UNIVERSITY OF LEICESTER
Associate Teaching Hospital

NHS
Northampton General Hospital
NHS Trust

Public Trust Board

Thursday 24 September 2020

09:30

Via ZOOM
Northampton General Hospital

UNIVERSITY OF LEICESTER
Associate Teaching Hospital

NHS
Northampton General Hospital
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A G E N D A

PUBLIC TRUST BOARD

Thursday 24 September 2020
09:30 via ZOOM at Northampton General Hospital

Time	Agenda Item		Action	Presented by	Enclosure
09:30	**INTRODUCTORY ITEMS**				
	1.	Introduction and Apologies	Note	Mr A Burns	**Verbal**
	2.	Declarations of Interest	Note	Mr A Burns	**Verbal**
	3.	Minutes of meeting 30 July 2020	Decision	Mr A Burns	**A.**
	4.	Matters Arising and Action Log	Note	Mr A Burns	**B.**
	5.	Patient Vlog	Receive	Ms S Oke	**Verbal.**
	6.	Chairman's Report	Receive	Mr A Burns	**Verbal**
	7.	Chief Executive's Report	Receive	Mr S Weldon	**C.**
PERFORMANCE					
	8.	Integrated Performance Report	Assurance	Mrs D Needham Non - Executive Directors	**D.**
GOVERNANCE					
	9.	NGH Improvement Plan	Assurance	Ms C Campbell	**E.**
	10.	IPC Board Assurance Framework	Assurance	Ms S Oke	**F.**
STRATEGY					
	11.	Post Covid-19 Reset	Assurance	Mr Pallot	**G.** **To Follow.**
	12.	Academic Strategy	Assurance	Mr M Metcalfe	**H.**
ANNUAL REPORTS					
	13.	Safeguarding Annual Report	Assurance	Ms S Oke	**I.**
	14.	Infection Prevention Annual Report	Assurance	Ms S Oke	**J.**

Time	Agenda Item		Action	Presented by	Enclosure
	16.	Fire Safety Annual Report & Fire Safety Board Compliance Statement	Assurance	Mr S Finn	**K.**
CLOSING ITEMS					
	16.	Questions from the Public (Received in Advance)	Information	Mr A Burns	**Verbal.**
11:50	**17.**	**ANY OTHER BUSINESS**		Mr A Burns	**Verbal**

DATE OF NEXT MEETING

The next meeting of the Public Trust Board will be held at 09:30 on 26 November 2020 in the Board Room at Northampton General Hospital.

RESOLUTION – CONFIDENTIAL ISSUES:

The Trust Board is invited to adopt the following:

"That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest" (Section 1(2) Public Bodies (Admission to Meetings) Act 1960).

UNIVERSITY OF LEICESTER
Associate Teaching Hospital

NHS
Northampton General Hospital
NHS Trust

Minutes of the Public Trust Board

Thursday 30 July 2020
09:30 by ZOOM teleconference

Present		
	Mr A Burns	Chairman (Chair)
	Mr S Weldon	Group Chief Executive Officer
	Mrs D Needham	Chief Operating Officer and Deputy CEO
	Mr M Metcalfe	Medical Director
	Ms S Oke	Director of Nursing, Midwifery and Patient Services
	Mr P Bradley	Director of Finance
	Ms J Houghton	Non-Executive Director
	Mr J Archard-Jones	Non-Executive Director
	Ms A Gill	Non-Executive Director
	Mr D Moore	Non-Executive Director
	Prof T Robinson	Associate Non-Executive Director
	Ms R Parker	Non-Executive Director
	Ms D Kirkham	Associate Non-Executive Director
In Attendance		
	Ms C Campbell	Director of Corporate Development Governance and Assurance
	Mr M Smith	Chief People Officer
	Mr S Finn	Director of Facilities and Capital Development
	Mr T Richard-Noel	Next NED Scheme
	Mr C Pallot	Director of Strategy and Partnerships
	Ms K Palmer	Executive Board Secretary
Apologies		

TB 20/21 013 **Introductions and Apologies**

Mr Burns welcomed those present to the meeting of the Public Trust Board. He also welcomed members of the public watching via the live stream.

TB 20/21 014 **Declarations of Interest**

Mr Richard-Noel declared an interest. He has taken up post in the IT department as Head of Emerging Technology under a bank contract.

TB 20/21 015 **Minutes of the Public Trust Board held on 28 May 2020**

The minutes of the Public Trust Board held on 28 May 2020 were presented and **APPROVED** as a true and accurate recording of proceedings subject to amendments raised by Ms A Gill.

TB 20/21 016 **Matters Arising and Action Log Public Trust Board**

The Matters Arising and Action Log were considered and noted.

Mr Burns advised the following with regard to the Hospital Group and Risks identified for risk Registers. The two Directors of Governance confirmed that the Risk Registers of the two Trust's would mirror one another where "group" risks had been identified, this was in response to this issue which was raised by the Chair of Audit Committee. Mr Burns welcomed Mr S Weldon to his first

NGH Public Trust Board as Group Chief Executive.

The Board **NOTED** the Matters Arising and Action Log.

TB 20/21 017 Patient & Staff Vlogs

Ms Oke introduced Ms C Portman who had agreed to share her story at Trust Board. Ms C Portman shared her experience of how COVID19 had affected her treatment for condition reflex dystrophy.

Ms Portman advised she had been having a treatment called radio frequency lumbar sympathectomy block. She suffers from excruciating pain and the blocks are administered every four months. This has had happened for many years. These blocks help reduce the pain for three of these months and in the last month she gets really poorly.

Ms Portman stated that the block she has managed the pain relatively well and it has made her life bearable. She remarked that without the block, she would struggle to see a way forward. The block was everything and for those three months she is able to do some things.

Ms Portman commented that Covid had affected a number of things. She was due to have a meniscus repair of her knee that had to be cancelled in April. The blocks had also been cancelled. Ms Portman has asked when treatments are likely to be done again and she was advised that treatments are still not being done in the clinic. The Consultant was hesitant to do the treatment till at least the end of the year potentially into next year.

Ms Portman advised that she was in agony and cannot bear thinking how much further it will be. She remarked that Covid has had a real impact on her. Prior to Covid her pain was manageable and highlighted that Covid had not only impacted the people who had the virus but people who rely on the services of the hospital.

Ms Oke confirmed that she was in regular contact with Ms Portman to ensure she is getting the support she needs. She has been very honest and open on the impact Covid has had on so many people.

Mr Metcalfe remarked that this story would be replicated many times. The Trust was acutely aware of the impact of delayed non-life threatening conditions and was working very hard to establish a Covid safe zone to allow the Trust to introduce some elective care. Mr Metcalfe stressed that the Trust has to be cautious due to the impact of contracting Covid. The patient story has strengthened Mr Metcalfe's efforts to get a Covid secure safe zone at NGH. Mr Burns agreed.

Mr Burns asked to be kept to update on the progress of Ms Portman's care and the establishment of a Covid secure zone at NGH.

Mr Metcalfe introduced Dr B Richardson who is a Consultant Chest Physician at NGH.

Dr Richardson shared his reflections of the Covid pandemic. From a professional perspective Dr Richardson was part of the Respiratory Support Group which was a group of experienced respiratory physicians and intensivists who were mainly working from home offering support to the nursing and medical staff looking after Covid patients. He was able to view x-rays, blood results and observations from his computer at home. This allowed him to keep an oversight of all the patients on all the wards rather than just looking

after patients on one ward.

Dr Richardson had found the situation challenging as he was at home protected whilst there was staff on wards exposed to increased risk. He found it emotionally difficult to cope with.

Dr Richardson stated that in terms of the Respiratory Support Group he had found it useful in particular for the physicians who were drafted in from non-acute specialities to take part in looking after Covid patients. The most value he perceived given was the support to the junior doctors and nursing staff in the middle of the night when it was not appropriate for them to call the on-call Consultant.

Dr Richardson shared his personal experience with the Board. He had suffered from Covid however did not have any of the cardinal symptoms the Government warned the public about. He required hospitalisation and support by Oxygen and CPAP.

Dr Richardson wished to stress the level of support and good feeling he had received from all members of staff. He had found this very humbling to receive this level of warmth and good wishes. . It reinforced that at NGH staff are not just colleagues but a family.

Dr Richardson commented that the care he had received in hospital was fantastic and he could not fault it. He was reluctant to consider escalation to ITU however in retrospect this was the correct thing to do as he as he knew it meant he would need to be ventilated and one step closer to succumbing to the illness that was taking people of his age.

