists on the 'shop-floor' then it needs to be understood and solved there (this may also be referred to as a Gemba Walk).

Value Stream Mapping

The concept of the 'value stream' comes from the Lean management approach. Value stream mapping analyses what is currently happening (the current state) to help identify and eliminate waste so that ultimately every step of the process adds value to the patient.

A3 Thinking

This is standardised problem solving methodology incorporating the PDSA cycle. It is framework for organising thinking for individuals and teams which tells a story – like a story board for a film. Like all lean tools it is visual which helps engage others.

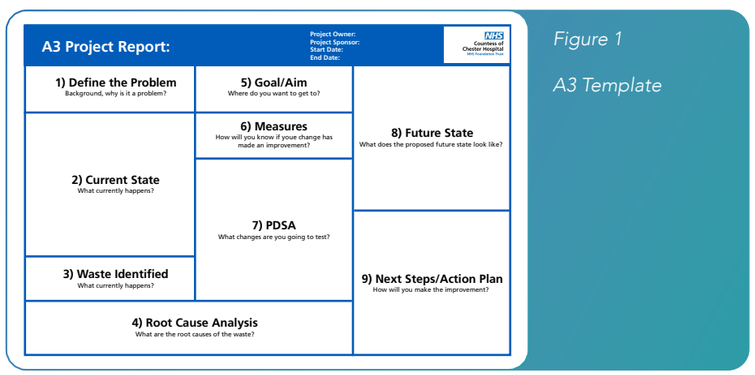


Figure 1

A3 Template

> "Lean is a set of operating philosophies and methods that help maximum value for patients by reducing waste and waits. It emphasizes the consideration of the customer's needs, employee involvement and continuous improvement. "
>
> **MICHELLE GREENE, DIVISIONAL MEDICAL DIRECTOR**

PDSA

We use PDSA cycles to test an idea by trialling a change on a small scale and asses its impact, building upon the learning from previous cycles in a structured way before wholesale implementation[9].

Although our predominant improvement methodology will be Lean we recognise that we may need to use other improvement approaches such as the Institute for Healthcare Improvement's Model for Improvement and Driver Diagrams. Driver Diagrams are a simple way to show an overall improvement goal. The diagram breaks down the improvement into manageable chunks. It is a visual tool which allows you to communicate your improvement strategy and support the development of a measurement framework.

Measurement for Improvement

We use measurement every day in our roles for example, taking a patients temperature in order to understand if they are getting better. Measurement is critical when making changes as it shows whether or not you are making an improvement. We must move away from hunches

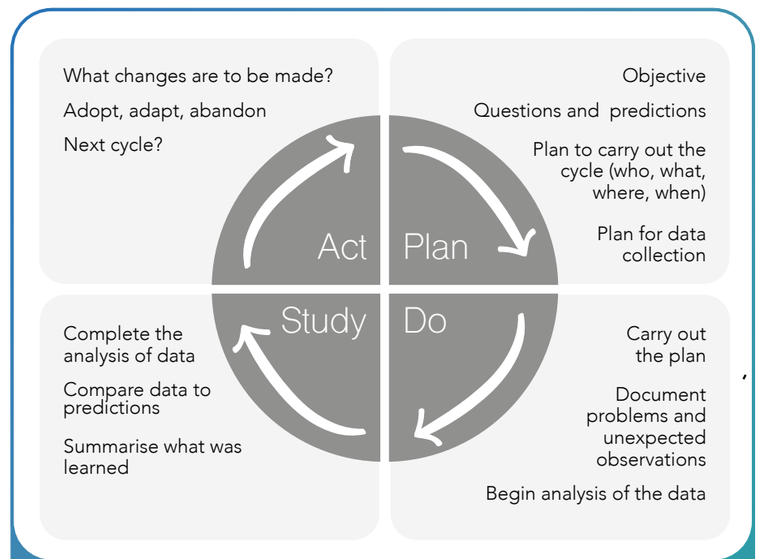


Figure 2 (PDSA Cycle), NHS Improvement

when it comes to evidencing improvements and instead use quantitate and qualitative data. Where appropriate run charts and statistical process control (SPC) should be used to plot data over time.

