Countess of Chester Hospital NHS Foundation Trust

Part B Pack

Board of Directors meeting – 9th March 2021

NHS
Countess of Chester Hospital
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Meeting	**9th March 2021**		**Board of Directors**					
Report	**Agenda item 14.a**		**Mortality Indicators report**					
Purpose of the Report	Decision		Ratification		Assurance	**X**	Information	
Accountable Executive	Darren Kilroy				Executive Medical Director			
Author(s)	Denise Wood Michelle Greene				Head of Information & Performance Divisional Medical Director			
Board Assurance Framework	Q1 Q5	Quality and Safety Patient safety - failure to identify preventable clinical harm and preventable avoidable death						
Strategic Aims	To provide assurance on the Learning from Deaths process							
CQC Domains	Safe							
Previous Considerations	Learning From Deaths Group – 28th January 2021 Quality and Safety Committee – 10th February 2021							
Summary	This report is intended to: • Summarise the key mortality indicators • Highlight areas of concern • Assure the Committee of actions in place for improvement							
Recommendation(s)	The Board is asked to note the overall performance against all areas and actions being taken to meet targets.							
Corporate Impact Assessment								
Statutory Requirements	Meets the Trust compliance with Learning from Deaths mandated reporting							
Quality & Safety	Improve patient safety							
NHS Constitution	Demonstrate improvements to HSMR and SHMI rates							
Patient Involvement								
Risk								
Financial impact								
Equality & Diversity								
Communication								

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Trust Mortality Indicator Report

January 2021

Contents

1. Executive Summary

Key Messages

- The SHMI remains constant and within the expected range, but all cases with a Covid-19 diagnosis are removed from this rate
- The HSMR has increased slightly and remains outside of the control limits
- The Trust continues to have a high number of patients within the HSMR basket where there is a Covid-19 diagnosis. A clinical coding review has been undertaken and out of 99 patients to the end of December 2019 who had a positive Covid-19 test result, 44 patients have had their diagnosis changed within coding rules, but it will take a number of months for this to be reflected within the HSMR
- The Trust continues to have lower activity levels compared to other hospitals. The impact of this is a lower number of patients within the HSMR basket of conditions
- The process for reviewing Covid-19 related deaths has been agreed and different routes in place depending on whether it was hospital acquired which go through the Serious Untoward Issues (SUI) process, otherwise the cases will be reviewed through the learning from deaths review process

Indicator	Result	Threshold	Date range	Previous Result
SHMI	**106.1**	100	Sept 19 to Aug 20	**106.8**
HSMR	**116.5**	100	Nov 19 to Oct 20	**115.6**
Elective HSMR Admissions: Crude Mortality Rate	0.2%	0.1%	Nov 19 to Oct 20	0.2%
Non-Elective HSMR Admissions: Crude Mortality Rate	6.8%	5.7%	Nov 19 to Oct 20	7.0 %
Mortality Reviews Completed	16%		Dec-19 to Nov-20	17%

1. **Crude Mortality Rate**: During the rolling 12 month period of November 2019 to October 2020 the Countess of Chester Hospital NHS Foundation Trust (COCH) crude mortality rate was 4.5% of HSMR admissions, which was consistent with the previous period of October 2019 to September 2020 (4.5%). Although the same period in November 2018 – October 2019 was 3.9%, a direct comparison is not appropriate due to the current period including Covid-19 related deaths.

2. **HSMR**: The rolling 12 month HSMR is higher than the previous period, at 116.5 for November 2019 to October 2020, compared to 115.6 for the period October 2019 to September 2020. Chart 1 on page 7 illustrates the monthly relative risk over the last year. One of the impacts of the pandemic is a significant reduction in the HSMR denominator, which has affected both the crude and risk adjusted mortality metrics. The figures should be viewed taking into account the impact of COVID-19.

3. **Reporting**: A monthly report is produced for the Learning from Deaths group. As part of the customer support we receive, our Dr Foster consultant has given specific advice and support on how to utilise the software to maximum benefit and identify areas of concern. The Trust has recently implemented the Dr Foster Early Warning Mortality tool to give an earlier high level view of mortality, and highlight any areas of concern. It has been agreed with Divisional Medical Directors that mortality will be discussed at

every specialty meeting as a standard agenda item, and then escalated to Divisional Governance Committees.

4. **Mortality reviews:** The overall completion rate is currently 16% (December 2019 to November 2020).

5. **Palliative Care and Comorbidities**: Palliative care coding rates remain lower than peers. Although levels of patient comorbidity are now improving an action plan is in place and is being monitored. Further detail on this is provided in section 6.3 of the report.

6. **R codes (signs and symptoms):** The percentage of spells with an 'R' code primary diagnosis (4.6%) is lower than both peers (mortality peer group) at 5.9% and the average national value (6.2%). Although the figure is lower, analysis of primary diagnosis of deaths indicates that further work is required on this measure.

HSMR breakdown by admission method November 2019 to October 2020

HSMR	Latest Result	Previous Result
All Admissions	116.5	115.6
Non-Elective Admissions	116.4	115.3
Elective Admissions	127.0	138.9

2. Introduction

This Mortality Indicators Report is produced by COCH Business Intelligence Department for the Learning from Deaths Group Meeting which is held on a monthly basis.

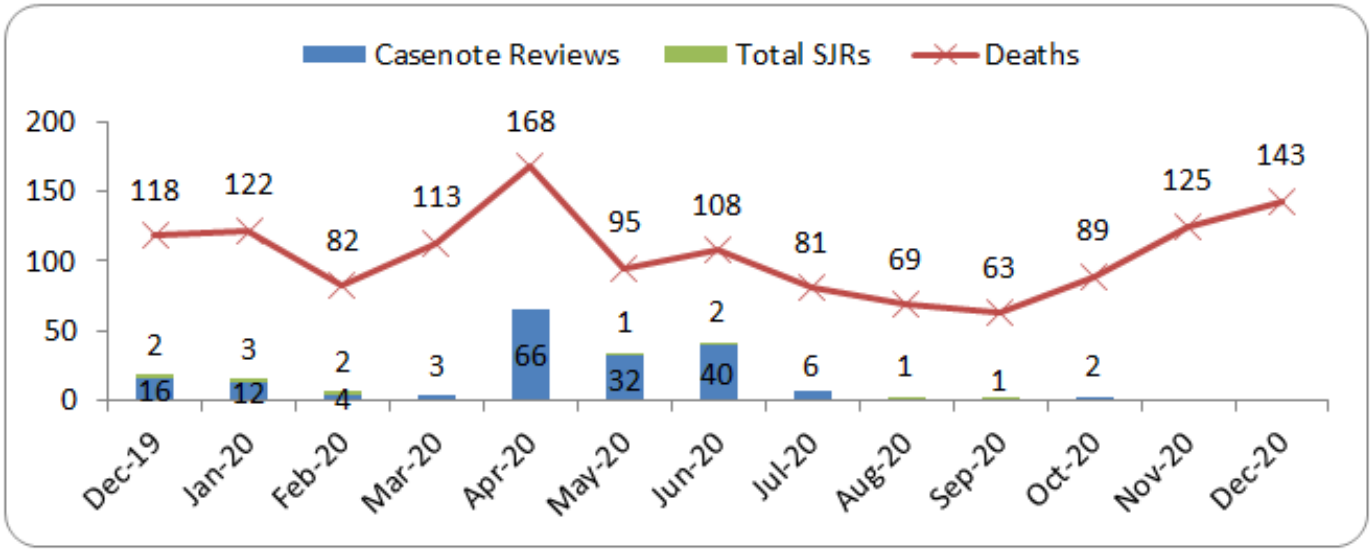
Details of how mortality rates are calculated are shown in appendix 1 of this report.

3. Learning from Death Reviews (December 2019- November 2020)

During January 2021 the process for reviewing Covid-19 deaths has been formalised. For all patients where a positive swab is returned 8 days or more after admission (including deaths), these patients are subject to an RCA through the Datix process and any learning will be disseminated through the Serious Untoward Incidents (SUI) process. For any covid deaths where a positive result is returned less than 8 days from admission, these patients will have a review through the Learning from deaths process, and feedback through the Learning from Deaths group. If it is unclear if the patient acquired Covid-19 as a nosocomial infection while in hospital an SJR will be undertaken. If the SJR finds that it is probable hospital acquired it will be sent through the Datix route for an RCA.

Although COVID 19 has produced some challenges for the Trust, it is expected that all 22 SJR's which were outstanding will have been completed by the end of January. This includes all of the elective care and cardiac arrest cases. 148 of the Covid-19 casenote reviews have also been undertaken.

Adult inpatient deaths (excl. maternity) / No. of SJR & casenote reviews completed (based on month of death)



4. Hospital Standardised Mortality Ratio (HSMR)

HSMR is a key performance indicator for quality of care and safety. COCH receives HSMR data from Dr Foster, which utilises data from the NHS Digital Secondary Users System (SUS) and Hospital Episodes Statistics (HES) published three months in arrears.

4.1 HSMR: 12 Month Rolling Score at Trust Level (Nov-19 to Oct-20)

The following summary provides an overview of the Trust HSMR compared to similar acute peer groups, for the HSMR Basket of 56 Diagnosis Groups. For the 12-month rolling period November 2019 to October 2020, the Trust's score is higher at **116.5,** when compared to the 12 month rolling period between October 2019 and September 2020, at 115.6, the **HSMR remains above the expected range**.

Table 3: HSMR for COCH sites compared to Peers Nov 19 – Oct 20

Covid-19 Peers	Observed	Expected	Relative risk
COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST	**870**	**746.6**	**116.5**
ROYAL UNITED HOSPITALS BATH NHS FOUNDATION TRUST	1055	941.8	112.0
NORTHAMPTON GENERAL HOSPITAL NHS TRUST	1254	1126.1	111.4
NORTH WEST ANGLIA NHS FOUNDATION TRUST	1612	1498.2	107.6
MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST	864	830.8	104.0
GREAT WESTERN HOSPITALS NHS FOUNDATION TRUST	1009	974.9	103.5
TORBAY AND SOUTH DEVON NHS FOUNDATION TRUST	844	831.2	101.5
MEDWAY NHS FOUNDATION TRUST	1042	1053.4	98.9
MILTON KEYNES UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	613	656.4	93.4
SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST	659	787.9	83.6

Using Dr Foster to select a comparable peer group the above Trusts have a similar case mix.

Figure 1: Trust HSMR – November 2019 to October 2020

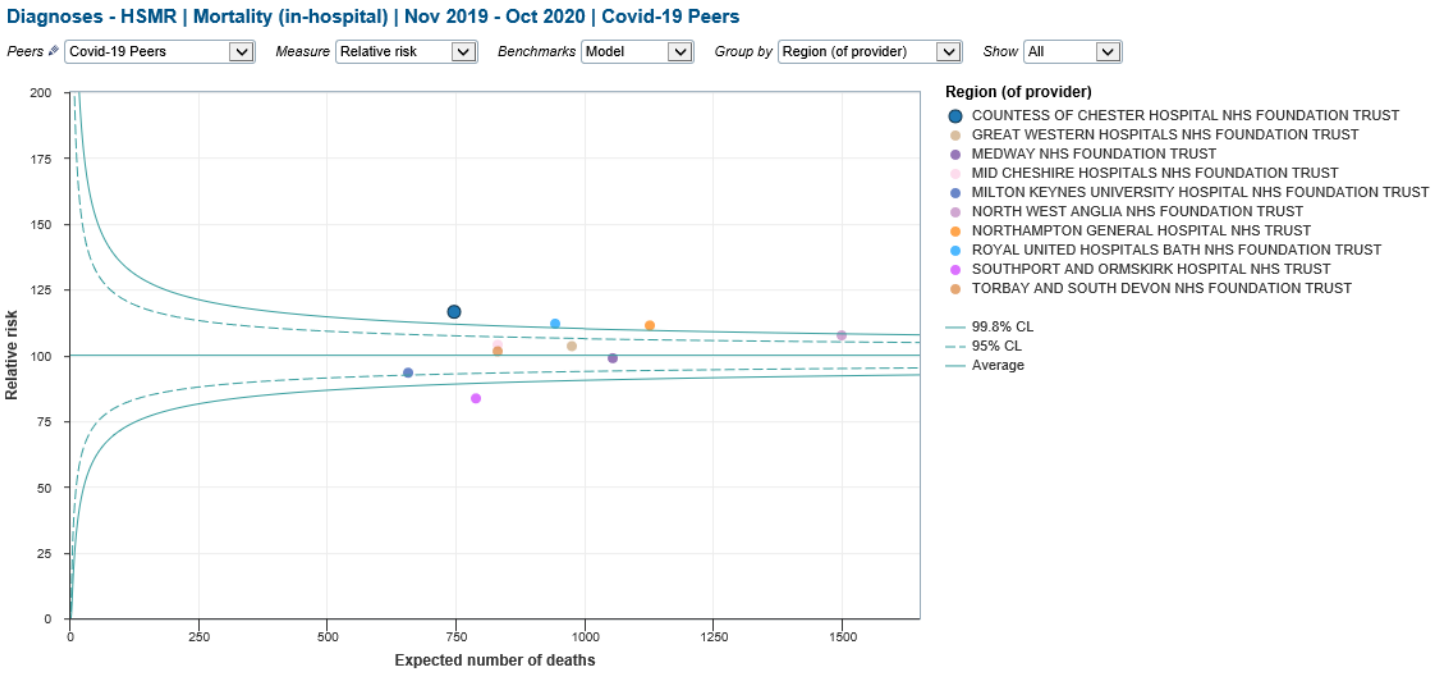
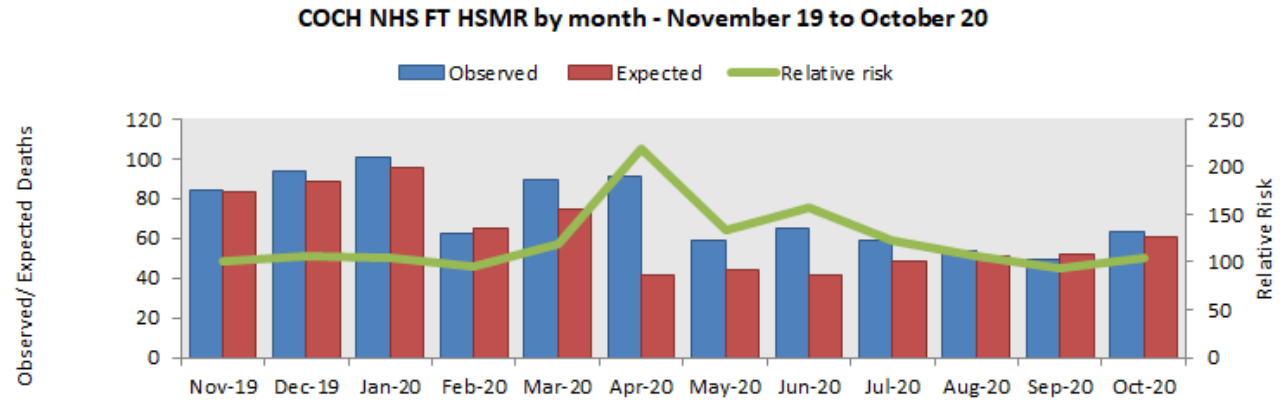