Dr Richardson praised the staff on Esther White and Walter Tull. He cannot thank the staff enough for their level of perceptive care and support.

Dr Richardson reiterated the point that despite NGH being a large organisation it did feel like a family. He thought that this was really important to the running of the hospital and the Trust must look to maintain this. The hospital has come on leaps and bounds in respect of camaraderie and hard work.

Dr Richardson noted the effect it had on his family not being able to visit him in hospital. The Trust needed to be aware of how difficult it was for all families in this situation and keep sight of this.

Mr Moore stated that was a very moving and humbling story. The key part for him was the consistent message of the Trust working as a whole. This spirit needed to be kept as the Trust moved out of Covid.

TB 20/21 018 Chairman's Report

Mr Burns welcomed Mr S Weldon, Group Chief Executive who had started in this role on 01 July 2020.

Mr Burns remarked that the emergency capital bid for £26m to build the new ITU had been approved. This included a new south entrance and a re-routed road. The money would also be used to completely replace the generator capacity which would give the site a more secure electrical system. The money covers this year and next year.

Mr Burns informed the Board that Mrs Needham was appointed as Managing Director on an interim basis. It was also noted that Mr M Smith had been appointed as permanent Chief People Officer for the group.

Mr Burns stated that Mr P White who had been Chair of the Healthcare Partnership has stepped down. The post will go out to a national advert for a two year appointment. The Trust thanked him for the work he had done over the past year.

The Board **NOTED** the Chairman's Report.

TB 20/21 019 Chief Executive's Report

Mr S Weldon presented the Chief Executive's Report.

Mr Weldon congratulated Mr Smith and Mrs Needham in their new roles. The success of the group would be founded on who was appointed into these senior posts.

Mr Weldon stated that the videos shared earlier were both very powerful. These made him think about was how COVID19 has had an impact on both people who have had the virus directly but also patients who treatment had been compromised. He noted that Northampton was under scrutiny due to the rising level of infections. The virus was very much still with us. All the latest advice was summarised within the CEO report. There have also been conversations across the hospital to strengthen PPE and visiting.

Mr Weldon remarked that the Trust would need to develop how to respond the virus itself but also keeping the services open to patients. There is the challenge of a second wave and how the Trust continued to provide core services to patients.

Mr Weldon referred back to Ms Portman and stated that the Trust would try to do better as it goes potentially into a second wave of COVID19.

Mr Weldon commented on the importance of working with partners. He referenced the work done with people in the community who had stuck to the lockdown rules which had helped prevent the hospital from being overrun in the first phase of COVID19. This was incredible important that these precautions are maintained going forward.

Mr Weldon thanked the staff for being phenomenal and keeping the services going.

Mr Weldon delivered an update on the Group. The group had to be approached with the spirit of optimism. He noted three key words; opportunities, patients and staff which had come out of the initial feedback. These need to be held as the watch words. Mr Weldon reminded the board that the Trust had a huge opportunity to do things differently.

Mr Weldon thanked all who were involved at securing the emergency capital bid. Mr Bradley went above and beyond the call of duty to achieve this. The plans are very exciting and this was game changing for the Trust.

Mr Weldon paid tribute to Dr Swart. The two videos at the start reflected everything she would have wanted to have been said about the Trust.

Mr Burns remarked that it was the responsibility of the Board to not only run the hospital but to develop the group. In the last month the first two clinical leads had also been appointed to the group.

The Board **NOTED** the Chief Executive's Report.

TB 20/21 020 Integrated Performance Report

Mrs Needham introduced the Integrated Performance Report. Each Director would deliver an update.

Ms Oke delivered the Director of Nursing update.

Ms Oke advised that Friends & Family Test had been suspended due to the pandemic. It was likely to recommence in September. The Trust had still been collecting local data via SMS/voice calls. She had not concerns to report.

Ms Oke stated that the complaints process had been paused on 29 March by NHS England. At this time the Trust had 15 complaints outstanding. The complaints process reopened on 29 June with 4 of these outstanding complaints still open. There are currently 49 new complaints which are being triaged. All patients had been contacted and timescales agreed for their complaints. She did not expect any significant performance concern from these complaints.

Mrs Needham presented the operational performance update to the Board.

Mrs Needham advised that A&E performance reduced to 86.9% in June however was pleased to note that this had increased to 94% in July. The Trust was in the top quartile in terms of benchmarking across other Trust's in the country. The deterioration in June in A&E was due to increase in attendees as well as the team getting used to how they would manage PPE and social distancing.

Mrs Needham reported that A&E was seeing on average a reduction of 100 patients per day.

Mrs Needham shared her concern in regards to 62 day performance. The performance in May was 68%. The national performance is 69.9% and in the Midlands 62.4%. She stressed that for her cancer is going to be one the main priorities moving forward over the next few months.

Mrs Needham stated that RTT the average wait had increased. It was 13.1 weeks and had increased to 17 weeks in July. She expected this to happen due to the pauses put in place as well as the reduction in outpatients and operations. The Trust had also prioritised cancer and urgent procedures.

Mr Bradley delivered the Director of Finance update.

Mr Bradley advised that the Trust remained on a block contract with top ups to cover loss of income due to COVID19. These arrangements were due to finish at the end of July however this had been extended to the end of August and most likely until the end of September. The Trust had spent £3m in June on COVID19 related items and required an additional top up of £2.8m.

Mr Bradley was pleased with the confirmation of the emergency capital to the Trust for the new ITU and electrical infrastructure. It would make the hospital far more resilient and would provide improved facilities to our patients and staff moving forward.

Mr Bradley stated that on the 22 July 2020 the Trust had received a letter from the Department of Health & Social Care in regards to balance sheet debt. The debt would be moved in to Public Dividend Capital in September. This would remove loan charges moving forward. A balance sheet review was shared at

the July Finance & Performance Committee to provide assurance to the Committee.

Mr Smith presented the Chief People Officer update.

Mr Smith advised that vacancy, the restarting of the international recruitment nurses campaign and the focus on the domestic supply for nurse had been discussed in detail at the July Workforce Committee. He noted the great support and dedication given by student nurses and doctors during the pandemic.

Mr Smith reported that incremental progression was being brought back this month. Therefore he expected to see an increase in performance in training and appraisals.

Prof Robinson asked in relation to vacancy rates decreasing however agency spends most notably in nursing had increased. He was of the belief that the agency spend would have decreased given the better vacancy rate. Mr Smith clarified that this was still linked to the number of colleagues of sick across the Trust or shielding/in isolation. Despite the number of wards that are open with lower bed occupancy as normal there is still a need to work these wards in a social distanced way. As the Trust moves into the rest the temporary staff levels should reduce.

Mr Smith commented that there was a big piece of work being undertaken with temporary staffing across the group and how could this be done in a more efficient way.

Ms Parker queried the sickness absence rate for June at 5.18% and how was this made up. Mr Smith confirmed that it was made of true sickness absence reasons not due to staff shielding or in self isolation. He noted that MSK and anxiety sickness reasons had increased again. This would be included within the Health & Wellbeing Plan moving forward.

Ms Gill asked how the Trust would manage the potential of self-isolation extending from 7 to 10 days and also how the Trust would cope with the new quarantine rules on returning from holiday. Mr Smith stated that the potential increase to self-isolation would impact on the Trust absent rate. He referred to the quarantine rules. The stance across the group was that the only exception to the quarantine rules was staff coming over to take a role in the NHS however those returning from holiday will require to do so. The position from the group was that if a member of staff was currently away and the guidance changed then individual discussions were being had. If a member of staff choses to holiday in a destination that requires isolation on return then the staff member would need to take unpaid leave or annual leave. The overall advice from the Trust is to not travel abroad given the continuing global pandemic.

Mr Metcalfe delivered the Medical Directors update.

Mr Metcalfe advised that Dr T Adeniji had been recruited as BAME clinical fellow at the Trust. He also welcomed Dr D Sedgewick to the post of chief registrar. He would be working on reviewing the medical establishment at the Trust and establishing the junior doctor workforce onto electronic rostering.

Mr Metcalfe noted the outstanding performance of the research team at NGH. The Trust remained the second highest recruiting centre nationally for the covid-19 RECOVERY trial, and has opened 5 additional covid-19 studies.