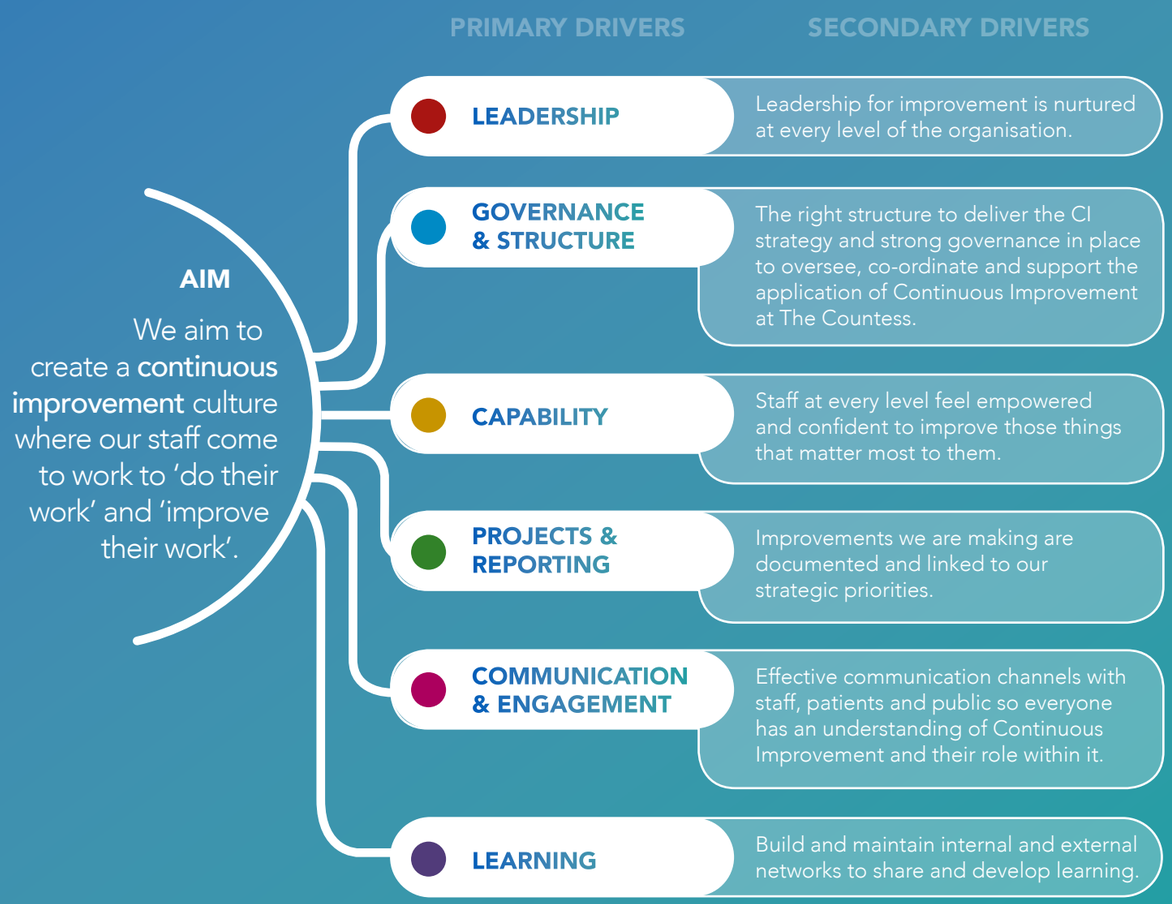
Using these techniques helps us understand variation and in so doing guides us to take the most appropriate action[10].

> "The way data is presented can sometimes not highlight the important issues that should be focussed on. SPC is really useful in identifying the real issues to help with decision making and monitoring of performance to drive improvements."
>
> **HELEN NOWAKOWSKA, BUSINESS PERFORMANCE MANAGER**

Our aim

Our aim is to create a culture in which staff working at the Countess of Chester Hospital come to work to 'do their work' and to 'improve their work'.

Our aim will be achieved through a number of drivers outlined below. Further information about each of the drivers will be provided through the remainder of this paper.



Common Language

We want to ensure there is widespread understanding of our approach to continuous improvement. There may be new terms used that our staff are not yet familiar with. We will create a common language which will become embedded in the way we do things, motivating staff with terms that highlight the benefits for patients.

Leadership

DRIVER ONE

Leadership for improvement is nurtured at every level of the Trust;

The CQC use 'key lines of enquiry' for their assessment of the 'well-led' domain. A rating of outstanding is defined as 'the leadership, governance and culture are used to drive and improve the delivery of high quality person-centred care'.

We need to ensure that everyone working here is committed to adopting our continuous improvement culture. You do not need to be in a management position to lead improvement and all staff will be expected to make improvement a daily routine.