Chart 1 below provides a summary of the observed number of deaths and relative risk at Trust level by month between November 2019 and October 2020. Within the 12 month rolling period the month of April 2020, now has the highest variance between the expected and observed mortality. It is advisable to review the full rolling twelve month period rather than one month, particularly as March 2020 onwards includes Covid-19 related deaths which have impacted on the effectiveness of the model used to calculate relative risk. For August and September where no Covid-19 deaths within the HSMR basked, the relative risk is much closer to the expected.

Chart 1: Trust HSMR by Month. November–19 to October-20 (HSMR Basket of 56 Diagnosis Groups)



	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20
Observed	84	94	101	62	89	91	59	65	59	54	49	63
Expected	83.5	88.9	95.9	65.3	74.6	41.5	44.0	41.4	48.4	50.7	52.1	60.3
Relative risk	100.6	105.7	105.3	94.9	119.3	219.1	134.1	157.2	121.8	106.6	94.0	104.5

4.2 Covid-19 update

The Trust continues to have a higher number of covid-19 related deaths within the HSMR basket. The risks associated with this group of patients will have a more pronounced effect on the trusts HSMR, as the risk of mortality is likely to be higher than the model will generate as an expected risk. This is because the model has no historical data on which to generate an expected risk of mortality.

Patients who present with a primary diagnosis of Covid-19, are mapped to the viral infections group, which sits outside of the HSMR basket. A clinical coding review has been undertaken and out of 99 patients to the end of December 2019 who had a positive Covid-19 test result within 7 days of admission, 44 patients have had their diagnosis changed within coding rules, but it will take a number of months for this to be reflected within the HSMR.

4.2 HSMR: Diagnosis groups of concern

Dr Foster provides CUSUM alerts (short for 'cumulative sum'). Alerts are designed to signal that a pattern of activity appears to have gone beyond a defined threshold and act as a smoke alarm, to inform users that something might be going wrong.

Initial analysis has been focused on CUSUM alerts but going forwards a process will be put in place for each specialty to review all deaths attributed to that specialty, co-ordinated by the M&M (Mortality & Morbidity) lead. The Divisional Medical Directors (DMD's) will agree this as part of the Learning from Deaths review.

CUSUM alert	Observed deaths	Expected deaths	Relative Risk (RR)
Residual codes, unclassified	40	13.5	296.4
Intestinal infection	15	6.2	242.5
Acute and unspecified renal failure	50	29.3	170.8
Urinary tract infections	22	11.7	188
Acute cerebrovascular disease	84	62.1	135.3
Pneumonia	179	155.1	115.4

Source: Dr Foster Mortality Summary for 12 months to Oct-2020

5. Summary Hospital-Level Mortality Indicator (SHMI)

The following summary provides an overview of the Trust SHMI score for the period September 2019 to August 2020 sourced from NHS Digital.

5.1 Trust SHMI Analysis

The COCH SHMI value for the most recent reporting period is 106.1 and remains within the expected range. Table 4 below provides an overview of the observed and expected deaths.

Table 4: COCH SHMI Score Sept-19 to Aug-20
Figures from NHS Digital (filtered to COCH Covid-19 Peer Group)

Provider name	SHMI value	SHMI banding	Number of spells	Observed deaths
MILTON KEYNES UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	1.1684	1	36,125	1,215
NORTH WEST ANGLIA NHS FOUNDATION TRUST	1.1423	1	75,335	2,795
MEDWAY NHS FOUNDATION TRUST	1.0710	2	52,475	1,790
SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST	1.0628	2	34,565	1,285
COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST	**1.0612**	**2**	**41,380**	**1,330**
ROYAL UNITED HOSPITALS BATH NHS FOUNDATION TRUST	1.0436	2	57,810	1,860
NORTHAMPTON GENERAL HOSPITAL NHS TRUST	1.0147	2	65,485	1,910
TORBAY AND SOUTH DEVON NHS FOUNDATION TRUST	1.0029	2	41,830	1,605
GREAT WESTERN HOSPITALS NHS FOUNDATION TRUST	0.9987	2	53,405	1,700
MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST	0.9645	2	48,940	1,380

5.2 Trust SHMI Diagnosis Groups of Concern (September-19 to August-20)

Analysis of the Trust SHMI at diagnosis level indicates the diagnosis groups in which the observed number of deaths rate was higher than the expected, but not statistically significantly high, using 95% confidence intervals.

Table 5: Trust SHMI Diagnosis Groups of Concern Sept-19 to Aug-20

SHMI Group - With 95% CI (Dr Foster)

SHMI Group	#	Obs	Exp	SHMI	Low / High
(140) Allergic reactions, Rehabilitation care, fitting of prostheses, and adjustment of		40	20	200.00	142.87 272.35
(66) Acute cerebrovascular disease		90	65	138.46	111.34 170.20
(99) Acute and unspecified renal failure		45	35	128.57	93.77 172.04
(98) Other gastrointestinal disorders		15	10	150.00	83.89 247.42
(83) Intestinal infection		15	10	150.00	83.89 247.42
(82) Influenza, Acute and chronic tonsillitis, Other upper respiratory infections, Other upper respiratory		15	10	150.00	83.89 247.42
(6) Hepatitis, Viral infection, Other infections; including parasitic, Sexually transmitted infections (not		15	10	150.00	83.89 247.42
(124) Intracranial injury		20	15	133.33	81.41 205.93

NOTE: There have been some methodological changes with the SHMI data nationally, which now follows a methodology employed by HES (Hospital Episodes Statistics). This disclosure control methodology has been updated to a methodology based on rounding, so the number of finished provider spells and observed deaths are now displayed to the nearest five.

Table 6: Trust SHMI Trend/Rate

Trend / Rate

12 Months to	May 20	Jun 20	Jul 20	Aug 20
SHMI	105.60	106.81	106.77	106.12
Crude Rate	3.1%	3.2%	3.2%	3.2%

6. Clinical Coding Indicators

The following section will provide an overview of some of the factors that can influence mortality and drive performance against the HSMR and SHMI. Table 7 provides a summary for COCH between November 2019 and October 2020 for selected coding and case-mix indicators, along with a comparison against peers.

Table 7: Selected coding and case-mix indicators that can influence mortality: COCH against mortality peers (Nov-19 to Oct-20)

Indicator	COCH value	Previous COCH value	Peer value	National value
% Non-elective deaths with palliative care	27.4%	29.6%	36.2%	33.6%
% Non-elective spells with palliative care	3.4%	3.7%	5.1%	4.4%
% Spells in Symptoms & Signs chapter	4.8%	4.7%	6.6%	6.9%
% Non-elective Spells with Charlson comorbidity score = 0	44.8%	44.6%	42.3%	41.9%
% Non-elective Spells with Charlson comorbidity score = 20+	12.9%	12.9%	13.9%	14.3%

6.1 Palliative Care Coding Rates

The presence of the diagnosis code 'Z515' or the national specialty code 315 is used to denote palliative care. The coding of palliative care is one of the twelve weighting factors applied to the calculation of HSMR, however is not considered in the calculation of SHMI.

Palliative care coding remains low compared to peers and this does have an impact on the relative risk calculation. Dr Foster have indicated that the risk adjustment for palliative care may be changed for future reporting to only consider palliative care where this is present at the start of the patient's admission.

6.2 Signs and Symptoms Coding ('R' Codes)

Both mortality models (HSMR & SHMI) discussed in this report use the primary diagnosis of the mortality dominant episode within a spell to attribute a 'weighting' in mortality score calculations. Diagnosis codes beginning with 'R' (signs & symptoms) map to the diagnosis group 140 in the SHMI model, which has a relatively low 'expected' mortality rate, therefore the greater the number of 'R' codes present in patient's records, the higher the 'Relative Risk' score attributed to the organisation.

6.3 Co-Morbidity Coding

Between November 2019 October 2020 COCH has a higher percentage of spells (44.8%) in the lowest category of patient complexity (with a Charlson score of 0) compared to both the Peer Trusts (42.3%) and all providers in England (41.9%).

COCH has a lower percentage of spells (12.9%) in the highest category of morbidity (a Charlson score of 20 or more) compared to the Peer Acute Trusts (13.9%) and all providers in England (14.3%).

From Dr Foster data COCH is also an outlier for elderly patients in the age range 75-84. The low morbidity associated with high elderly cohort of patients further illustrates a case mix where higher coding depth would be expected.

Average coding depth is now at 3.6 (to December 2019) from the baseline of 2.3 (based on June-May 18/19). This is slightly below the 50th percentile at 3.8, but care should be taken when interpreting this for activity from March 2020 due to lower activity levels.

The Trust continues to work with our Dr Foster consultant to understand our data, investigate areas highlighted for concern and support the implementation of the Early Warning System. Future training events will be scheduled to provide expert advice and training for clinicians and analysts.

Appendix 1 - SHMI & HSMR Methodologies

	Hospital Standardised Mortality Rate (HSMR)	Risk Adjusted Mortality Index (RAMI)	Summary Hospital-level Mortality Indicator (SHMI) **
Observed	All spells culminating in death at the end of the patient pathway, defined by specific diagnosis codes for the primary diagnosis of the spell: uses 56 diagnosis groups which contribute to approx. 80% of in hospital deaths in England*	Total number of observed in-hospital deaths	Number of observed in-hospital deaths plus deaths out of hospital within 30 days of discharge
Expected	Expected number of deaths	Expected number of deaths *Calculated using a 10 year data set (as of 2012) to get the risk estimate*	Expected number of deaths *Calculated using a 36 month data set to get the risk estimate*
Adjustments	▪ Sex ▪ Age in bands of five up to 90+ ▪ Admission method ▪ Source of admission ▪ History of previous emergency admissions in last 12 months ▪ Month of admission ▪ Socio economic deprivation quintile (using Carstairs) ▪ Primary diagnosis based on the clinical classification system ▪ Diagnosis sub-group ▪ Co-morbidities based on Charlson score ▪ Palliative care ▪ Year of discharge	▪ Sex ▪ Age ▪ Clinical grouping (HRG) ▪ Primary and secondary diagnosis ▪ Primary and secondary Procedures ▪ Hospital type ▪ Admission method Further detailed methodology information is included in CHKS products, or specific enquiries to CHKS www.chks.co.uk	▪ Sex ▪ Age group ▪ Admission method ▪ Co-morbidity ▪ Year of dataset ▪ Diagnosis group Details of the categories above can be referenced from the methodology specification document at http://www.ic.nhs.uk/services/summary-hospital-level-mortality-indicator-shmi
Exclusions	Excludes day cases and regular attendees	Excludes mental illness, obstetrics, babies born in or out of hospital, day cases, and patients admitted as emergencies with a zero length of stay discharged alive and spells coded as palliative care (Z515)	▪ Specialist, community, mental health and independent sector hospitals. ▪ Stillbirths ▪ Day cases, regular day and night attenders
Whose data is being compared and how much data is used for comparison e.g. all trusts or certain proportion etc.	All England provider trusts via SUS Data attributed to all Trusts within a 'super-spell' of activity that ends in death	UK database of Trust data and HES Data attributed to Trust in which patient died	All England non-specialist acute trusts except mental health, community and independent sector hospitals. Data attributed to Trust in which patient died or was discharged from

*HSMR does not exclude 20% of deaths, it looks for the diagnosis groups that account for the majority of deaths, and the figure of 80% is quite variable dependent on the case mix of the trust. HSMR could just as easily cover 100% of activity. It covers 80% of activity mostly for historical reasons and the fact that you get little extra value from the other 20%.

The Mortality indicators report provides information relating to mortality both in-hospital and during the 30 days following discharge from hospital. Whilst evidence suggests a mortality ratio as a single indicator of hospital quality is, at best, akin to a smoke alarm, it has been recognised nationally that regular examination and better understanding of mortality can potentially improve the way care is delivered, recorded and coded, and in turn help improve the quality of the data used.