Mr Archard-Jones asked for an update on VTE in light to the issues previously discussed with the software and the adherence to the paper system in the interim. Mr Metcalfe explained that due to the governance light process installed at the start of the pandemic the Thrombosis Committee was stood down. This has been restarted and it has agreed action plans to address this. Mr Metcalfe confirmed that a detailed update would be presented to the Quality Governance Committee.

Mr Weldon welcomed the appointment of the BAME clinical fellow. This was an important step.

Mr Weldon remarked on the research status. He and the two Medical Directors had met with the University of Leicester. The University of Leicester were very keen to recast the partnership moving forward. He hoped to bring a paper back to a future Board that detailed the road map for how this partnership would be developed in regards to teaching and further extend the work done on research. Mr Burns confirmed that one of the objectives moving forward would be improved links with the University of Leicester and Northampton.

Prof Robinson stated that there had been very productive conversations between KGH, NGH and the University of Leicester. There were a number of opportunities for both medical and AHP's due to the size of the group model. It would allow the two Trust's to build on their research studies.

Mr Burns also welcomed the BAME clinical fellow. He would like to meet the clinical fellow in due course. Mr Burns was also pleased with the appointment of the Chief Registrar and suggested that he could attend a future Board later in the year to discuss issues with Junior Medical staff. He noted that this was an important role.

The Board **NOTED** the Integrated Performance Report.

TB 20/21 021 **Board Assurance Framework**

Ms Campbell presented the Board Assurance Framework.

Ms Campbell advised this was the overarching review of the BAF whereas the previous month the Board had been presented the RESET document. It was noted that all Executives had been through the BAF and corporate risk references updated. Some of the risk titles had also been simplified.

Ms Campbell reported that the CQUIN risk 1.3 had been removed due to the scheme being suspended. A further COVID19 risk BAF 1.10 had been added which was in relation to Trust being unable to deliver the recovery plan post COVID19. It had been given a score of 20.

Ms Campbell stated that BAF Risk 5.3 in regards to the capital programme. Despite the good news with the ITU and the electrical generators there was still some outstanding capital which related to COVID19 related spend with the outcome unknown. It had increased in score from 20 to 25.

Ms Houghton commented on page 51 there was some controls in relation to the risk and the Board to Ward visits were mentioned. These have been suspended and she noted the importance of these. She asked if this was being considered. Ms Campbell confirmed she and Ms Oke had discussed this, with different ways of undertaking these being explored.

Mr Moore highlighted the target risk for BAF 1.7 and 1.8. He had raised this at the Finance & Performance Committee. It was not well articulated on how to

get from a risk score of 20 to a risk score of 10. Ms Campbell would be discussing this with the relevant Executive and would update these with further details for the next presentation of the report.
Action: Ms Campbell

The Board **NOTED** the Board Assurance Framework (BAF).

TB 20/21 022 **Covid-19 Reset**

Mr Burns advised that this was a very detailed report. It was a comprehensive approach and the plan needed to be coherent with KGH. It needed to think about the immediate issues and the opportunities that followed.

Mrs Needham, Mr Pallot and Mr Smith presented the Covid-19 Reset paper. The presentation was shared with the Board. Please see below copy of the presentation:

Reset Presentation - FOR BOARD PRESEN

Mr Pallot talked through the first part of the presentation. He would be leading the overall reset programme supported by colleagues. The presentation highlighted the key items within the report in the Board pack.

Mrs Needham followed and discussed the cancer performance part of the presentation with the Board. She invited Mr Metcalfe to explain how the Trust ensured cancer patients did not come to any harm due to the pause in some services. Mr Metcalfe advised that prior to COVID19 there was an established process in place to review patients who had waited a long time for their cancer treatment. The process involved the Hospital Cancer Service Team, Cancer Treatment MDT Leads and the Governance Team all collectively reviewed all the patients, and then developed a breach map to look for causes of avoidable delay. As part of the governance light approach in the pandemic the harm review process was stood down however this has been put back in place. Within these reviews it would be discussed if the delay was avoidable in the context of COVID19.

Mrs Needham asked the Board to acknowledge the main challenges with cancer. These were Endoscopy capacity; the Trust would need to work across the region to mitigate this and would need some capital investment. The other challenge was to make a surgical area which was ‘green’ and do not transfer infection at all into this area. This would provide some difficulty due to the small number of positive COVID19 patients within the Trust. There was currently a designated ward opened as ‘green’ currently. The Trust was focused on making sure all procedures are in place. The staff were fully aware of the use PPE and IPC guidelines.

Mrs Needham advised that the Trust was now planning for phase 2 of COVID19 and winter pressures.

Mr Smith then led the presentation which focused on the staff side of the report. Mr Smith thanked all staff and how all staff managed to perform their duties in this difficult time. He talked through the slides being shared on screen.

Mr Burns remarked that it was clear that achieving the cancer targets was one of the Boards main priorities. He has asked Ms Parker and Prof Robinson to support the cancer work moving forward. He noted the importance of having a

strong NED link with this piece of work.

Prof Robinson stated this was clear that cancer was a targeted focus for both Quality Governance Committee (QGC) and the Board. He was reassured that there was a clear plan in place which prioritises this area. At the July QGC a solid amount of time was spent on a cancer presentation from the Cancer Lead. There was significant amount of regional learning out there also which was positive. The Cancer Lead would present to a future Committee to give QGC the opportunity to see the clear progress made.

Prof Robinson commented that in regards to Imaging and Endoscopy these really needed to be supported by the Board to ensure the targets are met. These would benefit from the group model due to priority around IT and imaging investment. He noted that to deliver the cancer target for some sites are affected by partner organisations especially tertiary providers. Mrs Needham concurred. One the patients on the cancer list are waiting for an operation at Leicester who is one of the tertiary providers, this hospital was also suffering with capacity issues. The Trust did go out to other organisations in the midlands. It is a regional challenge and it was being escalated to the highest level.

Mrs Parker stated that she welcomed the opportunity to support the team with the progress made with cancer. She asked how long the Trust would use the Three Shires for and can the Trust also use the Woodlands. Mrs Needham clarified that KGH was using the Woodlands. It was noted that NGH was using the Three Shires and the Houghton at Banbury. The Trust would work with them to the end of financial year and she expected that this would continue into the next financial year. The Trust was one of the best users of the private sector within the region. The numbers at the Three Shires had decreased in the last month and the Trust needed to ensure that these increased again.

Ms Parker queried whether patient's uptake in appointments had increased. Mrs Needham commented that there was now a better uptake. The next challenge was that for elective patients the Government had advised that they did not need self-isolate for 14 days. The Trust was reluctant to relax this. The consultant body wanted the patients to continue their self-isolation period. Mr Burns believed that this needed to be thought in the current context of increased infections within Northampton.

Mr Metcalfe echoed Mrs Needham. He had a discussion with the Divisional Directors to the relaxed guidance to self-isolation. There was caution around this from the senior surgical leaders. The Trust was taking a very cautious approach to this due to the consequences of contracting COVID19.

Ms Houghton noted that mandatory training had been discussed at QGC. She welcomed the opportunity to look at this being reviewed and streamlined across the group. It does impact on clinical time.

Ms Houghton asked in regards to cadet nurses and whether this was a pipeline to pursue. Ms Oke confirmed that it was forming part of the Talent Academy.

Mr Weldon remarked that this was a really important presentation. The presentation sets out the challenges the organisation faces. There was no clear resolution as of yet of how the challenges could be met.

Mr Weldon referred to the slide in the pack on diagnostics. There was a structural imbalance which would be a cause for concern in regards to demand and capacity across the organisation.

Mr Weldon advised that there was a real need on how to describe to the Board and the public how the cancer position would be recovered. There was structural issue with cancer services pre-COVID19.

Mr Weldon highlighted the problems with elective and day case position. The 52 week breach position had continued to worsen.

Mr Weldon did not want to underestimate the challenge to the organisation to get back on track.

Mr Weldon noted the reduction in the patient self-isolation prior to their day case. There needed to be a balance of risk of managing COVID19 and patients neglecting to undergo treatment that was needed. This is a very difficult balance. He asked the September Committees to look at.

Mr Weldon requested that the September Board received a joint presentation which would look at diagnostic issue, elective/day case issue and cancer. He wanted statement of how and when it would be recovered. The Board **AGREED** to this approach.

Mr Richard-Noel asked how technology can play a part in some of these challenges. How could the Trust move to be a digitally focused organisation. There were some interesting innovations across the country.