As a Trust we need to ensure people looking to work at the Countess of Chester Hospital are aware of our continuous improvement journey and the culture in which we are working towards creating.

Developing a continuous improvement culture will require our leaders to adopt the behaviours required to lead improvement such as, embracing problems as opportunities for improvement, being visible, utilising improvement methodology and actively engaging in improvement efforts. These behaviours align to the Trust values and behaviours. Our leaders should also be empowering their staff to 'do their work and improve their work'.

To ensure leadership for improvement is nurtured at every level of the Trust we will:

- Provide our leaders with the training and support required to lead successful improvements;
- Leaders will be expected to use a structured approach to support improvements;
- Everyone working here will be asked to evidence at least one improvement effort at their annual appraisal;
- Ensure evidence of adopting continuous improvement behaviours are included in succession planning;
- Include our strategy aim within all future job descriptions and look to recruit staff with experience of continuous improvement or a commitment to adopt the behaviours;

> "Organisations who have paid attention to developing a leadership and culture for improvement, most typically demonstrate the greaterstrides toward achieving tangible improvements in safety, positive patient experience and clinical care outcomes."
>
> **DAVID FILLINGHAM AND LESLEY MASSEY, ADVANCING QUALITY ALLIANCE[11]**

Governance & Structure

DRIVER TWO

The right structure to deliver the strategy and strong governance in place to oversee, co-ordinate and support the application of Continuous Improvement at the Countess;

Governance

Quality & Safety Committee
The Quality and Safety Committee supports the Board in ensuring that the Trust's management, and clinical and non-clinical processes and controls are effective in setting and monitoring good standards and continuously improving the quality of services we provide.

Transformation Group
The Transformation Group will report to the Quality & Safety Committee and is responsible to drive forward the development and delivery of the strategy. A quarterly report will be submitted to the Quality and Safety Committee providing an update of progress made against the strategy delivery. We will also report to the Board twice a year.

"Investment in the infastructure is required to create a Continuous Improvement culture"

PETER FOLWELL, LEAD GOVERNOR

Structure

Embedding a continuous improvement culture will require everyone's support however; we have identified a guiding team who will play an active part in supporting the delivery of the strategy.

The Board
- Responsible for oversight and delivery of improvement work across the Trust
- Provide strategic direction in regards to priorities, key themes and outputs
- Leads for value streams and strategy drivers

Continuous Improvement Team
- A central team to ensure that staff have a single point of access to co-ordinate and support
- Provide structure, methods and rigor behind improvement methodology
- Build capacity and capability across the Trust by training and developing staff to use the methodology

Continuous Improvement Clinical Leads
- Ensure that improvements are clinically led, putting the needs of the patient first
- Support the identification and delivery of value streams (beyond own area of clinical expertise)
- Engagement and pace

To support the delivery of the strategy we will ensure the right structure and governance is in place by:
- Holding monthly a Transformation Group to drive forward the delivery of the strategy;
- Provide quarterly progress reports to The Quality and Safety Committee;
- Identify and confirm Continuous Improvement Clinical Leads;
- Ensure clear roles and responsibilities are in place for the Trusts guiding team and these are adhered to and we hold each other to account.

Capability

DRIVER THREE

To ensure our staff feel empowered and confident to improve those things that matter most to them;

We know that staff working here have an abundance of knowledge and expertise in their professions. We want to empower our staff to identify and lead improvements in their own area of work and providing them with the knowledge, skills and support to do so. Another key line of enquiry used by the CQC to establish if an organisation is well led is whether robust processes are in place to support learning, continuous improvement and innovation. It is therefore essential that staff have knowledge of our continuous improvement approach and access to improvement tools and techniques.

Although all staff working here must be familiar with our approach we will use a 'Dosing Formula' to develop different levels of improvement expertise across the Trust. This is demonstrated in figure 1 and has been based on the Advancing Quality Alliances adapted dosing formula[12]. The concept of 'dosing' was first developed by Dr Robert Lloyd at the Institute for Healthcare Improvement (IHI) and is derived from the principles used to establish the appropriate dose of a medicine. The dosage of the medicine would be based on the patient's needs. In a similar manner the 'dose' of the improvement knowledge will differ depending on the needs of the individual and their role in the making the continuous improvement journey a reality. The key point of dosing is that not everyone needs the same depth of knowledge about improvement concepts, methods and tools[13].