The majority of indicators presented in the report pertain to Standardised Mortality Ratios (SMRs). SMRs are the ratio of the number of deaths in hospital within a given time period to the number that might be expected if the hospital had the same death rates as some reference population (in this case the hospitalised population of England). As well as standardising for age, the hospital mortality measures discussed in this report, the Hospital Standardised Mortality Rate (HSMR) and Summary Hospital Mortality Indicator (SHMI), also make adjustments for patient differences which can influence deaths in a hospital, but are ultimately outside of its control (for example deprivation and sex) . An overview of the methodology applied to each of these mortality measures (HSMR & SHMI) can be found in Appendix 2.

The report standardised mortality measures with the presentation of contextual indicators that directly impact on the mortality rates discussed, namely, clinical coding measures including:

- Palliative Care
- Depth and accuracy of clinical coding (‘Signs and Symptoms’ coding)
- Co-morbidities (Charlson Comorbidity Index)

The coding of patient co-morbidities is one of the twelve weighting factors applied to the calculation of HSMR, and one of the six weighting factors applied to the calculation of SHMI. A high level of patient co-morbidities increases the ‘expected’ number of deaths in both methodologies, and thus reduces the relative risk rate. The Charlson Comorbidity Index is used to calculate comparative levels of co-morbidity, and consists of 17 conditions for which a ‘weighting’ is assigned. The higher the patient weighting, the higher the risk the co-morbidity is perceived to be as a contributing factor to a patient’s health outcome, and potential risk of death. In order to calculate a patient’s co-morbidity score, each spell is calculated as the sum of the weights for each of the conditions in all secondary diagnosis fields in the first episode of the spell.

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Meeting	**9th March 2021**		**Board of Directors**					
Report	**Agenda item 14.b**		**COVID-19 Board Assurance Framework**					
Purpose of the Report	Decision		Ratification		Assurance	X	Information	
Accountable Executive	Alison Kelly				Director of Nursing & Quality/DIPC			
Author(s)	Michael Woodward Alison Kelly				Matron, Infection Prevention & Control Director of Nursing & Quality/DIPC			
Board Assurance Framework	Q1 Q3	Quality & Safety Safety - Infection Prevention & Control						
Strategic Aims								
CQC Domains	Safe, Effective, Caring, Responsive, Well Led							
Previous Considerations	Board of Directors meeting - 1st December 2021 Quality and Safety Committee - 10th February 2021							
Summary	This report is intended to provide an update on progress with Infection Prevention and Control COVID-19 Board Assurance Framework (BAF). Further additional elements have been made following updated national guidance. In order to provide a further update on compliance, audits have been undertaken during January 2021. The attached summary sheet (Appendix 1) outlines where progress has been made since the last audit and also highlights areas for improvement. It is pleasing to note that a number of areas have shown significant improvements, these include: • Provision of Trust Signage • Delays in patients being moved from one clinical area to another • Cleaning of frequently touched surfaces • Decontamination of equipment • Physical separation of reception areas. Areas for further improvement are as follows: • All linen bags are tagged with ward/care area • Patients are separated by at least 2 metres • Possible cases awaiting lab confirmation are isolated in a single room with hand basin and den-suite facilities • Isolation rooms are decontaminated twice each day.								
Recommendation(s)	The Board is asked to note the content of the plan and to support ongoing actions which are articulated in an operational improvement plan.							

Corporate Impact Assessment	
Statutory Requirements	Reflects metrics that influences safe care delivery to meet regulatory standards
Quality & Safety	Supports delivery of safe care and CQC requirements
NHS Constitution	Supports compliance with NHS Standards
Patient Involvement	N/A
Risk	Reflects key aspects of the Board Assurance Framework
Financial impact	N/A
Equality & Diversity	N/A
Communication	Reflects metrics that influences safe care delivery to meet regulatory standards

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Publications approval reference: 001559 and now joint togther Publications approval reference: 001559

Infection Prevention and Control COVID-19
Board Assurance Framework

(National: 22 May 2020, Version 1.2 Reviewed: 19/10/20 in line with new National document: 22nd July 2020 Version 1.3
National updated version 15th October. Version 1.4 added in red along with new forward and introduction pages)

COCH Version 3 – Update 18th October 2020, 10th November 2020, 19th January 2021 and 2nd February 2021

Foreword

NHS staff should be proud of the care being provided to patients and the way in which services have been rapidly adapted in response to the COVID-19 pandemic.

Effective infection prevention and control is fundamental to our efforts. We have developed this board assurance framework to support all healthcare providers to effectively self-assess their compliance with PHE and other COVID-19 related infection prevention and control guidance and to identify risks. The general principles can be applied across all settings; acute and specialist hospitals, community hospitals, mental health and learning disability, and locally adapted.

The framework can be used to assure directors of infection prevention and control, medical directors and directors of nursing by assessing the measures taken in line with current guidance. It can be used to provide evidence and as an improvement tool to optimise actions and interventions. The framework can also be used to assure trust boards.

Using this framework is not compulsory, however its use as a source of internal assurance will help support organisations to maintain quality standards.

Ruth May

Chief Nursing Officer for England

1. Introduction

As our understanding of COVID-19 has developed, PHE and related guidance on required infection prevention and control measures has been published, updated and refined to reflect the learning. This continuous process will ensure organisations can respond in evidence- based way to maintain the safety of patients, services users and staff.

We have developed this framework to help providers assess themselves against the guidance as a source of internal assurance that quality standards are being maintained. It will also help them identify any areas of risk and show the corrective actions taken in response. The tool therefore can also provide assurance to trust boards that organisational compliance has been systematically reviewed.

The framework is intended to be useful for directors of infection prevention and control, medical directors and directors of nursing rather than imposing an additional burden. This is a decision that will be taken locally although organisations must ensure they have alternative appropriate internal assurance mechanisms in place.

2. Legislative framework

The legislative framework is in place to protect service users and staff from avoidable harm in a healthcare setting. We have structured the framework around the existing 10 criteria set out in the Code of Practice on the prevention and control of infection which links directly to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Health and Safety at Work Act 1974 places wide-ranging duties on employers, who are required to protect the 'health, safety and welfare' at work of all their employees, as well as others on their premises, including temporary staff, casual workers, the self-employed, clients, visitors and the general public. The legislation also imposes a duty on staff to take reasonable care of health and safety at work for themselves and for others and to co-operate with employers to ensure compliance with health and safety requirements.

Robust risk assessment processes are central to protecting the health, safety and welfare of patients, service users and staff under both pieces of legislation. Where it is not possible to eliminate risk, organisations must assess and mitigate risk and provide safe systems of work. In the context of COVID-19, there is an inherent level of risk for NHS staff who are treating and caring for patients and service users and for the patients and service users themselves in a healthcare setting. All organisations must therefore ensure that risks are identified, managed and mitigated effectively.

Infection prevention and control board assurance framework

Key lines of enquiry	Evidence	Gaps in assurance	Mitigating actions	Update
Systems and processes are in place to ensure:				
• infection risk is assessed at the front door and this is documented in patient notes	Clinical pathways altered to address triage of symptomatic patients – as per ED pathway; cohort areas commissioned to facilitate COVID-19 and non-covid-19 patients in ED and Haygarth Centre; Children's Respiratory Assessment has identified location; process to assess obstetric patients prior to arrival	Spot check assurance programme identified an overall compliance score of 89% with rapid triage systems	Localised action for improvement within any ward/department with identified gaps in compliance	21.11.20 – Process for screening for COVID-19 for all emergency admissions in place, with rapid screening of suspected cases. Overall Trust compliance with admission screening 85%. 19.01.21 – COVID-19 screening compliance report (w/e 10.01.21) for emergency admissions Day 1 - 89%
• patients with possible or confirmed COVID-19 are not moved unless this is essential to their care or reduces the risk of transmission	Local process for clinical teams to escalate any change in condition – appropriate bed allocation managed through Co-ordination Centre (Teletracking). COVID-19 screening results managed through the Coordination Centre 24/7 – communicated to wards, documented on EPR and	Spot check assurance programme identified an overall compliance score of 79% with limiting patient movement	Trust-wide action in progress to minimise the number of patient moves, both between wards and between beds within the same ward – this is inclusive of patients with possible or confirmed COVID-19	24.11.20 – initial learning from outbreak investigation (Bluebell Ward) identifies this to be an on-going challenge due to capacity and operational pressures. Patient moves are monitored very closely via the co-ordination centre.

	database of suspected/confirmed cases managed through Silver Control			19.01.21 – Patient flow continues to be an on-going challenge due to capacity and operational pressures. Patient moves are monitored very closely via the co-ordination centre with priority given to IPC /COVID risk
• compliance with the national guidance around discharge or transfer of COVID-19 positive patients	Discharge/transfer pathway developed, including patient screening programmes prior to discharge to a social care setting	Consider audit of discharge/transfer pathways to incorporate key actions identified within 'Hospital Discharge service Requirements'	Recommendations dependant on audit outcomes	Internal hospital discharge guidance introduced 16/4/20. **No patients discharged to care homes without a negative screen**  Covid 19 care Home discharge guidance 1` 27/4/20 Revised guidance issued System partner escalation call for mutual aid and IPC support Care home webnRs Staff redeployed into CCG team offering

				practical support on IPC and training on swabbing Close working with PH lead at local authority and Community Infection control team Therapists redeployed according to clinical prioritisation for acute inpatient wok Ongoing review of result of pathway and actions implement Ongoing audit against hospital discharge guidance to care homes.
• Monitoring of IPC practices, ensuring resources are in place to enable compliance with IPC champions to embed and encourage best practice	21.11.20 – Trust wide roll out of IPC Link Practitioner audit programme with audit tool. IPC team supporting with this.	We will review in two months' time as this programme has been revised		19.01.21 – IPC Link Practitioner audit programme established.
• Monitoring of compliance with PPE, consider implementing the role of PPE guardians/safety champions to embed	02.02.21 - Monitoring of compliance with PPE is embedded within both the IPC Link Practitioner audit programme and the IPC Ward/Departmental Audit			

and encourage best practice	Programme.			
• staff testing and self-isolation strategies are in place and a process to respond if transmission rates of COVID-19 increase	21.11.20 - 7 day system and process for staff screening, Test and Trace established through a multi-disciplinary team collaboration. Programme of staff testing in place in high risk areas. Lateral flow testing to start soon			19.01.21 – Lateral flow testing for all staff introduced in December 2021
• all staff (clinical and non-clinical) are trained in putting on and removing PPE; know what PPE they should wear for each setting and context; and have access to the PPE that protects them for the appropriate setting and context as per national guidance	Staff training, including reminders in practice are continually supported by the IPC Team/ Floorwalker Team, Fit Testing team, daily briefings, posters and screensavers. PPE supplies for individual areas are coordinated through Silver Control and the Supplies team. PPE meeting weekly to assess PPE sustainability, plus daily stock check	Action in progress to explore if PPE training can be formalised through ESR as a mandatory annual competency	Spot check assurance programme identified an overall compliance score of 100% - current actions to continue to support sustained compliance	21.11.20 – Clinical based staff training, including reminders in practice continues to be supported by the IPC Team/ daily briefings, posters and videos screensavers.
• training in IPC standard infection control and transmission-based precautions are provided to all staff	21.11.20 - Included on IPC mandatory training programme (clinical and non-clinical staff)			
• IPC measures in relation to COVID-19 should be	21.11.20 - Included on IPC mandatory training			

included in all staff Induction and mandatory training	programme (clinical and non-clinical staff) and Trust Induction			
• all staff are regularly reminded of the importance of wearing face masks, hand hygiene and maintaining physical distance both in and out of work	21.11.20 - Clinical based staff training, in practice continues to be supported by the IPC Team/ daily briefings, posters and screensavers. Also we moved ahead of the recommendation of all patients to wear surgical masks on all wards to reduce the risk of transmission of COVID19. Also we had staff isolate for longer than national recommendation along with staff and patients screening/swabbing.			
• all staff (clinical and non-clinical) are trained in putting on and removing PPE; know what PPE they should wear for each setting and context; and have access to the PPE that protects them for the appropriate setting and context as per national guidance	21.11.20 - Clinical based PPE training, continues to be supported by the IPC Team/daily briefings, posters and screensavers. Access to PPE donning and doffing demonstration videos via COVID-19 intranet hub.			

• national IPC guidance is regularly checked for updates and any changes are effectively communicated to staff in a timely way	Information received from various national teams through formal routes e.g. CAS alerts, CMO/CNO letters etc.; IPC Team receive automated PHE updates and have escalated to NHS England for a similar process to be enabled for NHSe/i updates – updates communicated via Silver Control and approved Comms routes depending on content/intended audience		Spot check assurance programme identified an overall compliance score of 100% for Floorwalker daily briefings being shared with staff - current actions to continue to support sustained compliance	21.11.20 – local and national updates co-ordinated an disseminated via Silver Control, EPRR and IPC
• changes to guidance are brought to the attention of boards and any risks and mitigating actions are highlighted	Executive Team receive updates directly from national correspondence, or via Silver Control/IPC Team (see above)	Any gaps in assurance will be identified through the BAF and ongoing assessment	Current actions to continue to support sustained compliance	21.11.20 – local and national updates co-ordinated an disseminated via Silver Control, EPRR and IPC
• risks are reflected in risk registers and the Board Assurance Framework where appropriate	IPC/COVID-19 risk register is under review regularly via Senior Leaders Group & Quality Governance Group	Outcome of spot check assurance programme to inform updates of COVID-19 risk register and BAF	COVID-19 risk register to be updated utilising spot check assurance programme outcomes	21.11.20 – Action – For COVID-19 risk register to be reviewed. 19.01.21 – COVID-19 risk register format reviewed , further updates planned regarding content.