Mr Burns had spoken to members of the public who had been admitted to NGH for treatment recently. There was one patient was very complimentary and took advantage of the technology offered. The then there were others that mentioned the randomness of telephone calls for virtual appointments. Mr Burns noted that there were issues of how hospital contacted patients with the number coming up withheld which people can be reluctant to answer. This needed to be thought about.

Ms Kirkham commented on how the Trust can move forward innovatively and think outside the box. She asked how the areas within the reset plan can be recovered due to the capital requirement needed for some. Mrs Needham explained that there was a list of capital requests to the total of £1.5m. This list needed to be prioritised for the remainder of the year. There was a meeting organised to discuss with the senior clinical leaders.

Mr Finn advised that the Trust had gone ahead with the designs for the air handling equipment so the Trust would be ready to go out to tender once approved.

Mr Burns asked the Committees to spend time looking at the Committee specific issues as requested by Mr Weldon in September. This would then feed into the September Board meeting.

The Board **NOTED** the Covid-19 Reset.

TB 20/21 023 NGH Improvement Plan

Ms Campbell presented NGH Improvement Plan.

Ms Campbell advised that this had not been presented to the Board since the start of the year due to COVID19. The NGH Improvement Plan had been reset last month. She confirmed that 34 actions had been closed and good progress had been made. It was reported that all the ‘must dos’ had been closed with only a small number of ‘should-dos’ outstanding.

Ms Campbell believed that the next CQC inspection would be towards the end of the calendar year. The Board would need some additional Board preparation for this due to that there was new NED's on the Board since the previous inspection. The well-led aspects would also need a refresh session. Mr Burns agreed and that some of these would be picked up through Board development sessions.

The Board **NOTED** the NGH Improvement Plan.

TB 20/21 024 Group Governance Paper

Mr Burns advised that this had been discussed in a recent workshop session. The Board were keen to ensure that this work was taken forward in a coherent way.

Ms Campbell stated that the Board would need to approve the ToR. These were also being presented to the KGH Board the following day. She explained that there would be two NED's co-chairing the Board who would alternate the chairing of the meetings. The NED from NGH was Ms Parker.
Ms Gill asked in regards to the membership would there be any other NEDs on the membership. Ms Campbell remarked that this was up to the Board if the Board felt appropriate. Mr Burns commented that this was an important Committee and a full Board Committee. He was happy to add an additional NED to the membership and believed that this should be discussed in the NED group. He was mindful of the many additional requirements at current for the NEDs.

The Board APPROVED the CPC Terms of reference

TB 20/21 025 Equality, Diversity and Inclusion – BAME Staff Support

Mr Smith presented the Equality, Diversity and Inclusion – BAME Staff Support to the Board.

Mr Smith welcomed Mr T Brown and Ms L Luxton. He shared his screen with the Board. This had also been included in the Board pack. There were clearly challenges in relation to diversity and inclusion within the organisation and the organisation was taking steps to address this. He noted that there was still a great amount of work to be done. The impact that COVID19 has had on the BAME workforce had been acknowledged by the Trust and in national reports. He would provide a further update in six months.
Action: Mr Smith

Mr Smith delivered the presentation to the Board. He requested that Mr T Brown talk through the Workforce Equality Standards slide of the presentation. The standards helped NGH review their data against the WRES standards and the close the gap between groups of the staff. It was also to improve BAME representation at Board level. The data was primarily sourced from the NHS Staff survey and the electronic staff record. He then discussed the slide being shared with the Board?? Which slide should it say each slide

A 'Black Lives Matter' video was shared with the Board.

Ms Luxton (Chair of the BAME Staff Network Group) then discussed the BAME network slide being shared She stated that the current black lives matter work had increased the membership to the BAME group at NGH. She believed that this could be due to members of the group now feeling that their voice could be heard and that they would be supported. The group has focused on increasing their visibility in the Trust.

Ms Luxton asked for a commitment from a strategic level to the delivery of the WRES action plan. From an operational level the group would look at what parts of the plan the group could operationalise and how this would be done. This involved the group having enablers in place to help push the agenda.

Mr Luxton stated that there was six workstreams that the group was working towards. This included networking and engagement with all staff. The BAME clinical fellow has also helped reach hard to reach staff groups.

Ms Luxton advised staff can join the BAME group by contacting her.

Please see below presentation.

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Mr Smith discussed the future plan across the Trust. These actions have come from the BAME group. The slide included specific board action and the following side detailed how these could be monitored.

Mr Burns thanked Ms Luxton and Mr Brown for their input. The Trust must not shy away from the idea of positive actions.

Mr Richard-Noel fully supported the actions. He suggested a deep-dive into why this happened and noted the increased spike in discrimination. The Trust is in the position where they could help educate patients and staff. Secondly equality updates every six months to Board and queried whether an update to the Workforce Committee more frequently. His third point was that COVID19 highlighted that BAME has a variety of different groups within this. There was a huge disproportion how it affected different groups within the BAME category. He queried how this data could be shared and segment groups that are at even more risk to others within the BAME staff cohort.

Ms Gill remarked that it was good to see specific actions. She agreed with Mr Richard-Noel for this item to be discussed more regularly at the Workforce Committee. It would also need to be considered how it could be taken across the group. Ms Gill offered her services at attending the BAME Group and further support in regards to mentoring.

Mr Archard-Jones commented that the Board need to look how to get BAME representation at the Board and this could filter down. He referred to page 101 of the report pack where it stated that the Trust had identified 1983 BAME staff however Mr T Brown reported this number to be lesser. Mr Smith stated that 1983 included all staff in vulnerable categories.

Ms Houghton remarked that this was a brilliant presentation and video. She asked how this was being addressed across the HCP. The Trust needed to look at clinical service delivery specifically on information from the BAME network.

Prof Robinson referred to bullying & harassment statistics in the Staff Survey. There was 20% of BAME staff who had experience bullying & harassment whilst white staff was approximately 7%. The aim had been to reduce the 20% to 15%. He believed that this gave out the wrong message. It should not be acceptable for any member of staff to receive bullying & harassment. The

message should be that it was unacceptable for all and this needed to be zero tolerance. Mr Smith agreed that a zero tolerance approach was needed; however the target was included to show improvements. He was trying to show the incremental progression that hoped to be made.

Mr Smith explained that at the System People Board there was a domain of staff health and wellbeing, in which BAME featured. This feeds up to the Regional People Board. It was also being discussed at a national level. There was a national and regional approach to this.

Mr Burns agreed with Prof Robinson. He noted there needed to be milestones on the way however this needed to be careful how this was presented.

Ms Kirkham concurred and noted that she was also uncomfortable with this being the target.

Mr Metcalfe echoed these opinions. The messaging needed to clear. It was not acceptable to state that double the amount of BAME staff were allowed to experience bullying & harassment in comparison to white staff. He believed that some staff may be unwilling to come forward for fear of retribution. These themes have come up before.

Mr Richard-Noel remarked that it should be framed as a target of reduction. The Trust needed to aim for equality not racism.

Mr Weldon noted that the presentation was very thought provoking and challenging. He stated that the Trust would be making some important group appointments later on in the summer. This would not happen until the group had done that unconscious unbiased training and implemented the recruitment challenge set us. If needed to be corrected at the top of the organisation. He committed that on his return from leave he would request his reverse mentoring to be organised. It was important that he demonstrated this. Mr Weldon looked at the challenges that exist in both organisations and how could the issue be talked across the Northampton System at a greater length. He hoped that this would be the group story of how black lives matter and a long term commitment should be made on this.

Mr Weldon noted the importance that this subject consistently came back for discussion at the Board. This was not a single step but a journey of improvement. Mr Burns agreed.

The Board **NOTED** the Equality, Diversity and Inclusion – BAME Staff Support

TB 20/21 026 Freedom To Speak Up Annual Report

Ms Campbell presented the Freedom To Speak Up Annual Report.

Ms Campbell advised that she was pleased that there had been an increase in cases since she had started due the low number of cases previously.

Ms Campbell noted that this year had been difficult to see if there had been a real decline due to the first quarter being impacted by COVID19. She hoped to see a plateauing of cases and expected approx. 45 cases per annum which was the benchmark for medium sized Trusts last year.

Ms Campbell reported that most cases were in the Bullying & Harassment category and the second most common theme was patient safety and quality. .

Ms Campbell stated that the ambassador training needed to be reset. She

hoped to recruit some BAME representation into these roles with the support of the BAME network.

Ms Campbell commented that there was a high number of staff who had reported cases to be within midwifery. This had reduced in the new year.