> "Successful delivery 'will rely on local health systems having the capability to implement change effectively' and commit 'supporting service improvement and transformation across systems and within providers'"
>
> **THE NHS LONG TERM PLAN[14]**

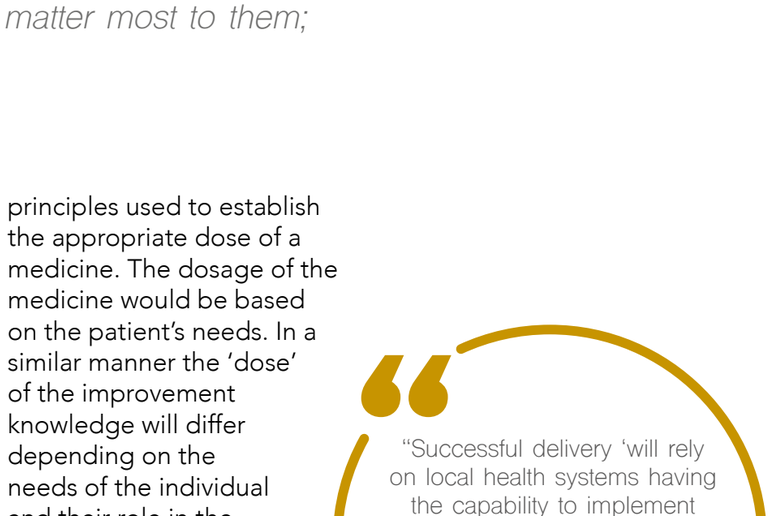
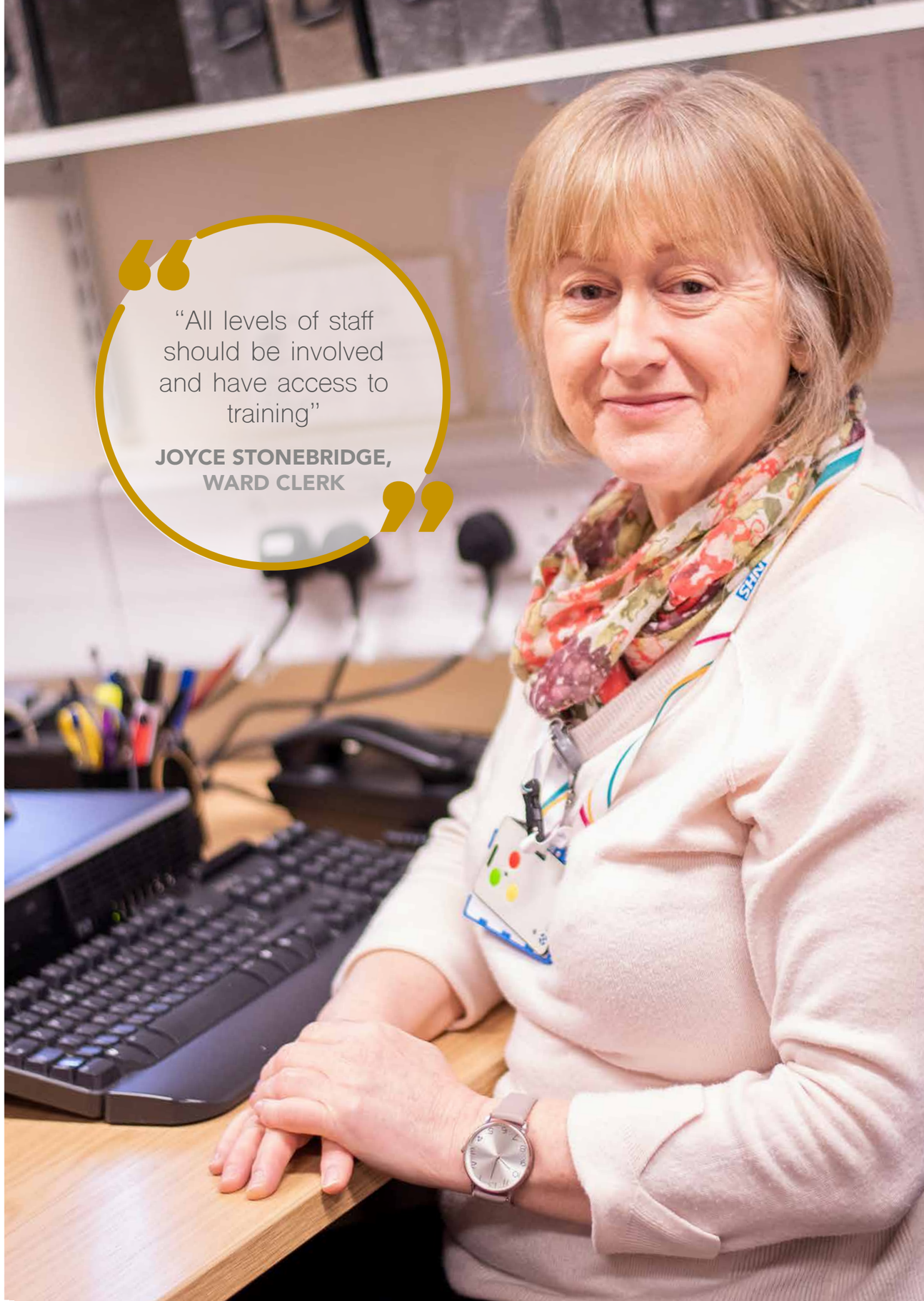