• robust IPC risk assessment processes and practices are in place for non COVID-19 infections and pathogens	Established systems and processes remain in place for non-COVID-19 infections and pathogens, including mandatory reporting requirements	Limitations on single room capacity have resulted in a change to isolation risk assessments , to include COVID-19 criteria and other 'alert' organisms	COVID-19 and other infections are risk assessed and prioritised for single rooms accordingly e.g. suspected COVID-19, C. difficile infection, diarrhoea etc. Confirmed COVID-19 cohort area utilised to full capacity to optimise use of single rooms	21.11.20 – Established IPC risk assessment process remains in place
• That Trust CEOs or the executive responsible for IPC approve and personally signs off, all data submissions via the daily nosocomial sitrep. This will ensure the correct and accurate measurement and testing of patient protocols are activated in a timely manner.	21.11.20 – Established process in place via Silver Control for daily submission of nosocomial data sitrep. DIPC oversite of all submissions			
• ensure Trust Board has oversight of ongoing outbreaks and action plans.	21.11.20 – daily outbreak review meetings established with dissemination of action log to all key stakeholders. Regular updates presented to board.			19.01.21 – Formal outbreak meeting held weekly. Daily outbreak monitoring and update provided by IPCT at COVID-19 tactical meeting.

1. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.				
Key lines of enquiry	Evidence	**Gaps in assurance**	**Mitigating actions**	**Update**
Systems and processes are in place to ensure:				
• designated teams with appropriate training are assigned to care for and treat patients in COVID-19 isolation or cohort areas	Dedicated team identification for Ward 43 and JDSU/identified elective surgery on identified rotas	Dedicated teams are not routinely assigned in all areas due to workforce limitations - spot check assurance programme identified an overall compliance score of 68%	Implementation of IPC guidelines to minimise the risk of transmission of all micro-organisms, including COVID-19	21.11.20 – Dedicated staff to COVID-19 cohort areas remains an on-going challenge due to workforce limitations, and pressures on capacity and patient flow. Movement of staff risk assessed on an individual basis. Medical staffing team and the central nursing workforce team provide oversite of staff movements. 02.02.21 – Repeat spot-check audit undertaken by IPC Team identified compliance score of 57%. This was from verbal feedback of staff who reported that staff may be moved during shift due to the extreme operational and staffing pressures across the organisation. Staff

				moves try to minimised via the co-ordination of staffing via the Centralised Nursing workforce team, however this is difficult as risk across the Trust has to be managed re all staff groups
• designated cleaning teams with appropriate training in required techniques and use of PPE, are assigned to COVID-19 isolation or cohort areas	Domestic Teams cover all ward/department areas regardless of COVID status, in conjunction with appropriate mask fit testing to enable the service to be delivered in higher risk areas	Spot check assurance programme identified an overall compliance score of 86% for designated cleaning teams	Implementation of IPC guidelines to minimise the risk of transmission of all micro-organisms, including COVID-19	21.11.20 - Domestic Teams continue to cover all ward/department areas regardless of COVID status, ensuring compliance with IPC precautions are maintained.
• decontamination and terminal decontamination of isolation rooms or cohort areas is carried out in line with PHE and other	Facilities support terminal cleaning requirements – advised by the Coordination Centre (Note: within limitations of patient remaining in situ if terminal cleaning required due to IPC stepdown)	Terminal cleaning is completed by a separate team who specialise in this bespoke service	Spot check assurance programme identified an overall compliance score of 100% - current actions to continue to support sustained compliance.	21.11.20 – Established Rapid Response domestic service in place to ensure decontamination and terminal decontamination of isolation rooms is undertaken.
• increased frequency, at least twice daily, of cleaning in areas that	National guidance updated to include patient isolation rooms/cohort areas to be	Spot check assurance programme identified an	Facilities have undertaken an assessment of updated guidance and a draft paper has been developed to identify the resources	21.11. Draft paper received by Trust Execs, some re-work currently underway .

have higher environmental contamination rates as set out in the PHE and other national guidance	cleaned twice daily (minimum) – currently cleaned on a daily basis with additional wipe downs of frequently touched surfaces	overall compliance score of 36%, due to resource requirement for full implementation of requirements	required to meet this requirement – requires progression. This is currently with the Director of Infection Prevention & Control for review before progressing	19.01.21 – Paper approved by SLG. Facilities in the process of actioning/recruitment process to enhance service. 02.02.21 – Repeat spot-check audit undertaken by IPC Team identified an increased compliance score of 50%. Recruitment process for the enhanced domestic service is in progress.
• attention to the cleaning of toilets/bathrooms, as COVID-19 has frequently been found to contaminate surfaces in these areas	National guidance updated as above, to include toilet/bathroom and staff areas – toilets/bathrooms currently cleaned as per frequency within national cleaning standards	Spot check assurance programme identified an overall compliance score of 36%, due to resource requirement for full implementation of requirements (as previous)	Facilities have undertaken an assessment of updated guidance and a draft paper has been developed to identify the resources required to meet this requirement – requires progression.	21.11.20 – Draft paper received by Trust Execs, some re-work currently underway. 19.01.21 – Paper approved by SLG. Facilities in the process of actioning/recruitment process to enhance service. 02.02.21 – Repeat spot-check audit undertaken by IPC Team identified an increased compliance score of 50%. Recruitment process for the enhanced

				domestic service is in progress.
• cleaning is carried out with neutral detergent, a chlorine-based disinfectant, in the form of a solution at a minimum strength of 1,000ppm available chlorine, as per national guidance. If an alternative disinfectant is used, the local infection prevention and control team (IPCT) should be consulted on this to ensure that this is effective against enveloped viruses	All environmental and equipment cleaning/disinfection is being undertaken with a combined neutral detergent/chlorine-based disinfectant (1,000ppm available chlorine); 70% isopropyl alcohol wipes as standard disinfectant for more fragile equipment that is physically clean; approved disinfectants for specialist equipment/areas as per standard practice		Spot check assurance programme identified an overall compliance score of 100% - current actions to continue to support sustained compliance	21.11.20 – Established process in place for decontamination of all clinical areas with chlorine based disinfectant (1,000ppm)
• manufacturers' guidance and recommended product 'contact time' must be followed for all cleaning/disinfectant solutions/products	As per standard disinfectants in use within the Trust – no new products have needed to be introduced for COVID-19	Spot check assurance programme identified an overall compliance score of 97%	Not always sufficient time to allow items to air dry within the Resuscitation area (Emergency Department)	21.11.20 – Roll out of additional patient monitoring equipment undertaken by EBME

• as per national guidance: o 'frequently touched' surfaces, e.g. door/toilet handles, patient call bells, over-bed tables and bed rails, should be decontaminated at least twice daily and when known to be contaminated with secretions, excretions or body fluids o electronic equipment, e.g. mobile phones, desk phones, tablets, desktops, and keyboards should be cleaned at least twice daily o	Facilities undertake touch point cleaning throughout the day e.g. door/toilet handles, hand rails, toilet door handles and lift call buttons in all public areas, with additional wipe downs of frequently touched surfaces in clinical areas Clinical teams – cleaning/ decontamination communication has been shared and frequently updated via Floorwalker Team and daily briefing messages, plus other team meetings 02.02.21 – Checklist for Equipment/ Environment decontamination piloted on Bluebell Ward – for roll out across all clinical areas	Spot check assurance programme identified an overall compliance score of 68%	Staff report that decontamination is undertaken; however, there is a gap in compliance as there is no standard/formal method to evidence that decontamination has been undertaken as required – action identified to introduce a monitoring sheet (or similar) to support evidence of compliance with the cleaning that is being undertaken	21.11.20 –environment / equipment cleaning schedules undertaken by Individual departments. Action standardised monitoring tool to be used across clinical areas 19.01.21 – Checklist for Equipment/ Environment decontamination piloted on Bluebell Ward – propose for roll out across all clinical areas 02.02.21 – Repeat spot-check audit undertaken by IPC Team identified an increased compliance score of 81%.
o rooms/areas where PPE is removed must be decontaminated,	National guidance updated as above, to include rooms where PPE is removed	Spot check assurance programme identified an overall compliance	Facilities have undertaken an assessment of updated guidance and a draft paper has been developed to identify the resources required to meet this requirement –	21.11.20 – Draft paper received by Trust Execs, some re-work currently underway . 19.01.21 –

timed to coincide with periods immediately after PPE removal by groups of staff (at least twice daily)		score of 36%, due to resource requirement for full implementation of requirements (as previous)	requires progression	Paper approved by SLG. Facilities in the process of actioning/recruitment process to enhance service. 02.02.21 – Repeat spot-check audit undertaken by IPC Team identified an increased compliance score of 50%. Recruitment process for the enhanced domestic service is in progress.
• linen from possible and confirmed COVID-19 patients is managed in line with PHE and other national guidance and the appropriate precautions are taken	As per established linen handling policy	Spot check assurance programme identified an overall compliance score of 90% for the compliance monitoring section relating to linen	Localised action for improvement within any ward/department with identified gaps in compliance, with a particular focus on correctly labelling linen bags (55% overall compliance score achieved for correctly labelling linen bags)	21.11.20 – Linen policy amended to reflect requirement to label linen bags. Policy update disseminated via Trust wide daily briefings. 02.02.21 – Repeat spot-check audit undertaken by IPC Team identified a drop in compliance (20%) of the labelling of linen bags. IPC to develop further comms and education to ensure compliance with linen policy.

• single use items are used where possible and according to Single Use Policy	As per established decontamination of medical devices policy	Spot check assurance programme identified an overall compliance score of 97%	Localised action for improvement within any ward/department with identified gaps in compliance	21.11.20 – Established decontamination and medical device policy in place.
• reusable equipment is appropriately decontaminated in line with local and PHE and other national policy	As per established decontamination of medical devices policy and supported by Floorwalker Team and daily briefing messages	Spot check assurance programme identified an overall compliance score of 58%, with the gap in compliance identified as insufficient equipment being available in a number of areas to facilitate practice	A Trust-wide action is currently in progress to assess equipment deficits and provide the required quantity of equipment to identified areas	21.11.20 – Roll out of additional patient monitoring equipment/medical devices undertaken by EBME. Migration over to a streamlined process of 2 in 1 cleaning and disinfection wipes. 02.02.21 – Repeat spot-check audit undertaken by IPC Team identified 100% compliance in the decontamination of equipment.
• review and ensure good ventilation in admission and waiting areas to minimise opportunistic airborne transmission	Air flow assessment undertaken within ICU and single rooms within the Trust (February 2020) with remedial works progressed in ICU to optimise air flow direction National guidance updated	Estates action is in progress to assess how ventilation and cooling measures can be used in support of infection prevention and	Await the outcome of Estates ventilation assessment and report any requirements for improvement within the BAF Capital monies requested through national process to include improvements n Trust wide	21.11.20 –Detailed work has been undertaken in the respiratory unit to incorporate isolation rooms with compliant ventilation as a priority. Engineering assessment now has been indicated

	to recommend that local consideration is given to any enhancements that could be made to improve ventilation in healthcare premises	control	ventilation systems.	in specific areas of the Trust eg CRV and Spirometry services. The Trust is taking a risk based approach to identified areas of concern ie services that require review as part of our restoration programme.
• ensure cleaning standards and frequencies are monitored in non-clinical areas with actions in place to resolve issues in maintaining a clean environment	21.11.20 – roll out of 2 in 1 cleaning and disinfection wipes across all non-clinical areas			
• there is evidence organisations have reviewed the low risk COVID-19 pathway, before choosing and decision made to revert to general purpose detergents for cleaning, as opposed to widespread use of disinfectants	21.11.20 – Standardised decontamination process across all COVID-19 pathways (using combination of detergent and disinfectants)			

2. **Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance**				
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**	**Update**
Systems and process are in place to ensure: • arrangements around antimicrobial stewardship are maintained • mandatory reporting requirements are adhered to and boards continue to maintain oversight	Established systems and processes remain in place for operational antimicrobial stewardship, including point prevalence assessments as per local programme and mandatory reporting requirements; local COVID-19 antibiotic guidelines have also been developed 02.02.21 – Antibiotic Stewardship reports to the IPC strategy group on a monthly basis to provide assurance of mandatory reporting requirements.	COVID-19 specific 'Start smart then focus' audit completed and results/learning are being shared through medical unit meetings Antimicrobial Stewardship Committee (ASC) is currently paused	Antimicrobial stewardship is a standing agenda item for the IPC Strategy Group – gaps in assurance can be escalated through this route pending ASC being reconvened DIPC has discussed on going medical engagement in this agenda with the medical Director	21.11.20 – ASC re-established in September 2020 and continues to feed into the IPC Strategy Group**.**

3. **Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion**				
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**	**Update**
Systems and processes are in place to ensure:				
• implementation of national guidance on visiting patients in a care setting	National guidance for visiting patients has been implemented, with support systems developed to patients, families and friends	Spot check assurance programme identified an overall compliance score of 45% regarding clear signage for visiting restrictions	Action has been taken since the time of this baseline assessment, with appropriate signage indicating visiting restrictions now displayed in all areas	21.11.20 – visiting restrictions remain in place as per NHSE guidelines. Signage in place at key entrances to the Trust. 02.02.21 - Repeat spot-check audit undertaken by IPC Team identified 100% compliance for visitor signage.
• areas in which suspected or confirmed COVID-19 patients are being treated are clearly marked with appropriate signage and have restricted access	Signage is in place for wards or identified single rooms; not all areas have restricted access as there is the potential for a suspected case of COVID-19 to be isolated within any single room in the Trust	Spot check assurance programme identified an overall compliance score of 70% regarding doors to isolation/cohort rooms/areas being closed with clear signage displayed	Action has been taken since the time of this baseline assessment, with Trust-wide standardised signage introduced to indicate red/amber/green zones, plus the requirement for doors to be kept closed is consistently reinforced through ward visits and Floorwalker briefings	21.11.20 – Standardised red/amber/green zone signage in place across the Trust. Central access to signs available via Trust Shared drive. Requirement to keep door closed continually reinforced by IPC during clinical visits
• information and guidance on COVID-19 is available on all Trust	Trust website links to national resources, including easy read versions		Current actions to continue to support sustained compliance	21.11.20 – enhanced COVID-19 intranet hub developed.

websites with easy read versions				
• infection status is communicated to the receiving organisation or department when a possible or confirmed COVID-19 patient needs to be moved	Clinical handover routinely includes infection risk/status, including electronic and ED handover proforma; infection status is also included with e-discharge and transfer of care documentation	Spot check assurance programme identified an overall compliance score of 93% for transfers within COCH 100% compliance with communicating infection status was identified for discharges or transfers to other healthcare or social care providers	Localised action for improvement within any ward/department with identified gaps in compliance Current actions to continue to support sustained compliance	21.11.20 – Established process includes Infection risk/status on handover, transfer documentation.
• there is clearly displayed and written information available to prompt patients' visitors and staff to comply with hands, face and space advice.	21.11.20 – Enhanced comms, posters and signage in place at key areas across the Trust promoting compliance with 'hands, face and space' advice.			