The Board **NOTED** the Freedom To Speak Up Annual Report.

TB 20/21 027 National Inpatient Survey Feedback 2019

Ms Oke presented the National Inpatient Survey Feedback 2019.

Ms Oke advised that the results had been published in early July with the data taken from June 2019. The national response rate was 45% and the Trust had a 44% response rate.

Ms Oke reported that the survey was broken down into 12 sections with 63 questions in total. The results showed whether the Trust was the same, better or worse than other Trusts. It was noted that NGH's results were better than most Trusts for 0 questions and NGH's results were worse than most Trusts for 7 questions. She stated that NGH's results were about the same as other Trusts for 56 questions

Ms Oke informed the Board that the priority areas were communication, doctors and discharge

Ms Oke confirmed that a number of workstreams were underway to address the concerns. There would be further analysis of the results. The feedback had been shared with the Divisional Teams and was part of the hospital reset work

Ms Oke clarified that the date for data collection for the next National Inpatient Survey had moved to November 2020.

Prof Robinson advised that this had been discussed at QGC. The QGC expressed concerns on medicine management and a future deep-dive was to be shared at a future QGC.

Mr Burns reminded the Board that it must not argue with the data and react correctly.

The Board **NOTED** the National Inpatient Survey Feedback 2019.

TB 20/21 028 Questions from the Public (Received in Advance)

There were no questions received in advance from the Public.

TB 20/21 029 Any Other Business

There was no other business to discuss.

Date of next meeting: Public Trust Board - Thursday 24 September 2020 at 09:30 in the Board Room at Northampton General Hospital.

Public Trust Board Action Log **Last update** **02/09/2020**

Item No	Month of meeting	Minute Number	Paper	Action Required	Responsible	Due date	Status	Updates
Actions - Slippage								
Actions - Current meeting								
Actions - Future meetings								
123	Jul-20	TB 20/21 021	Board Assurance Framework	Mr Moore highlighted the target risk for BAF 1.7 and 1.8. He had raised this at the Finance & Performance Committee. It was not well articulated on how to get from a risk score of 20 to a risk score of 10. Ms Campbell would be discussing this with the relevant Executive and would update these with further details for the next presentation of the report	Ms Campbell	Oct-20	On Track	
124	Jul-20	TB 20/21 025	Equality, Diversity and Inclusion – BAME Staff Support	The Board requested a further update in 6 months	Mr Smith	Jan-21	On Track	

Report To	**Public Trust Board**
Date of Meeting	**24 September 2020**

Title of the Report	**Chief Executive's Report**
Agenda item	**7**
Presenter of Report	Simon Weldon, Group Chief Executive
Author(s) of Report	Simon Weldon, Group Chief Executive

This paper is for: (delete as appropriate)

√ Note

For the intelligence of the Board without the in-depth discussion as above

In this report, I want to concentrate on three key areas of work: first, the program that is in place to restore the amount of elective work we do; secondly, the plans we are making to prepare for winter, in particular, a second wave of COVID and thirdly, the work that is ongoing to develop the hospital group.

Restoring elective work

As Boards met at the end of July, NHS England published its expectations in respect of restoring elective work in the NHS. The full letter can be found here: https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/07/20200731-Phase-3-letter-final-1.pdf

The phase 3 letter set out a range of expectations of local systems. Key among them were the requirements associated with restoring elective work, as follows:

- 'In September at least 80% of their last year's activity for both overnight electives and for outpatient / day case procedures, rising to 90% in October (while aiming for 70% in August);
- This means that systems need to very swiftly return to at least 90% of their last year's levels of MRI/CT and endoscopy procedures, with an ambition to reach 100% by October.
- 100% of their last year's activity for first outpatient attendances and follow-ups (face to face or virtually) from September through the balance of the year (and aiming for 90% in August).'

In response to this letter, local systems were required to submit a plan that showed how these requirements would be delivered. Delivery against these requirements will be monitored at a system as well as a Trust level. The financial regime for the NHS will be adjusted to support these new requirements: block payments will remain but will be adjusted to reflect whether the required activity levels are delivered.

As I write, the system has made an initial planning submission and is currently doing further work to develop what can be delivered locally with a further submission being made on 21st September. Boards will have an opportunity to debate the latest position when they meet. It is complex work and while it is still too early to make definitive statements on what will be achieved, I would like to offer some

observations that will need to be considered:

- Both hospitals are making progress in meeting the challenges set out in the phase 3 letter: the recovery of the cancer backlog and the plans to recover the 62 day standard are welcome signs. Screening programmes are returning to pre-COVID levels of activity. I would like to thank all the clinical teams who have helped to deliver this including those services who work behind the scenes to enable this.
- However, there are a number of key challenges that need to be addressed. Among these:
    - COVID has had an impact on how hospitals use the physical capacity that is available to them. For example, in Kettering we have access to less theatres than we did pre COVID as some are in the COVID secure zone.
    - Activity levels in theatres have to be constrained to allow for enhanced cleaning procedures
    - Where patients cancel, normally we would seek to replace them on operating lists.
    - Elective beds could be removed due increased winter or COVID activity, resulting in cancellations.
    - There is a risk of staff absence increasing especially as schools return and with community infection rates increasing.
- That said, as Boards we need to rigorously scrutinise the proposed plans and make sure that we have done everything we can to maximise the number of patients that we treat. It is, after all, what we would want for our family, or for us, if we needed a surgery or a procedure.

I would now like to address the preparations we are making for winter. The Board and its committees will have the opportunity to scrutinise the plans that have been made. Again, I would like to offer some observations on some of the key deliverables required of us:

- In the near future, we can expect the flu vaccination campaign for 2020 to launch. Both hospitals performed well in this area last year reaching levels in excess of 80% uptake. This year, we are asked to promote universal uptake. It is clearly right that we do so.
- Expanding the 111 First offer to provide low complexity urgent care without the need for an A&E attendance, ensuring those who need care can receive it in the right setting more quickly.
- Working with our system partners to maintain the historically low levels of long stay patients that we achieved during the first phase of COVID.

Turning to the progress we have made on establishing the hospital group. Since we met in July, we have made a great deal of progress in developing a shared vision, mission, values and priorities for our new hospital Group. We have also undertaken a number of activities to involve and engage colleagues from across both organisations, with many more planned.

Having completed my second month in a Group role, I have endeavoured to start as I intend for us to go on with regard to engaging and involving staff, patients and other stakeholders in shaping and informing what we do. I have now undertaken two Group briefings with staff colleagues, both of which saw more than 400 staff attend from across KGH and NGH. I have also been out and about, meeting as many people as I possibly can from various services and departments to learn more about what colleagues do, the challenges they face, and the plans and ambitions they have. It has given me a great deal of pride – as well as a sense of responsibility – to see the fantastic work underway and to hear about the quality improvements already made and the plans underway to improve services further. At the last Group briefing staff had the opportunity to share what they felt the core values could be and I thought it would be informative for the Board to see the emerging views of staff.

Over the next few months, together with my Board colleagues from both organisations, I will continue to engage with colleagues, patients, partners and others regarding our future direction, and we will also discuss relevant programmes and projects, for example, our ambitious programme to re-develop our hospital estates, and our emergent clinical and people strategies. Further to that period of engagement, I will bring back final proposals on the Group vision and mission early in the new year.

Finally, I would like to inform the Board that this month we will commence the recruitment to Group roles. These are the two site Managing Directors, the Chief Financial Officer and the Chief Digital and Information Officer. Further, we will have completed the recruitment to the Group Communications Director.