Figure 1



LEVEL	DEFINITION	TRAINING OFFERINGS
Foundation	All staff will receive 'foundation' training, as part of their Trust induction. Staff will receive a refresh every 3 years via mandatory training. The session will provide an overview of the Trusts approach and personal responsibilities.	• Welcome Event • Mandatory Training
Champion	Our 'champions' will attend a training session which introduces and enables individuals to do their work and to improve their work. This is a ½ day session for apprentices and bands 1 – 4.	• Lean Basics
Practitioner	This programme is designed to provide individuals with an introduction to lean concepts. 'Practitioners' will have a sound knowledge of lean concepts which can be transferred back into the place of work. This is a one day programme with an ½ day follow up session to review the application of learning.	• Introduction to Lean
Advanced	A 6 month programme during which individuals will have an 'advanced understanding of lean methodology and the extensive range of tools and techniques which help them to transform services they deliver on a daily basis whilst also inspiring and leading others through change.	• Lean for Leaders
Expert	A small group of staff who are responsible to build the capacity to teach, coach and mentor others in improvement tools and techniques.	• External

We recognise that there are sometimes different needs and there are further opportunities to transfer improvement knowledge and skills, we will also support:

Introduction to Improvement Programme Team Approach

This is a bespoke training programme for a team looking to deliver improvements.

The Nurse Leadership and Development Programme (ACORN)

We will continue to provide aspiring nurse leaders with an introduction to improvement tools and techniques which will enable them to deliver an improvement project.

Junior Doctors Foundation Programme

Provide improvement training and coaching for our junior doctors who are required to complete an improvement project.

Student Nurses

Work with local universities to provide student nurses an overview of the Trusts approach and their role within it prior to them commencing work with us.

Improvement Clinics, Coaching and Mentoring

Experts and where appropriate, Advanced level staff will be required to provide improvement coaching and mentoring other staff looking to develop their knowledge and skills.

To ensure our staff feel empowered and confident to improve those things that matter most to them we will:

- Deliver an overview of our continuous improvement approach at each welcome event.
- Create and deliver a continuous improvement mandatory training session.
- Deliver monthly Lean Basics training.
- Deliver 2 cohorts of Lean for Leaders per year.
- Ensure experts continually develop their skills
- Deliver quarterly. introduction to lean training.

Projects and Reporting

DRIVER FOUR

Ensure that the improvements we are making link to our strategic priorities;

Projects

Continuous improvement projects are essential to ensure good quality care for our patients. We must ensure that all improvement projects support one or more of the CQC's domains of safe, effective, caring, responsive and well-led. For maximum benefit the projects should also be meaningful to the person(s) delivering them whilst support strategic priorities, such as CQC recommendations.

To ensure that improvement efforts are meeting the requirements, coordination of projects is essential. Coordination will also ensure that duplication does not occur and that widespread dissemination of improvements and lessons learned are adopted, where appropriate.

We recognise visiting the place of work 'go see' is one of the best ways to identify areas for improvement. We are committed to adopting this approach to identify problems on the 'shop floor' and also to improve them on the 'shop floor'. We will develop value streams (improvement programmes) by using 'go see' and utilising a technique named Rapid Improvement Events (RIE) to make improvements.

What is a RIE?

The aim of RIE is to rapidly improve a process to produce a step-change in performance, safety or patient experience. The event will be typically run over one week during which stakeholders will focus on improving the process of a specific area.