4. **Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people**				
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**	**Update**
Systems and processes are in place to ensure:				
• screening and triaging of all patients as per IPC and NICE Guidance within all health and other care facilities must be undertaken to enable early recognition of COVID-19 cases.	21.11.20 – Process for triaging patients and screening for COVID-19 for all emergency admissions in place, with rapid screening of suspected cases. Overall Trust compliance with admission screening (w/c 09.11.20) was 84%. High level of compliance (98%) demonstrated from key admission pathway are (AMU).			19.01.21 - COVID-19 screening compliance report (w/e 10.01.21) for emergency admissions Day 1 - 89%
• front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed COVID-19 symptoms and to segregate them from non-COVID-19 cases to minimise the risk of cross-infection, as per national guidance	Clinical pathways have been altered to address triage of symptomatic patients. This can be found in ED pathway. Segregation areas commissioned to facilitate COVID-19 and non-covid-19 patients in ED (and Haygarth Centre). The Children's Respiratory Assessment area has also been given a separate	Spot check assurance programme identified an overall compliance score of 89%	Localised action for improvement within any ward/department with identified gaps in compliance	21.11.20 – Process for screening for COVID-19 for all emergency admissions in place, with rapid screening of suspected cases. Established 'hot/cold' zones in place within the ED. Overall Trust compliance with admission screening (w/c 09.11.20) was 84%.

	location; process to assess obstetric patients prior to arrival			High level of compliance (98%) demonstrated from key admission pathway are (AMU). 19.01.21 - COVID-19 screening compliance report (w/e 10.01.21) for emergency admissions Day 1 - 89%
• staff are aware of agreed template for triage questions to ask	21.11.20 – Standardised triage process with the ED with established red and amber zones in place.			
• triage undertaken by clinical staff who are trained and competent in the clinical case definition and patient is allocated appropriate pathway as soon as possible	21.11.20 – Competency assessed locally with ED to ensure staff are trained and competent to undertake patient triage. Manchester triage process implemented			
• face coverings are used by all outpatients and visitors • face masks are available for patients with respiratory symptoms	21.11.20 – Face covering and Face masks available at all Trust entrances and distributed to all staff and visitors entering the Trust			
• provide clear advice to patients on	21.11.20 – posters and comms distributed on the			

• use of face masks to encourage use of surgical facemasks by all inpatients in the medium and high-risk pathways if this can be tolerated and does not compromise their clinical care	correct use of facemasks. All patient's continue to be encouraged by staff to use facemasks where tolerated			
• ideally segregation should be with separate spaces, but there is potential to use screens, e.g. to protect reception staff	21.11.20 – Trust wide assessment of key reception areas undertaken and led by estates. Areas of 'high traffic' identified and perspex screens in place.			
• mask usage is emphasised for suspected individuals	Local recommendation that all patients wear a surgical face mask, at all times, if tolerated	Spot check assurance programme identified an overall compliance score of 87% with local policy	Localised action for improvement within any ward/department with identified gaps in compliance and consistently reinforced through ward visits and Floorwalker briefings	21.11.20 – posters and comms distributed on the correct use of facemasks. All patient's continue to be encouraged by staff to use facemasks where tolerated
• ideally segregation should be with separate spaces, but there is potential to use screens, e.g. to protect reception staff	Some front door areas/departments have a screened reception desk - all reception desks, including outpatients require assessment for physical separation options e.g. screens	Spot check assurance programme identified an overall compliance score of 24% with screened reception areas	Trust-wide action in progress through Estates, to complete the assessment/installation works required for physical separation options	21.11.20 – Trust wide assessment of key reception areas undertaken and led by estates. Areas of 'high traffic' identified and perspex screens in place. 02.02.21 - Repeat spot-check audit

				undertaken by IPC Team identified 100% compliance. All reception areas identified as areas of 'high traffic' now have perspex screens in place.
• for patients with new-onset symptoms, it is important to achieve isolation and instigation of contract tracing as soon as possible	Process developed to isolate/cohort patients who develop signs/symptoms of COVID-19 during their admission, or who screen positive for COVID-19 as part of any assessment – this includes routine contact tracing	Spot check assurance programme identified an overall compliance score of 38%, with the gap in assurance identified as limitations for enhanced contact tracing – project in development with Teletracking Team (US) to address this	Interim action has been taken since this baseline assessment was undertaken, to introduce a method of enhanced contact tracing through Meditech data, while awaiting the outcome of the Teletracking project	21.11.20 – patient contact tracing system established utilising teletracking. System under further development with additional resource to ensure robust system of contact tracing is maintained. Senior leadership provided by a consultant. 19.01.21 Service Improvement now leading on project to establish a joint patient/staff contact tracing system. 02.02.21 - Repeat spot-check audit undertaken by IPC Team identified an increase in compliance to 71%.

• patients with suspected COVID-19 are tested promptly	Laboratory capacity supports patient testing for COVID-19	Process to monitor compliance with emergency admission COVID-19 screening, plus screening on day 3 and day 5 of admission, is in development	Spot check assurance programme identified an overall compliance score of 100% - current actions to continue to support sustained compliance	21.11.20 – Process for screening for COVID-19 for all emergency admissions in place, with rapid screening of suspected cases. Overall Trust compliance with admission screening 85%. Process established to monitor compliance with day 1, day 3 and day 5 admission screening. 19.01.21 - COVID-19 screening compliance report (w/e 10.01.21) for emergency admissions Day 1 - 89%
• patients who test negative but display or go on to develop symptoms of COVID-19 are segregated and promptly re- tested and contacts traced	Process developed to isolate/cohort patients who develop signs/symptoms of COVID-19 during their admission, or who screen positive for COVID-19 as part of any assessment – this includes routine contact tracing	Spot check assurance programme identified an overall compliance score of 38%, with the gap in assurance identified as limitations for enhanced contact tracing – project in development with	Interim action has been taken since this baseline assessment was undertaken, to introduce a method of enhanced contact tracing through Meditech data, while awaiting the outcome of the Teletracking project	21.11.20 – patient contact tracing system established utilising teletracking. System under further development with additional resource to ensure robust system of contact tracing is maintained. 19.01.21 Service Improvement now leading on project

		Teletracking Team (US) to address this		to establish a joint patient/staff contact tracing system. 02.02.21 - Repeat spot-check audit undertaken by IPC Team identified an increase in compliance to 71%.
• patients who attend for routine appointments and who display symptoms of COVID-19 are managed appropriately	Only urgent/essential elective/planned services are currently being delivered		Spot check assurance programme identified an overall compliance score of 100% - current actions to continue to support sustained compliance	21.11.20 – Process for COVID-19 screening of all emergency and elective admissions in place. Temperature checking and symptom checking in place at key entrances to the Trust
5. **Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection**				
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**	**Update**
Systems and processes are in place to ensure:				
• Separation of patient pathways and staff flow to minimise contact between pathways. For example, this could include provision of separate entrances/exits	21.11.20 – Review of trust entrance/exits being undertaken. Dedicated patient/visitor entrance and exit points in place. No visitor access to staff restaurant.			

(if available) or use of one-way entrance/exit systems, clear signage, and restricted access to communal areas				
• all staff (clinical and non- clinical) have appropriate training, in line with latest PHE and other guidance, to ensure their personal safety and working environment is safe	Staff training, including reminders in practice are supported by the IPC Team/ Floorwalker Team, daily briefings, posters and screensavers. PPE supplies for individual areas are coordinated through Silver Control and the Supplies Team.	Action in progress to explore if PPE training can be formalised through ESR as a mandatory annual competency	Spot check assurance programme identified an overall compliance score of 100% - current actions to continue to support sustained compliance	21.11.20 – Clinical based staff training, including reminders in practice continues to be supported by the IPC Team/ Floorwalker Team, daily briefings, posters and screensavers. Action – to formalise training as a mandatory competency 19.01.21 – IPCT to link with Education and Training to include PHE training videos for PPE as part of mandatory training/annual appraisal
• all staff providing patient care are trained in the selection and use of PPE appropriate for the clinical situation	Staff PPE training is supported by IPC Team, Floorwalker Team, Fit Testing Team, daily briefing messages, posters, screensavers, videos, FFP3 fit testing programme.	Action in progress to explore if PPE training can be formalised through ESR as a mandatory annual competency	Spot check assurance programme identified an overall compliance score of 100% - current actions to continue to support sustained compliance	21.11.20 – Clinical based staff training, including reminders in practice continues to be supported by the IPC Team/ Floorwalker Team, daily briefings,

and on how to safely don and doff it safely				posters and screensavers. Action – to formalise training as a mandatory competency 19.01.21 – IPCT to link with Education and Training to include PHE training videos for PPE as part of mandatory training/annual appraisal
• a record of staff training is maintained	Staff FFP3 fit test record is held on ESR	Action in progress to explore if PPE training can be formalised through ESR as a mandatory annual competency	Spot check assurance programme identified an overall compliance score of 100% - current actions to continue to support sustained compliance	21.11.20 – Clinical based staff training, including reminders in practice continues to be supported by the IPC Team/ Floorwalker Team, daily briefings, posters and screensavers. Action – to formalise training as a mandatory competency Strategic and operational management of FFP3 fit testing now led by a collaborative of EPRR and Silver Control. Review of FFP3 staff record database in progress.

• appropriate arrangements are in place that any reuse of PPE in line with the MHRA CAS Alert is properly monitored and managed	Local thresholds developed for when reuse of PPE may need to be considered, this would be monitored/recorded via Silver Control as central control point for PPE; daily stock checks plus PPE Group meets weekly to assess PPE sustainability		Spot check assurance programme identified an overall compliance score of 100% for staff access to the PPE they require - current actions to continue to support sustained compliance Central decontamination processes developed for 3M Jupiter hoods and reuseable eye protection	21.11.20 – Established central process for decontamination of reusable eye protection and powered respirator hoods in place.
• any incidents relating to the re-use of PPE are monitored and appropriate action taken	PPE related incidents would be recorded via incident reporting system (Datix) and actioned accordingly	Gaps in assurance would be identified via Datix reports		21.11.20- established incident reporting system (datix) in place. No themes or trends identified.
• adherence to PHE national guidance on the use of PPE is regularly audited	BAF compliance monitoring process has now been developed to standardise assurance		Spot check assurance programme identified an overall compliance score of 100% with PPE use - current actions to continue to support sustained compliance Action in progress to include IPC COVID-19 spot check assurance programme as part of the ward accreditation rolling programme	21.11.20 – Formal monitoring of compliance with PPE guidance is incorporated into the IPC departmental audit programme and the IPC Link Practitioner audit programme.
• staff regularly undertake hand hygiene and observe standard	As per established hand hygiene compliance monitoring programme		Spot check assurance programme identified an overall compliance score of 100% with hand hygiene	21.11.20 – Established hand hygiene compliance monitoring

infection control precautions			following PPE removal - current actions to continue to support sustained compliance	programme in place.
• hygiene facilities (IPC measures) and messaging are available for all patients/individuals, staff and visitors to minimise COVID-19 transmission such as: **1.** hand hygiene facilities including instructional posters **2.** good respiratory hygiene measures **3.** maintaining physical distancing of 2 meters wherever possible unless wearing PPE as part of direct care **4.** frequent decontamination of equipment and environment in both clinical and non-clinical areas **5.** clear advice on use of face coverings and facemasks by patients/individuals, visitors and by staff in non-patient facing areas	21.11.20 – hand hygiene facilities available to all patients/staff within clinical areas (hand wash basins, hand sanitizer). Roll out undertaken to ensure hand hygiene instructional posters are displayed in all toilet areas across the Trust. A review of the availability of hand sanitizer identified a requirement for additional wall mounted sanitizer dispensers. Works in progress to fit additional dispensers. Signage promoting physical 2 meter distancing in place across communal (corridors, stairwells). Provision of environmental cleaning materials (2in1) detergent/disinfectant wipes and hand sanitizer distributed to all non-clinical areas. Posters and comms	Availability of wall mounted hand sanitizer dispensers.	Procurement of portable hand sanitizer bottles to be distributed to all staff to ensure access to hand sanitizer.	