Related Strategic Pledge	Which strategic pledge does this paper relate to? 1. *We will put quality and safety at the centre of everything we do* 2. *Deliver year on year improvements in patient and staff feedback* 3. *Create a sustainable future supported by new technology* 4. *Strengthen and integrate local clinical services particularly with Kettering General Hospital* 5. *Create a great place to work, learn and care to enable excellence through our people* 6. *Become a University Hospital by 2020 becoming a centre of excellence for education and research*
Risk and assurance	Risks arising from the Phase 3 planning and work undertaken around the Group Model will be identified and managed via both Trusts' risk registers
Related Board Assurance Framework entries	All
Equality Analysis	Is there potential for, or evidence that, the proposed decision / document will not promote equality of opportunity for all or promote good relations between different groups? (N) Is there potential, for or evidence that, the proposed decision / document will affect different protected groups/characteristics differently (including possibly discriminating against certain groups/protected characteristics)? (N)
Financial Implications	To be advised as the plans develop
Legal implications / regulatory requirements	None

Actions required by the Board

The Board is asked to:

- Note the paper

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Associate Teaching Hospital

NHS
Northampton General Hospital
NHS Trust

Appendix 1:

- Limit contact with others outside of your household or bubble
- Work from home if you can
- Keep 2 metres from others at all times, use a face covering where you are less than 2 metres apart
- Avoid using public transport or car sharing, wear face coverings if you cannot avoid these
- If you have COVID-19 symptoms, stay at home, self-isolate and get a test
- Avoid meeting those outside of your household or bubble in an indoor space
- Wash your hands regularly and thoroughly for 20 seconds each time
- Do not share items with others outside of your household or bubble
- If you have COVID-19 symptoms, do not go to work, either work from home or report sick, self-isolate and get a test
- Even if you only have mild COVID-19 symptoms, get a test
- If you are contacted by test and trace and asked to self-isolate, stay at home for 14 days

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Associate Teaching Hospital

NHS
Northampton General Hospital
NHS Trust

Report To	**Public Trust Board**
Date of Meeting	**24 September 2020**

Title of the Report	**Integrated Performance Report**
Agenda item	**8**
Presenter of Report	Executive Directors
Author(s) of Report	Sean McGarvey (Head of Information) Directors

This paper is for: (delete as appropriate)

☐ Approve	X Receive	☐ Note	☐ Assurance
To formally receive and discuss a report and approve its recommendations OR a particular course of action	To discuss, in depth, a report noting its implications for the Board or Trust without formally approving it	For the intelligence of the Board without the in-depth discussion as above	To reassure the Board that controls and assurances are in place

Executive summary

The integrated performance report highlights via SPC charts any adverse variances in performance relating to national performance targets, financial performance, Quality & workforce metrics.

Each Director has provided a summary.

Related Strategic Pledge	1. *We will put quality and safety at the centre of everything we do* 2. *Deliver year on year improvements in patient and staff feedback* 3. *Create a great place to work, learn and care to enable excellence through our people*
Risk and assurance	Does the content of the report present any risks to the Trust or consequently provide assurances on risks Assurance on risk
Related Board Assurance Framework entries	BAF – All
Equality Analysis	Is there potential for, or evidence that, the proposed decision /

	document will not promote equality of opportunity for all or promote good relations between different groups? (N) If yes please give details and describe the current or planned activities to address the impact. Is there potential, for or evidence that, the proposed decision / document will affect different protected groups/characteristics differently (including possibly discriminating against certain groups/protected characteristics)? (N) If yes please give details and describe the current or planned activities to address the impact.
Financial Implications	NA
Legal implications / regulatory requirements	None

Actions required by the Trust Board

The Trust Board is asked to receive the paper and note the performance & individual Directors summaries, seeking any areas of clarification to gain assurance during the meeting.

Corporate Scorecard – Integrated Performance Report

Date: September 2020
Reporting Period: August 2020

Northampton General Hospital NHS
NHS Trust

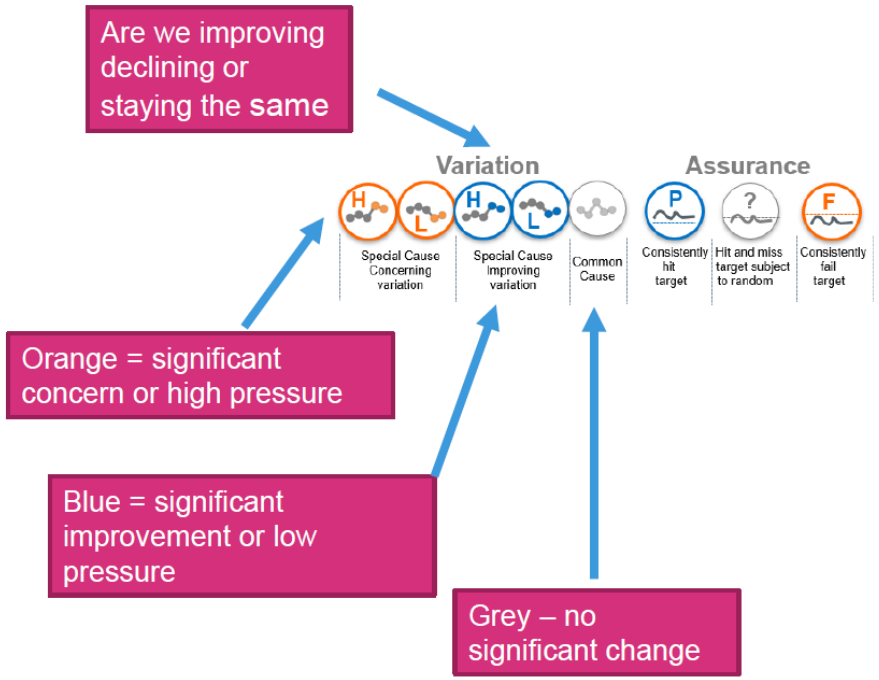
Pilot SPC Charts

Collaboration work with KGH and a wish to move to a common style of Board reporting was agreed by the Collaboration Steering Group in August 2019. Subsequently, an assessment of both Boards' report was completed, leading to eight metrics being agreed for both trusts to report on using SPC. The number of metrics moved to SPC will increase over the next few months, with the format of the Corporate Scorecard changing accordingly.

The reports that follow use the key below. A recap of using these descriptions is also included

Variation			Assurance		
					
Common cause – no significant change	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or lower pressure due to (H)igher or (L)ower values	Variation indicates inconsistently passing and falling short of the target	Variation indicates consistently (P)assing the target	Variation indicates consistently (F)alling short of the target

High level key - variation



High level key - assurance

Domains: Caring, Effective & Safe

Domain	Metric	Target	Variation	Assurance	Chart
Caring	Complaints responded to within agreed timescales	90%	No Update due to Covid-19		
Caring	Friends & Family Test % of patients who would recommend: A&E	86%	1st Month return to reporting - no variation trend	?	
Caring	Friends & Family Test % of patients who would recommend: Inpatient/Daycase	96%		?	
Caring	Friends & Family Test % of patients who would recommend: Maternity - Birth	97%		?	
Caring	Friends & Family Test % of patients who would recommend: Outpatients	94%		?	
Caring	Mixed Sex Accommodation	0	L	?	

Caring Domain - Non-SPC Metrics

Section:	Indicator:	Target:	Jul-20	Aug-20	Chart
Caring	Compliments	N/A	No Update due to Covid-19		

Domain	Metric	Target	Variation	Assurance	Chart
Effective	Length of stay - All	4.2		?	
Effective	Percentage of discharges before midday	25%	L	F	Page 9
Effective	# NoF - Fit patients operated on within 36 hours	80%		?	
Effective	Maternity: C Section Rates	29%		?	
Effective	Mortality: HSMR	106	Outside Control Limits	?	Page 27
Effective	Mortality: SHMI	109		P	
Effective	Stranded Patients (ave.) as % of bed base	40%	Outside Control Limits	?	Page 10
Effective	% Daycase Rate	80%	H	P	
Effective	Super Stranded Long Stay Patients (ave.) as % of bed base	25%	Outside Control Limits	?	Page 11
Effective	Readmissions within 30 days of previous reporting month	12%	Data under review		

Effective Domain - Non-SPC Metrics

Section:	Indicator:	Target:	Jul-20	Aug-20	Chart
Effective	Patient Ward Moves Overnight (22:00 - 06:59)	=0	348	257	

Domain	Metric	Target	Variation	Assurance	Chart
Safe	HOHA and COHA (C-Diff > 2 Days)	3		?	
Safe	MSSA > 2 Days	1		?	
Safe	VTE Risk Assessment	95%	Outside Control Limits	F	Page 28
Safe	Transfers: Patients transferred out of hours (between 10pm and 7am)	60		?	Page 19
Safe	Transfers: Patients moved between 10pm and 7am with a risk assessment completed	98%	Outside Control Limits	?	