To have successful and sustainable outcomes, sound planning is required together with a clear structure, alongside smart metrics and measurement for improvement. To ensure organisational engagement is secured from the outset we need to demonstrate executive and senior clinical commitment to drive the initiative.

WEEK 1	WEEK 2	WEEK 3	WEEK 4	WEEK 5	WEEK 6	WEEK 7	WEEK 8	WEEK 9	WEEK 10	WEEK 11	WEEK 12
Initial observations		Planning Meetings				RIE	PDSA Cycles			Action Planning	

Reporting

Keeping a register of all the improvement projects taking place will enable us to generate regular reports to provide awareness of improvement efforts taking place in different departments across the Trust.

To ensure that the improvements we are making link to our strategic priorities we will:

- Use goal deployment to link improvements projects or value streams to Trust priorities;
- Create a repository of Trust-wide projects in which staff can choose to lead or support;
- Develop a centralised database to record new and historical improvement projects;
- Identify value streams by utilising 'Go See'
- Complete a minimum of eight Rapid Improvement Events per year.
- Provide quarterly reports of improvement projects to Divisions and Medical Education;
- Work closely with Clinical Audit and Research to optimise the links between the audit and PDSA cycle.

JENNIFER BELLAMY, JUNIOR DOCTOR

"As a group of foundation doctors we found that the medical weekend ward cover shift could be very challenging and we were eager to see what changes we could introduce to improve the experience for future junior doctors and patient safety at the weekend.

Learning about Quality Improvement has enabled us to measure changes we are making to the medical weekend review request system. We are confident this can lead to permanent improvements."

Communication and Engagement

DRIVER FIVE

Ensure we have effective communication channels with our staff, patients and public so everyone has an understanding of our Continuous Improvement Strategy and their role within it;

Change can often feel overwhelming and sometimes worrying, it is therefore essential that we have effective communication channels with our staff making them aware of progress in our improvement journey. Unfortunately, we know that effectively communicating messages can sometime be challenging as not 'one size fits all'. We will ensure that we tailor our communications in different forms such as newsletters, posters, email, events and roadshows to reach as many of our staff as possible.

Continuous improvement should always focus on what matters to the patient. It is therefore essential that the voice of patients, users of our services, carers and the wider public is heard when we are improving our services. As well as listening to feedback from our staff, Governors and groups such as Health Watch, we are keen to create a 'Lived Experience Panel (LEP)'. The LEP will play an active part in our improvement journey, working with them to ensure that improvements are co-produced through use of their experience and stories.

To ensure we have effective communication channels with our staff, patients and public we will:

- Recruit a lived experience panel to support our improvement efforts;
- Train our lived experience panel in improvement methodologies;
- Produce a monthly continuous improvement communication briefs to highlight progress and successes;
- Hold regular communication and engagement events;
- Increase our Friends and Family Test scores in identified value streams.

"Effectively communicate to our staff, ensuring consistent messages are being delivered to all staff groups"

STEPHEN WORRALL, URGENT CARE MATRON

“Create improvement groups for support and motivate others”

KAUSIK CHATTERJEE, CONSULTANT PHYSICIAN ELDERLY AND STROKE MEDICINE

Learning

DRIVER SIX

Build and maintain internal and external networks to share & develop learning and motivate others;

We know change can be a challenge so we recognise the importance of creating opportunities for staff to discuss their improvement efforts, share learning and discuss solutions to problems. We aim to create an internal improvement network where staff that have improvement expertise can come together regularly. Building these networks will strengthen our continuous improvement culture and support staff to go further.

During the COVID-19 pandemic we had to change the way we worked overnight. Effective learning is hard when change is happening at pace however, we do need to capture and learn from the rapid innovation and improvements that have taken place to help us to ‘lock in’ beneficial changes and document any lessons learned.

We will build local learning systems to capture and share best practice to support and benefit our people and the patients they care for.

We recognise the value of having external partnerships with improvement experts

to continually develop our learning and to accelerate the work outlined in this strategy. We will continue to work closely with our partners in the wider healthcare system as host of the West Cheshire Integrated Care Partnership (ICP) and use consistent improvement methodologies for system wide improvements.

To build and maintain internal and external networks to share & develop learning and motivate others we will:

- Ensure we utilise improvement expertise by creating internal improvement networks
- Build a platform for staff to share their learning
- Work with external partners to continually learn from others.

"To ensure we continually improve everything that we do we should learn from others"

HOLLIE SALISBURY, HEAD OF CONTINUOUS IMPROVEMENT

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