	distributed on the correct use of facemasks. All patient's continue to be encouraged by staff to use facemasks where tolerated			
• hand dryers in toilets are associated with greater risk of droplet spread than paper towels. Hands should be dried with soft, absorbent, disposable paper towels from a dispenser which is located close to the sink but beyond the risk of splash contamination, as per national guidance	Use of disposable paper hand towels is standard practice within all clinical areas		Progress check required with Facilities on progress with removing the small number of hand dryers located within some public toilet areas	21.11.20 – Action – Facilities to provide assurance that hand dryers not in use. 19.01.21 – Update from facilities required.
• guidance on hand hygiene, including drying, should be clearly displayed in all public toilet areas as well as staff area	Staff information, including reminders in practice supported through staff communication e.g. daily briefings	Spot check assurance programme identified an overall compliance score of 52%, with this gap in assurance relating to displaying	Action required to purchase click frames to appropriately display the national hand hygiene guidance poster within all patient/public bathrooms/toilets – adjacent, or near to hand wash basins for ease of reference	21.11.20 – Collaborative project between estates and IPC. Appropriate posters and click frames procured. Programme now established and works on-going to ensure hand hygiene instructional posters are

		guidance posters as standard in public toilet areas - currently hand hygiene reminders are on display only		displayed in all toilet areas across the Trust. 19.01.21 – works progressing, await feedback from estates of completion date. 02.02.21 - Repeat spot-check audit undertaken by IPC Team identified an increase in compliance to 74%.
• staff understand the requirements for uniform laundering where this is not provided for on site	Staff information, including reminders in practice supported by Floorwalker Team and through staff communication e.g. daily briefings	Spot check assurance programme identified an overall compliance score of 94%	Localised action for improvement within any ward/department with identified gaps in compliance	21.11.20 – Established uniform policy. Provision of scrubs to all staff working on COVID-19 cohort areas.
• all staff understand the symptoms of COVID-19 and take appropriate action in line with PHE and other national guidance if they or a member of their household displays any of the symptoms	Staff information, including reminders in practice are supported by Occupational Health, Floorwalker Team and through staff communication e.g. Intranet resources, daily briefings		Spot check assurance programme identified an overall compliance score of 100% - current actions to continue to support sustained compliance	21.11.20 – Established process/SOP for staff screening. If staff develop COVID-19 symptoms to inform their manager, arrange to be screened via Trust screening service and self-isolate pending screen result.

• a rapid and continued response through ongoing surveillance of rates of infection transmission within the local population and for hospital/organisation onset cases (staff and patients/individuals	21.11.20 – COVID-19 surveillance processes established and maintained by a collaborative of the Business Intelligence and IPC Team. Surveillance process identifies community/hospital cases with escalation/incident reporting process for all hospital onset cases.			
• Positive cases identified after admission who fit the criteria for investigation should trigger a case investigation. Two or more positive cases linked in time and place trigger an outbreak investigation and are reported.	21.11.20 – Process established for SBAR investigation of all hospital onset COVID-19 cases. All cases linked to a declared outbreak reviewed as part of an enhanced outbreak investigation process.			19.01.21 – IPC (RCA) risk recovery plan in place with identified project lead, supported by risk, IPC and clinical input.
• robust policies and procedures are in place for the identification of and management of	21.11.20 – Robust surveillance system in place within the IPC service for the identification of outbreaks. Management of			19.01.21 – Management of outbreaks currently led by the (Acting) Lead Infection Prevention and

outbreaks of infection	outbreaks led by the Associate Director for IPC /Lead Infection Control nurse and IPC Doctor utilising PHE COVID-19 IPC guidance.			Control Nurse and IPC Doctor utilising PHE COVID-19 IPC guidance.
6. Provide or secure adequate isolation facilities				
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**	**Update**
Systems and processes are in place to ensure:				
• restricted access between pathways if possible, (depending on size of the facility, prevalence/incidence rate low/high) by other patients/individuals, visitors or staff	21.11.20 – Trust escalation strategy to maintain COVID-19 cohort areas within a dedicated area of the Trust. Including restricted access at entrance/exits of dedicated area.	Standardisation of pathway terminology across the organisation. ('Hot/Cold' zones in the ED).	Established process within the ED for identification and segregation of suspected COVID-19 and non-suspected cases.	
• areas/wards are clearly signposted, using physical barriers as appropriate to patients/individuals and staff understand the different risk areas	21.11.20 – Established red/amber/green zones with appropriate door signage in place across inpatient clinical areas.			
• patients with possible or confirmed COVID-19 are isolated in	Process in place to triage patients who have confirmed COVID-19, are	Spot check assurance programme	Challenges with resources (infrastructure) to achieve compliance – insufficient single	21.11.20 – Action – Estates to provide assurance of Trust

appropriate facilities or designated areas where appropriate	suspected to have COVID-19 (high suspicion or low suspicion), patients who are shielding or vulnerable and patients who have no COVID-19 risk factors, to support decision making for bed allocation.	identified an overall compliance score of 52% for isolation in a single room with clinical wash hand basin and en-suite facilities Other wards with non-COVID-19 bays may have confirmed COVID-19 positive and/or suspected cases in single rooms	rooms with required en-suite Patients are cohorted by identified risk group, single rooms prioritised for immunosuppressed patients, clinically extremely vulnerable patients (shielding) or patients with another increased risk factor	strategy for infrastructure/capital refurbishments plans to increase appropriate single room facilities. Established process to isolate/cohort suspected COVID-19 cases. Single rooms prioritized for patients assessed as vulnerable – patient status flagged and tracked via teletracking. 19.01.21 5 isolation PODS received by the Trust on 24.01.21, Joint estates/facilities/ IPC plan to safely operationalize PODS. 02.02.21 - Repeat spot-check audit undertaken by IPC Team identified slight increase in compliance to 56%.
• areas used to cohort patients with possible or confirmed COVID-19 are compliant with	The Trust does not currently have a standard 2m separation between patients in all areas Privacy curtains/screens are	Spot check assurance programme identified an overall compliance	Action required to consider how the standard 2m separation may routinely be achieved, plus options for alternative screens that will not obscure visibility and will continue	21.11.20 – Action – Estates leading on project to procure and install 'clear' screens across all clinical areas.

the environmental requirements set out in the current PHE national guidance	not currently used routinely as indicated, as these would obscure patient visibility There is no thoroughfare through any of the identified cohort wards/areas after leaving the main access corridor	score of 38% with standard 2m separation Spot check assurance programme identified an overall compliance score of 96%	to support use of privacy curtains when required for care activity Request for Capital monies through national process submitted to fund separation screens to support this action. Localised action for improvement within any ward/department with identified gaps in compliance	Recommend process is expedited to provide additional mitigation against the risk of nosocomial transmission of COVID-19. 19.01.21 - Clear screens now in place within a limited number of clinical areas (Renal Dialysis, Ward 44). Wider role out across the Trust currently limited due to resource within facilities to maintain/decontaminate clear screens. 02.02.21 - Repeat spot-check audit undertaken by IPC Team identified a slight decrease in compliance (for 2m bed spacing) to 30%.

• patients with resistant/alert organisms are managed according to local IPC guidance, including ensuring appropriate patient placement	Established systems and processes remain in place for patients with a resistant/alert organism, to ensure risk assessment for the most appropriate placement in conjunction with available resources	A number of resistant/alert organisms are taking a lower priority for isolation in a single room than previously e.g. MRSA, VRE, due to limitations on single room capacity and patients with a higher priority for isolation e.g. COVID-19 or vulnerable patient groups Spot check assurance programme identified an overall compliance score of 80% - with the gap in compliance identified as the requirement for improved documentation of infection risk	Localised action for improvement within any ward/department with identified gaps in compliance	21.11.20 - Established processes in place for patients with a resistant/alert organism, to ensure risk assessment for the most appropriate placement in conjunction with available resources

		within patient records		
7. Secure adequate access to laboratory support as appropriate				
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**	**Update**
There are systems and processes in place to ensure:				
• ensure screens taken on admission given priority and reported within 24hrs	21.11.20 – Process for screening for COVID-19 for all emergency admissions in place, with rapid screening of suspected cases. Monitoring process of screening compliance established with overall Trust compliance for admission screening (w/c 09.11.20) reported as 84%. High level of compliance (98%) demonstrated from key admission pathway are (AMU).			19.01.21 - COVID-19 screening compliance report (w/e 10.01.21) for emergency admissions Day 1 - 89%
• regular monitoring and reporting of the testing turnaround times with focus on the time taken from the patient to time result is available	21.11.20 – Action – Microbiology Laboratory to provide assurance of result reporting and specimen turnaround times.			
• testing is undertaken by competent and	As per Microbiology Laboratory SOPs and staff training records			21.11.20 - As per Microbiology Laboratory SOPs and staff training records

trained individuals				
• patient and staff COVID-19 testing is undertaken promptly and in line with PHE and other national guidance	Laboratory capacity supports patient testing for COVID-19 On-site staff screening process in place for identified staff groups	Process to monitor compliance with emergency admission COVID-19 screening, plus screening on day 3 and day 5 of admission, is in development	Spot check assurance programme identified an overall compliance score of 100% - current actions to continue to support sustained compliance	21.11.20 - Monitoring process of screening (day 1,day 3 and day 5) compliance established 19.01.21 – Trust compliance for admission screening (w/e 10.01.21) for emergency admissions Day 1 - 89% Day 3 – 61% Day 5 – 79% Screening tool prompts rolled out trust wide (recorded in beside folders and process interventions on meditech) Established staff screening service and SOP in place.
• regular monitoring and reporting that identified cases have been tested and reported in line with the testing	21.11.20 – Action – Microbiology Laboratory to provide assurance of specimen testing and result reporting protocols.			

protocols (correctly recorded data)				
• screening for other potential infections takes place	Established processes for infection/colonisation screening remain in place		Compliance monitoring via established systems	21.11.20 - Established processes for infection/colonisation screening remain in place
8. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections				
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**	**Update**
Systems and processes are in place to ensure that:				
• staff are supported in adhering to all IPC policies, including those for other alert organisms	Established IPC systems and processes remain in place, with these being strengthened by the COVID-19 response; supported by staff information, including reminders in practice by IPC Team /Floorwalker Team and through staff communication e.g. daily briefings	Assurance monitoring supported through established systems plus COVID-19 spot check assurance programme		21.11.20 – Formal monitoring of compliance with IPC policies is incorporated into the IPC departmental audit programme and the IPC Link Practitioner audit programme.
• any changes to the PHE national guidance on PPE are quickly identified and effectively communicated to staff	Information received from various national teams through formal routes e.g. CAS alerts, CMO/CNO letters etc.; IPC Team receive automated PHE		Spot check assurance programme identified an overall compliance score of 100% for Floorwalker daily briefings being shared with staff - current actions to continue to support sustained compliance	21.11.20 – local and national updates co-ordinated an disseminated via Silver Control, EPRR and IPC

	updates and have escalated to NHS England for a similar process to be enabled for NHSe/i updates – updates communicated via Silver Control and approved Comms routes depending on content/intended audience			
• all clinical waste related to confirmed or suspected COVID-19 cases is handled, stored and managed in accordance with current national guidance	All COVID-19 related clinical waste is disposed of via 'orange' Category B waste stream. Waste is segregated at source and housed in clinical waste containers. Removed from Trust site by approved/licenced waste contractor		Spot check assurance programme identified an overall compliance score of 100% - current actions to continue to support sustained compliance	21.11.20 – Action – Facilities to provide assurance of compliance with waste management guidelines. 19.01.21 – Update from facilities required.
• PPE stock is appropriately stored and accessible to staff who require it	PPE is appropriate stored and availability to all areas is coordinated through Silver Control and the Supplies Department	Spot check assurance programme identified an overall compliance score of 87% for appropriate storage of PPE, due to a temporary challenge with	Spot check assurance programme identified an overall compliance score of 100% for accessibility - current actions to continue to support sustained compliance	21.11.20 – Central process and access to PPE maintained and co-ordinated through Silver Control and the Supplies Department.

		plastic aprons being supplied via PUSH in flat packs – not able to use usual ward/department based dispensers for these – this has now been resolved		
9. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection				
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**	**Update**
Systems and processes are in place to ensure:				
• staff in 'at-risk' groups are identified and managed appropriately including ensuring their physical and psychological wellbeing is supported	Local risk assessments for staff have been developed, with staff allocated to appropriate areas, guided by risk assessment outcomes	Consistency of application of risk assessment and changes to risk assessment as more national guidance is provided requires regular updating and communication to staff and managers	Regular briefings are provided to staff and work to develop an electronic RA tool will provide central oversight to identify gaps and allow for identification of emerging issues.	21.11.20 – Co-ordination by Workforce Planning of staff risk assessment with staff allocated/redeployed to appropriate areas, guided by risk assessment outcomes.