Safe Domain - Non-SPC Metrics

Section:	Indicator:	Target:	Jul-20	Aug-20	Chart
Safe	Never event incidence	0	No Data	No Data	
Safe	Number of Serious Incidents (SI's) declared during the period	N/A	No Data	No Data	
Safe	MRSA > 2 Days	0	0	0	
Safe	New Harms	<=2%	No Update due to Covid-19		
Safe	Appointed Fire Wardens	>=85%	100.0%	100.0%	
Safe	Fire Drill Compliance	>=85%	90.5%	91.7%	
Safe	Fire Evacuation Plan	>=85%	100.0%	100.0%	

Domains: Responsive

Domain	Metric	Target	Variation	Assurance	Chart
Responsive	A&E: Proportion of patients spending less than 4 hours in A&E	90%			
Responsive	Average Ambulance handover times	00:15:00	No Data		
Responsive	Ambulance handovers that waited over 30 mins and less than 60 mins	25	Outside Control Limits		Page 12
Responsive	Ambulance handovers that waited over 60 mins	10			
Responsive	Operations: Number of patients not treated within 28 days of last minute cancellations - non clinical reasons	0			
Responsive	Average Monthly DTOCs	23	Outside Control Limits		Page 13
Responsive	Cancer: Percentage of patients treated within 31 days	96%			

Responsive Domain - Non-SPC Metrics

Section:	Indicator:	Target:	Jun-20	Jul-20	Chart
Responsive	RTT median wait incomplete pathways	<=10.9	14.4	13.5	Page 14
Responsive	Cancer: Faster Diagnosis Standard	>=63%	67%	61%	

Section:	Indicator:	Target:	Jul-20	Aug-20	Chart
Responsive	Unappointed Follow Ups	=0	5,535	6,503	

Domain	Metric	Target	Variation	Assurance	Chart
Responsive	Cancer: Percentage of Patients for second or subsequent treatment treated within 31 days - drug	98%			
Responsive	Cancer: Percentage of Patients for second or subsequent treatment treated within 31 days - radiotherapy	94%			
Responsive	Cancer: Percentage of patients for second or subsequent treatment treated within 31 days - surgery	94%			Page 15
Responsive	Cancer: Percentage of patients treated within 62 days urgent referral to treatment of all cancers	85%	Outside Control Limits		Page 16
Responsive	Cancer: Percentage of patients treated within 62 days of referral from screening	90%	No Data		
Responsive	Cancer: Percentage of patients treated within 62 days of Consultant Upgrade	85%			
Responsive	RTT over 52 weeks	0	Outside Control Limits		Page 17
Responsive	Diagnostics: % of patients waiting less than 6 weeks for a diagnostic test	99%	Outside Control Limits		Page 18
Responsive	Stroke patients spending at least 90% of their time on the stroke unit	80%	No Update Due to Covid-19		
Responsive	Suspected stroke patients given a CT within 1 hour of arrival	50%			

Domains: Well Led

Domain	Metric	Target	Variation	Assurance	Chart
Well Led	Income YTD (£000's)	0	Outside Control Limits	?	Page 21
Well Led	Surplus / Deficit YTD (£000's)	0	Outside Control Limits	?	Page 22
Well Led	Pay YTD (£000's)	0		F	Page 23
Well Led	Non Pay YTD (£000's)	0		?	
Well Led	Bank & Agency / Pay %	7.5%	Outside Control Limits	F	Page 24
Well Led	Sickness Rate	3.8%		?	

Domain	Metric	Target	Variation	Assurance	Chart
Well Led	Staff: Trust level vacancy rate - All	9%	No Update due to Covid-19		
Well Led	Staff: Trust level vacancy rate - Medical Staff	9%			
Well Led	Staff: Trust level vacancy rate - Registered Nursing Staff	9%			
Well Led	Staff: Trust level vacancy rate - Other Staff	9%			
Well Led	Turnover Rate	10%	1st Month return to reporting	P	
Well Led	Percentage of all trust staff with mandatory training compliance	85%	No Data submitted		
Well Led	Percentage of all trust staff with role specific training compliance	85%	No Update due to Covid-19		
Well Led	Percentage of staff with annual appraisal	85%			
Well Led	Job plans progressed to stage 2 sign-off	90%			

Well Led Domain - Non-SPC Metrics

Section:	Indicator:	Target:	Jun-20	Jul-20	Chart
Well Led	Percentage of all trust staff with mandatory refresher fire training compliance	>=85%	80.9%	No Data submitted	

Directors view – Director of Nursing

Friends & Family Test

In line with national guidance the Trust is not required to submit FFT data to NHSE. The Trust continues to collect locally through SMS messaging and automated voice calls, we are however, not using postcards on the advice of NHSE. We are one of the few Trusts across the country to maintain this service. Feedback will be reviewed as a period of time, separate to normal data collection months to prevent the skewing of data. We continue to collate the information and consider other ways that we can share feedback in the form of comments and themes, as opposed to just scores, with the departments across the organisation.

Complaints Service:

The NHS Complaints Procedure was suspended for a period of three months during the height of the Covid-19 Pandemic. All complaints received during that time were triaged to identify and escalate any key areas of risk i.e. serious care concerns, potential incidents & safeguarding. All other complaints were placed on hold during the suspended period, with the agreement of the complainants. Now that the procedure has recommended the Complaints & PALS teams have been working together to look at areas of best practice to implement improvements across the services with more focus on local resolution at ward level, using new documentation that was introduced as part of the Relative Helpline, more focused and early contact with families when a complaint is received.

Overseas Recruitment:

The first of our Overseas cohorts joined the Trust in August and commenced their intensive OSCE training. Further cohorts will be arriving on a monthly basis throughout the next 5 months. There have been delays in the arrival of our staff due to the pandemic; visas being released by the 'home' countries, and the need to maintain IPC principles ('self-isolation'). However, we have not seen any reduction in staff wanting to join the Trust.

Our Nursing Careers Pathways have also recommenced including trainee Nursing Associates and Apprenticeship Programmes, with proactive recruitment of Health Care Assistance across the Trust.

Infection Prevention & Control Service:

During August there was 1 reported case of Clostridium difficile Toxin A & B, identified as hospital onset on Cedar ward. A post infection review is currently in progress and will be reviewed internally and action plan completed. We had 1 reported case of MSSA BSI reported during August; post infection review is still in progress and awaiting the source of the bacteraemia. The Vascular Access Group has met twice in August , the focus for the group will be peripheral cannula.

Focused work has been undertaken to strengthen the Governance processes across the Trust, including the IPC Board Assurance Framework, Ward Environmental Risk Assessments and development of a comprehensive training data base.

Directors view – Chief Operating Officer

Performance - A&E 4hrs

- Performance was at 87.94% for August
- Emergency activity continues to increase as activity in ED returns to near normal presentations . Activity remains below the same period last year
- Acuity of patients has started to increase but remains below last years levels
- Stranded & super stranded patient numbers have increased to 260 and 90 respectively although bed occupancy is stable below 85% with 3 wards currently closed.

Cancer waiting times

- Cancer legacy patients >62 days has reduced from 150 to 90 which is a 40% reduction and well above the 20% reduction requested by NHSEI
- Number of patients waiting over 104 days has reduced from 69 to just 10

Actions being taken:
2 x weekly PTL meetings being undertaken with a focus on all patients over 62 days.
Bronze cancer cell in place as part of reset.
Daily NHSE/I calls with all regional Trusts to support an increase in
diagnostic capacity.
Additional CT colon and capsule endocopy being sourced to support the colorectal pathway.

RTT – Average wait time

- The average wait to be seen has continued to be a challenge nationally with the COVID shut down of elective work. The median wait is 13.5 weeks a reduction of 1 week on the previous month. There are currently 350 patients waiting over 52 weeks to be seen and 1991 patients over 40 weeks