• that risk assessment(s) is (are) undertaken and documented for any staff members in an at risk or shielding groups, including Black, Asian and Minority Ethnic (BAME) and pregnant staff	21.11.20 – Co-ordination by Workforce Planning in collaboration with Occupational Health to ensure appropriate staff risk assessment is undertaken with staff allocated/redeployed to appropriate areas, guided by risk assessment outcomes.			
• staff required to wear FFP reusable respirators undergo training that is compliant with PHE national guidance and a record of this training is maintained	Staff PPE training is routinely supported by the IPC Team, Floorwalker Team, Fit Testing Team, daily briefing messages, posters, screensavers, FFP3 fit testing programme		Reuseable respirators are not currently in standard use; however introduction is planned through a phased programme within identified areas and an associated training programme, including record keeping, is in development to support this (initially within ICU)	19.01.21 – Reusable respirators introduced and integrated within the Fit Testing strategy/programme – led by Emergency Planning
• staff who carry out fit test training are trained and competent to do so	21.11.20 - Strategic and operational management of Centralised FFP3 fit testing service led by a collaborative of EPRR and Silver Control. 02.02.21 – FFP3 Fit Testing delivered via quantitative process using a Portacount			

	machine. All staff who provide fit testing have been trained in the use of the Portacount machine, currently 15 Trainers in place (Training provided by 'Full Support Healthcare')			
• all staff required to wear an FFP respirator have been fit tested for the model being used and this should be repeated each time a different model is used	As above. 02.02.21 – All staff who undergo fit testing are advised to only use the model of mask they have been successfully fit tested for. Central database (ESR) maintains a record of all FFP3 masks that a staff member has undergone a successful fit test.			
• a record of the fit test and result is given to and kept by the trainee and centrally within the organisation	21.11.20 – A review of the ESR staff fit testing record is being undertaken by Silver Control. 02.02.21 – All staff who achieve a successful fit test take a picture of the mask (for their own record) they have achieved a successful fit test with. Central database (ESR) accessible to departmental			

	managers and can be accessed if staff require assurance of the information in relation to their successful mask fit.			
• for those who fail a fit test, there is a record given to and held by trainee and centrally within the organisation of repeated testing on alternative respirators and hoods	As above - 21.11.20 - A review of the ESR staff fit testing record is being undertaken by Silver Control. Strategic and operational management of Centralised FFP3 fit testing service led by a collaborative of EPRR and Silver Control. 02.02.21 – All staff who fail a mask fit are informed of the mask they have had an unsuccessful fit test with. Central database (ESR) accessible to departmental managers and can be accessed if staff require assurance of the information in relation to their unsuccessful mask fit.			
• for members of staff who fail to be adequately fit tested a discussion should be had, regarding re	As above - 21.11.20 - Strategic and operational management of Centralised FFP3 fit testing service led by a collaborative of EPRR			

deployment opportunities and options commensurate with the staff members skills and experience and in line with nationally agreed algorithm	and Silver Control. 02.02.21 – Staff who fail a mask fit with a disposable or reusable FFP3 respirator advised they can only then use a powered respirator if FFP3 level respiratory protection is required within their area of work. If redeployment of staff is identified as required then this is discussed with the staff member by their line manager/matron in conjunction with the workforce team. Record of discussion documented and maintained within staff personal file.			
• a documented record of this discussion should be available for the staff member and held centrally within the organisation, as part of employment record including Occupational health	21.11.20 - Strategic and operational management of Centralised FFP3 fit testing service led by a collaborative of EPRR and Silver Control. 02.02.21 – Staff who fail a mask fit with a disposable or reusable FFP3 respirator advised they can only then use a powered respirator if			

	FFP3 level respiratory protection is required within their area of work. If redeployment of staff is identified as required then this is discussed with the staff member by their line manager/matron in conjunction with the workforce team. Record of discussion documented and maintained within staff personal file.			
• following consideration of reasonable adjustments e.g. respiratory hoods, personal re- usable FFP3, staff who are unable to pass a fit test for an FFP respirator are redeployed using the nationally agreed algorithm and a record kept in staff members personal record and Occupational health service record	21.11.20 - Strategic and operational management of Centralised FFP3 fit testing service led by a collaborative of EPRR and Silver Control. Strategy in relation to use of powered respirators and reusable masks in development. 02.02.21 – Process as outlined above			19.01.21 – SOPs developed for decontamination of powered respirators and decontamination of reusable respirators.
• boards have a system in place that demonstrates how, regarding fit testing, the organisation	As above - 21.11.20 - A review of the ESR staff fit testing record is being undertaken by Silver			

maintains staff safety and provides safe care across all care settings. This system should include a centrally held record of results which is regularly reviewed by the board	Control. Strategic and operational management of Centralised FFP3 fit testing service led by a collaborative of EPRR and Silver Control. 02.02.21 – Respiratory Protective Equipment (RPE) group (sub-committee of the IPC Strategy Group). The RPE group reports to the IPC Strategy Group monthly – providing assurance of the governance processes in place for fit testing.			
• consistency in staff allocation is maintained, with reductions in the movement of staff between different areas and the cross-over of care pathways between planned and elective care pathways and urgent and emergency care pathways, as per national guidance	For nursing, Centralised Nursing Workforce Team in place. This 'hub' supports safe deployment of staff, tracks movements, staff absences and screening. Medical Staffing team in place to support medical staff deployment.	Spot check assurance programme identified an overall compliance score of 81%	Planned/elective pathways and urgent/emergency pathways established in a number of areas – identified that staff are moved between areas of the Trust as staffing levels do not always support dedicated teams of staff for identified areas – this is risk assessed	21.11.20 - For nursing, Centralised Nursing Workforce Team continue to support and facilitate safe deployment of staff, tracks movements, staff absences and screening. Medical Staffing team continue to support medical staff deployment.

• all staff adhere to national guidance on social distancing (2metres) wherever possible, particularly if not wearing a facemask and in non-clinical areas	Staff information, including reminders in practice supported by Floorwalker Team and through staff communication e.g. daily briefings Staff routinely wear a face mask in all areas of the Trust, both clinical and non-clinical areas, as per updated national guidance	Spot check assurance programme identified an overall compliance score of 90% with social distancing	Localised action for improvement within any ward/department with identified gaps in compliance	21.11.20 – Trust protocol for all staff to wear facemasks at all times (unless in single occupancy office with the door closed). Review of staff rest areas to be expedited to ensure compliance with 2 metre social distancing when staff attend rest areas. 19.01.21 – Review and reconfiguration of staff rest areas completed with compliance to 2 metre social distancing in place.
• Health and care settings are COVID-19 secure workplaces as far as practical, that is, that any workplace risk(s) are mitigated maximally for everyone	02.02.21 - Health and Safety assessments of all workplace settings undertaken across the organisation by Health and Safety Team. Central record of these assessments that have been undertaken is maintained by Health and Safety. Space Utilisation group formed – with			

	objective to evaluate the safe utilisation of work space across the organisation. Scoping exercise undertaken by the estates team to identify and ensure areas of increased traffic have appropriate perspex screens in place at reception areas. All staff rest areas adjusted to be COVID-19 secure (to ensure 2 metre distancing, provision of wipes for environmental decontamination.			
• Staff are aware of the need to wear facemask when moving through COVID-19 secure areas.	02.02.21 – Use of facemasks applies to all staff in all areas of the organisation. (Exclusions being if in a single occupancy office with the door closed or when eating/drinking when in a staff rest area).			
• consideration is given to staggering staff breaks to limit the density of healthcare workers in specific areas		Spot check assurance programme identified an overall compliance score of 90% with social distancing	Localised action for improvement within any ward/department with identified gaps in compliance	21.11.20 – Action – A review of staff break times is required to mitigate the density of healthcare workers in specific rest areas 19.01.21 –

				Staff restaurant hours (Lunch time) now extended to enable break times to cover a broader period.
• staff absence and well-being are monitored and staff who are self-isolating are supported and able to access testing	Staff information on wellbeing and how to access testing is supported by managers, Occupational Health, Floorwalker Team and through staff communication e.g. Intranet resources, daily briefings Staff absence is routinely monitored through eRoster/ESR			21.11.20 - Staff wellbeing and how to access testing continually supported by managers, Occupational Health, Workforce Planning and through staff communication e.g. Intranet COVID-19 hub, daily briefings Staff absence is routinely monitored through eRoster/ESR.
• staff that test positive have adequate information and support to aid their recovery and return to work	Staff are routinely signposted to national resources and are supported by their manager and Occupational Health Occupational Health contact individuals directly on receipt of test results and provide advice and guidance as required.			21.11.20 - Staff continue to be guided to national PHE/NHS guidance and are supported by their manager and Occupational Health Occupational Health continue to contact individuals directly on receipt of test results (during office hours) and provide advice and

				guidance as required. Communication of positive result (out-of hours) is facilitated by the staff test and trace system.

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Appendix 1.			
Audit Question Number		1st spot check 2020	Repeat Spot check 2021
71	Signage regarding visitor restrictions is clearly visible.	45%	100%
66	All linen bags are tagged with ward/care area and date.	55%	20%
58	Patients are taken directly to and from clinical departments, if any transfer is for an investigation, with no delays as part of this process.	62%	81%
54	Posters for how to wash and dry hands are clearly displayed in all public toilets and staff areas.	52%	74%
46	Frequently touched surfaces are decontaminated at least twice daily and when they are known to be contaminated with secretions/blood/bodily fluids – check:	68%	81%
	• Toilets		
	• Commodes		
	• Door handles/push plates		
	• Locker tops		
	• Bedside tables		
	• Bed rails		
	• Work surfaces		
	• Telephones		
	• Mobile phones		
	• All touch screens, including mobile devices e.g. tablets		
	• Computer keyboards		
45	Isolation rooms and cohort areas have been decontaminated twice each day, including toilets, bathrooms, areas where PPE is removed and staff areas.	36%	50%
40	Cleaned/disinfected equipment is allowed to air dry before reuse.	55%	100%
37	Re-useable equipment (non-invasive) is dedicated to a single patient as much as possible and decontaminated after each use.	58%	100%
20	Staff are assigned to care for patients in isolation/cohort rooms/areas and are dedicated to those areas for the entire shift.	68%	57%
12	Patients are separated by at least 2 metres and screens are in place between bed spaces to minimise opportunities for close contact.	38%	30%
9	Patients with new onset symptoms during admission have been isolated immediately and contacts have been traced.	38%	71%
5	Possible cases (awaiting lab confirmation) and confirmed cases are isolated in a single room with clinical wash hand basin and en-suite facilities.	52%	56%
3	There is physical separation of reception staff e.g. Perspex screens.	24%	100%
14	Signage for zoned areas is clear and there is restricted access.	65%	96%

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Meeting	**9th March 2021**		**Board of Directors**					
Report	**Agenda item 14.c**		**IPC formal report following NHSE/I visit (27th November 2020)**					
Purpose of the Report	Decision		Ratification		Assurance	**X**	Information	
Accountable Executive	Alison Kelly				Deputy CEO/Director of Nursing & Quality			
Author(s)	Alison Kelly				Deputy CEO/Director of Nursing & Quality			
Board Assurance Framework	Q1 Q3	Quality & Safety Safety - Infection Prevention & Control						
Strategic Aims	To deliver safe care and treatment							
CQC Domains	Safe, Effective, Caring, Responsive, Well Led							
Previous Considerations	Infection Prevention & Control Strategy Meeting - 26th January 2021 Quality and Safety Committee – 10th February 2021							

Summary

This report provides an overview of the site visit undertaken by NHSE/I in November 2020. It highlights areas of good practice for example:

- Visible clinical leadership and effective communication in place
- Robust Ward Accreditation programme in place
- Good adherence with the wearing of PPE
- Business intelligence support for IPC in place

There are 19 recommendations regarding actions and areas for improvement. These include:

- Review required of Track and Trace processes
- Replace all fabric curtains
- Improve compliance against the Day 3 and 5-7 patient screening
- Increase cleaning across all areas
- Further review of patient placement in terms of cohorting.

All 19 recommendations are incorporated into a NHSE/I action plan (which cross references with the gaps in the BAF and thus features in the Improvement plan). The plan is monitored monthly at the IPC Strategy Group meeting. Out of the 19 recommendations, 10 have been fully completed, all others are on track to deliver by the end of Quarter 4 2020/2021.

Recommendation(s)	The Board is asked to note the content of the report
Corporate Impact Assessment	
Statutory Requirements	Reflects metrics that influences safe care delivery to meet regulatory standards
Quality & Safety	Supports delivery of safe care and CQC requirements
NHS Constitution	Supports compliance with NHS Standards
Patient Involvement	N/A
Risk	Reflects key aspects of the Board Assurance Framework
Financial impact	N/A
Equality & Diversity	N/A
Communication	Document to be published on the website and intranet

NHS England/ NHS Improvement Visit Report

Peer Review of IPC -COVID Pathway:

Countess of Chester Hospital

Date of Review:27 November 2020

Date of Report: 22 December 2020

Report authors:

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NHS England and NHS Improvement

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1 Executive Summary

1.1 Introduction

A peer review support visit to Countess of Chester Hospital was carried out on 27 November 2020. This report provides you with findings and recommendations from the visit.

The visit was led by Rosie Dixon, Head of IPC, it was also attended by Marisa Alexia, Lead Nurse IPC and Hilda Gwilliams, Relationship Lead Support COVID-19.

The purpose of the visit was in response to a rise in the number of nosocomial infections and outbreaks at the Trust.

Introductory discussions were held with the members of the Senior Leadership Team, these were particularly helpful in understanding the context and issues specific to Countess of Chester Hospital. The peer review team visited in-patient Wards and the Emergency Department (ED) to observe the medium risk pathway and review compliance with IPC principles for prevention and management of COVID-19.

1.2 Background

The Countess of Chester Hospital NHS Foundation Trust consists of a 600 bedded large district General Hospital, which provides its services on the Countess of Chester Health Park, and a 64 bedded Intermediate Care Service at Ellesmere Port Hospital. The Trust has almost 4,000 staff and provides a range of medical services to more than 445,000 patients per year from an area's covering Western Cheshire, Ellesmere Port, Neston and North Wales.

1.3 Scope

Five key IPC (infection Prevention and control) KLOE (Key Lines of Enquiry) were identified. The KLOE are based on the IPC BAF (board assurance framework.
For this visit the KLOE's were identified as:

- **Operational-** Communications and messaging of key IPC principles, and reporting mechanisms for outbreaks.

- **IPC Practice-** Observations of adherence to basic IPC practice and an understanding of the education and training undertaken.
- **Leadership-** Explore leadership re IPC is there evidence that it is embedded across all areas.
- **Environmental-** Observations of the estate, including bed spacing and processes to mitigate against environmental shortfalls i.e. ventilation.
- **Testing -** Compliance with admission, day 3 and 5-7 screening protocols and turnaround times.

1.3.1 Trust Staff participating:

- A Kelly, Director of Nursing& Quality and Deputy Chief Executive.
- D Coyle, Chief Operating Officer.
- J Scott, Interim Head of Infection Prevention and Control.
- Focus Groups for Infection Prevention and Control (multidisciplinary), Estates and Facilities including Soft FM and Senior Nurse Leadership team.
- Ward based staff, nursing, medical, allied health professionals.

1.4 Purpose of the review

Recognising good practice and areas of improvement, together with identifying additional areas for continuous improvement are key elements of the review process. Reviewers were asked to undertake and provide feedback from the review in a professional, respectful and supportive manner.

1.5 High Level feed back

High level feedback was provided to the Trust at the end of the visit.

On the day of the visit, the ED was busy but not at capacity, and the wards visited were fully occupied.

- During the visit, areas of good practice were highlighted: these include strong leadership, good communication mechanisms including signage, use of PPE champions and opportunities for sharing good practice throughout the organisation.
- In addition, staff reported feeling valued by the organisation and that their Well-being is considered.

- During the visit availability and access to hand hygiene and PPE was good and at the time of the visit was observed to be used. We did not observe care being delivered behind curtains or closed side room doors.
- A number of areas for improvement were identified these included: the need to increase the provision of domestic services, the prioritisation of estates work, particularly in clinical areas, clinical staff may benefit from an algorithm to aid initial decision making, specifically, around patient assessment and placement pathways and the reinstatement of the IPC audit programme for monitoring and identifying areas of concern. In addition, the review team observed significant challenge in relation to those patients deemed 'fit for discharge' due to lack of designated care homes, particularly patients from other countries i.e. Wales.

2 Main Report

2.1 Context

The Executive Team at the Countess of Chester is mainly stable with a new Chair in April 2020 and a new Chief Executive in April 2019. Of note, is the strong clinical background of four of the Executive Directors.

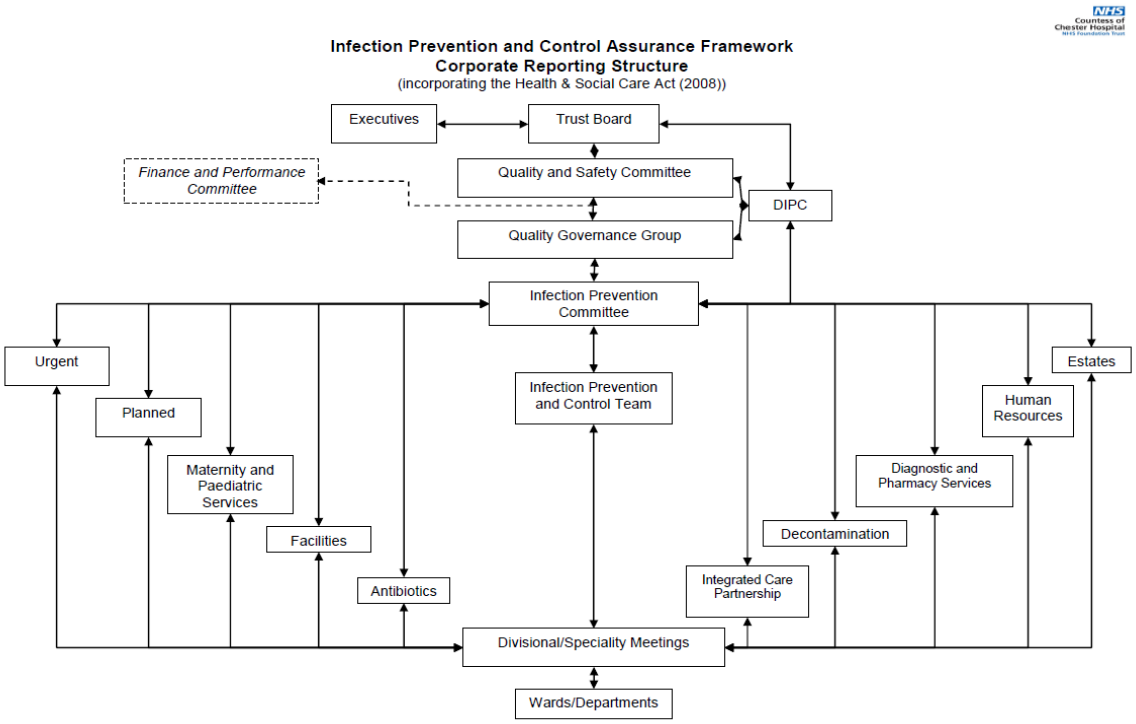
2.1.1 Infection Prevention and Control Team Structure (IPCT)

The operational structure of the Infection Prevention and Control (IPC) Team remained unchanged since 2008. However, following the recognition by the Senior Leadership Team that in order to have a robust, sustainable service in place to deliver the quality and IPC agenda, significant investment was required. Following a successful business case in the summer of 2020, a new structure was approved. The new model demonstrates strengthened leadership, an increase in skills and competencies and the substantive positions increased by approximately 40%. The new IPC model below:

- 1 x Associate Director of Nursing (new – band 8C)
- 1 x Lead IPCN, band 8A
- 2 x Specialist IPCN, band 7
- 3 x IPCN, band 6 (2 new)
- 1 x Support IPCN, band 5 (new)
- 1 x Administrative support, band 4

The Trust is proactively recruiting to all posts within the new structure.

2.2 Governance and Assurance:



- Each Division/Speciality has its own group IPC committee which feed into a monthly group clinical effectiveness and clinical risk group meeting, which feeds into an overarching Trust wide IPC committee.
- The overarching IPC committee feeds into a monthly subgroup of the board.
- An IPC Board Assurance Framework in place.

2.3 Leadership

- IPCT feel well supported in the divisions and within the Trust.
- Strong clinical leadership with 'Board to Ward' executive programme in place, albeit deferred due to COVID.
- Front facing staff felt well supported with weekly communication with Director of Nursing and weekly executive led team brief via TEAMS.
- National outbreak checklist had been used by the IPC.
- Continues communication in the Trust about COVID-19, via the bulletin.

2.4 Testing and Staff Tracing

- Laboratory turnaround times extreme with no end-to-end process mapping, longest wait estimated at 36 hours.
- The Trust had strong performance in relation to admission COVID testing, above 90% compliance. However, recognise improvement required for 3 and 5-7 day testing compliance.
- Staff felt that staff contact tracing could be improved.

2.5 Estates and Facilities including Soft FM

- On inspection of the areas visited, the need for ongoing repair work was very apparent. Some of the issues noticed in the AMU includes broken/ out of place ceiling tiles, dirty grouting in bathrooms and damaged doors.
- Staff working in the organisation, acknowledged the challenges the estate posted to Infection prevention and control. It was felt the estate teams is too small to meet the demands on the service, recommend a review of the structure.
- Increase cleaning frequency in patient areas is a challenge, particularly of frequently touched surfaces. The Trust has developed a successful business case and are in the implementation phase. The mitigation currently is the use of temporary workforce.
- The Trust continued to decontaminate with chlorine-based products throughout the site, good practice shared during the visit related to the introduction of enhanced cleaning system such as HPV.
- In the clinical areas it was noted there is a mixed approach to curtains and a recommendation to replace fabric curtains where Covid-19 patients are being assessed with disposable ones or suitable Perspex screens.
- Communal rest facilities in the main staff restaurant had been reviewed and provide adequate spacing between staff. However, some of the communal Ward areas did not consistently provide adequate social distancing, areas were cluttered, and large numbers of chairs were available if staff choose not to comply with the appropriate number of staff allowed in the area.

2.6 Patient Placement

- The Trust acknowledged the current occupancy levels, 98% and testing concerns impacted on the decisions of patient placement.
- Increased isolation capacity by requesting isolation PODs to assist with cohorting and isolating suspected cases on admission.
- Infection prevention messaging to clinical staff. Specifically, around patient assessment and placement pathways. Clinical staff may benefit from an algorithm to aid initial decision making.
- Mixed COVID status inpatient areas, increasing risk of nosocomial spread and operationally difficult for Ward Managers to maintain safety, learning from across the NHS is that single designated Wards have better outcomes and Trust has large enough nosocomial cases to implement.
- All inpatients, outpatients and visitors are required to wear a facemask when entering the building.
- All visiting was currently restricted to essential visiting only.
- The Trust shared that their bed spaces were 2 meters apart from middle to middle, with a set routine pattern of chair, bed and locker to increase the space between patients, however observed a lack of consistency across all areas.
- Repurposing of wards into a designated facility supporting flow, could potentially lead to the double counting of cases.

2.7 Staff Well-Being

- Feedback from staff indicated that the Trust makes good provision to ensure that staff member's mental health and well-being was considered.
- Since the start of the pandemic the Macmillan team have become heavily involved in staff pastoral care.
- Bespoke initiatives in place for staff in areas where Covid-19 positive patients are being cared for.
- External counselling support is available for staff who may require it.

2.8 Clinical visit

2.8.1 Trust wide

- On arrival to the main hospital entrance, patients and visitors were greeted by a security guard and a member of staff, carrying out temperature checks. Additionally, they are providing masks and alcohol hand rub before signposting them to the department they require.
- Staff were proud of the care and treatment being delivering to patients.
- The Trust reported an ongoing 'Dump the junk' campaign, that encourages departments to declutter and facilitates easy removal of unwanted items.
- Staff expressed concern about the level of sickness within some teams and the impact this could have on meeting staffing requirements. In addition, staff that are shielding have the potential to significantly impact on these further.
- Covid-19 signage observed in the main corridor and Emergency Department were of good quality and easily noticeable.
- Newly appointed EPR officer as a standalone post.
- Business Intelligence support to develop in-house IPC/staffing dashboard inclusive of community prevalence.
- Robust Ward Accreditation programme in place.
- Roles reviewed and responsibilities realigned releasing time to care such as Matron of the week/or day rather than all Matrons.
- There is an increase in sickness rates leading to the reduction in the available staff to manage the Ward roster, local request for HR/finance/nursing to expedite recruitment processes.

2.8.2 IPC Practice

- Hand hygiene equipment and signage was available and observed to be used consistently during the time of the visit. The Trust had invested in improved hand hygiene facilities at the entrance to wards we visited. Observations of adherence to basic IPC practice was good.
- PPE including masks and visors were being used appropriately.
- The existing audit programme has been paused due to the challenges of COVID-19, it is recommended to reinstate audit for monitoring and identifying areas of concern.

- The staff in AMU raised concern that not all staff who care for Covid-19 positive patients and may be involved in aerosol generating procedures were not yet face fit tested. This is despite the Trust recently purchasing 2 Portacount machines to expedite the Face Fit Testing programme.
- We did see evidence of a process for decontamination of equipment, including 'Green' stickers when equipment has been fully cleaned, further communication to reinforce cleaning processes would be beneficial. In addition, equipment stored in linen rooms are not always clearly marked with 'Green' stickers therefore potential to be mixing clean and used equipment together in close contact with bed linen.
- Kitchen facilities on wards we visited were small and often shared between areas, some of these areas had both patients diagnosed and COVID positive and non-COVID positive patients nursed within them, the potential for transmission in these areas. Housekeeper/catering assistant from each Ward accessed at the same time due to mealtimes and clearing/cleaning schedules.
- Limited toilet facilities were available on the wards we visited to enable segregation of all patients.

3 Recommendations

At the time of the visit verbal feedback was provided to members of the Senior Leadership Team. Several recommendations were provided that aim to contribute to the continued reduction and ongoing mitigation against nosocomial Covid cases and outbreaks. The below list follows the format of the report in order of presentation;

1. Day 3, and 5-7 testing is not fully compliant. Examine end to end process and audit to identify gaps.
2. Review process of staff contact tracing, audit identifying any gaps.
3. Ensure ongoing estate works for repairs in clinical areas is prioritised.
4. Undertake a review of the estates workforce structure to ensure there is enough capacity to meet the demands on the service.
5. Increase cleaning frequency in patient areas, particularly of frequently touched surfaces.
6. Introduce enhanced cleaning system, such as HPV.

7. Replace fabric curtains in clinical areas where Covid-19 patients are being assessed with disposable ones or suitable Perspex screens.
8. Reinforce the important message to consistently maintain 2-meter distancing in the clinical environment.
9. Review data methodology to ensure no double counting in association with repurposing Wards supporting flow and discharge.
10. All staff rooms, offices and other shared areas should have clear signage and chairs for correct amount of people. Remove additional chairs and add maximum number of people at any one time.
11. Develop an IPC patient placement algorithm to help staff with decision making.
12. Review the placement of COVID-19 patients to ensure they are treated in the most suitable area. Consider creating a system of designating whole wards. This would improve patient flow and reduce the risk of transfer.
13. The IPC audit programme must be re-instated to monitor compliance of IPC standards across the organisation.
14. Ensure that face fit testing programme prioritises staff in areas where Covid-19 patients are being cared for.
15. Undertake an audit of equipment decontamination processes and action improvements particularly around labelling and segregation in the labelling of equipment to show “I am clean”, and ensure appropriate segregation.
16. Allow for a slight variation in mealtimes in order staff not in same confined space at the same time, review patient placement to reduce risks of transmission.

4 Final Note

In conclusion**,** thank you once again for your hospitality, openness and co-operation during the visit. The feedback from the review is not intended to be a regulatory process but should support the Trust with its ongoing improvement work. It is hoped that the feedback from the review can be used in a supportive and developmental way but also to provide constructive challenge to help improve the quality of care.

For any further queries regarding the review process or feedback please contact NHS England / Improvement North West Region.

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