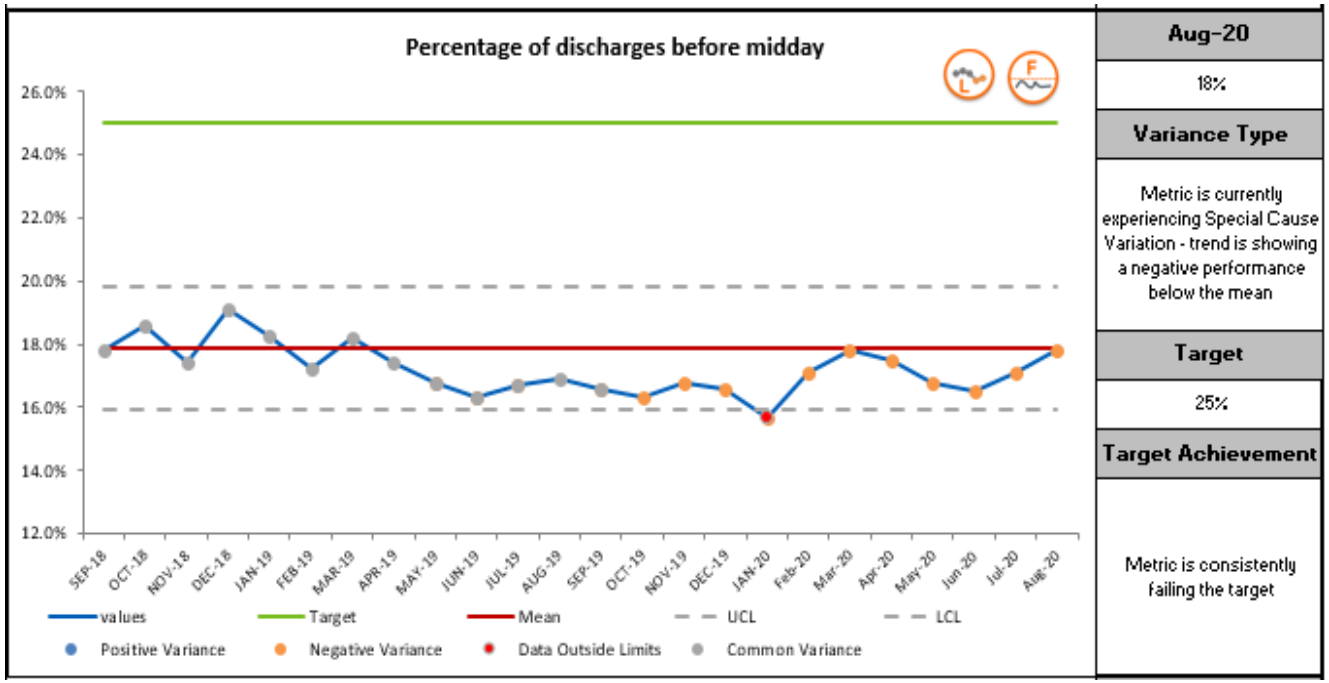
Diagnostics – 6 weeks

- Performance has decreased significantly to 46% due to all routine diagnostic procedures being placed on hold during the covid-19 pandemic.

Actions being taken:
Additional capacity (internal & external) is in place to manage the demand.
Daily NHSE/I regional provider calls in place to support recovery.
Recovery will be slow due to the need to use PPE & socially distance which will make processes slower.
Elective & Outpatient/diagnostic bronze cell in place as part of reset.

Please note variability in all performance metrics which is due to the covid-19 pandemic

SPC Charts – Discharges by Midday



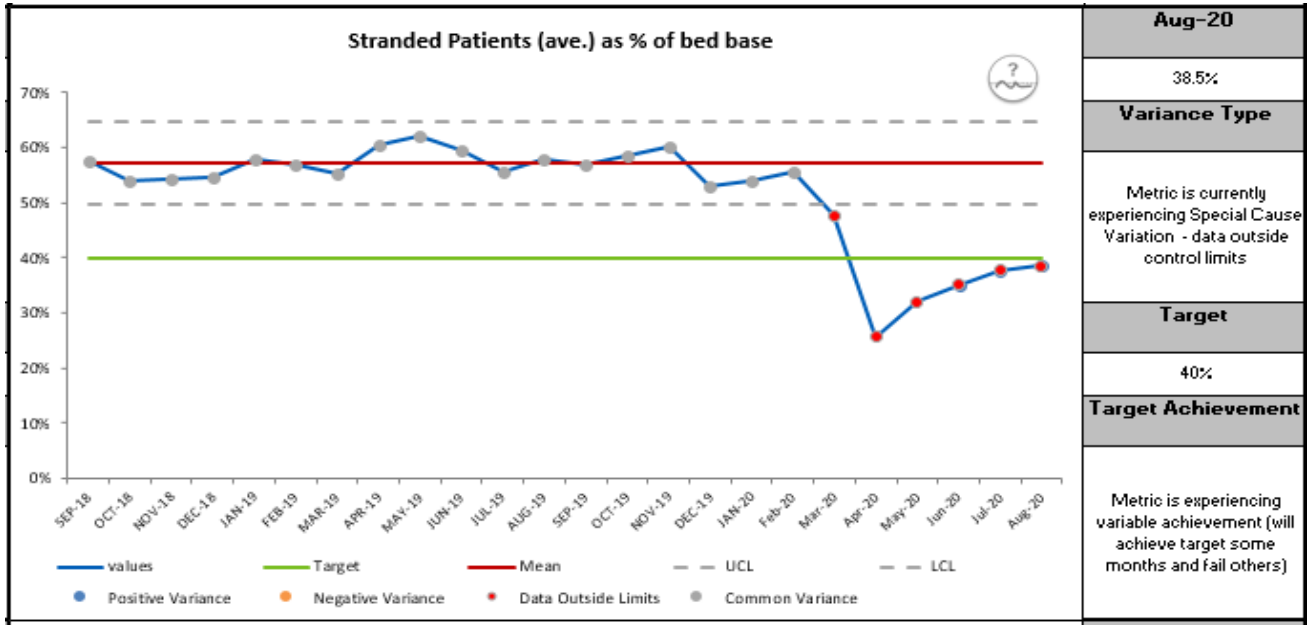
Aug-20
18%
Variance Type
Metric is currently experiencing Special Cause Variation - trend is showing a negative performance below the mean
Target
25%
Target Achievement
Metric is consistently failing the target

Context:
During covid there has been suspension of normal elective activity and often the early discharges were for this cohort of patients.

There has been no discharges suite for several months which is where a proportion of early discharges from the ward could be attributed to.

Actions:
Ongoing work with the Reason to Reside Discharge Cell as a part of the ICAN Discharge long term project.
Reviewing target and consideration given to metrics relating to quality.
National guidance released at the end of August on discharge makes far reaching expectations that the Trust and the 'system' are currently developing locally

SPC Charts – Stranded patients (avg.) as a % of bed base

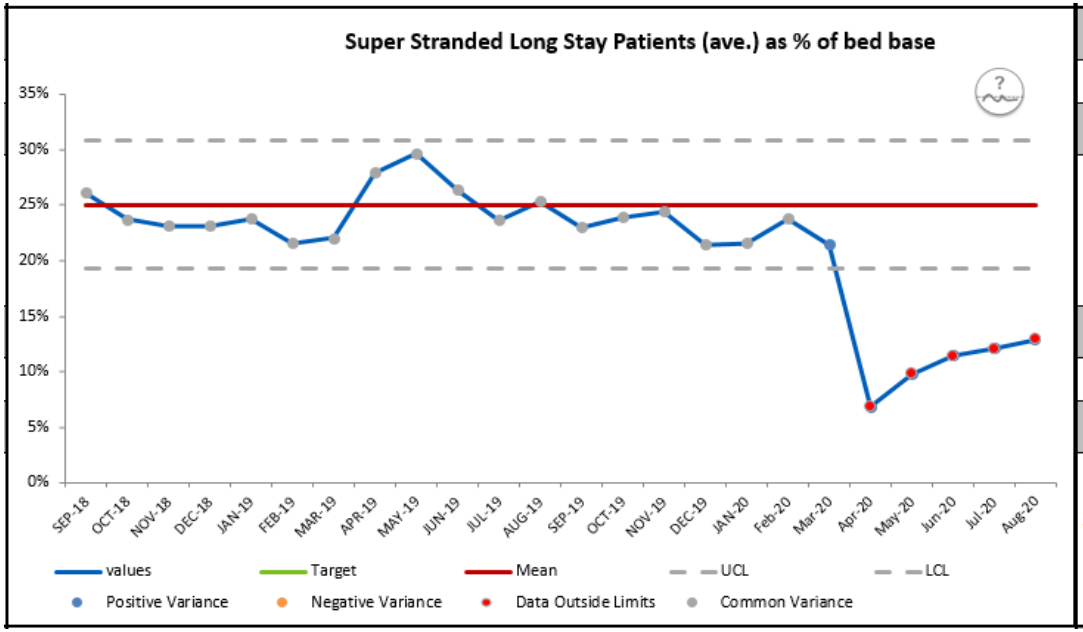


Aug-20
38.5%
Variance Type
Metric is currently experiencing Special Cause Variation - data outside control limits
Target
40%
Target Achievement
Metric is experiencing variable achievement (will achieve target some months and fail others)

Context: Stranded figures continue to increase slowly from the lowest ever figure during the pandemic when the hospital prepared to receive COVID patients. However the figure remains well below the previous years figures .

Actions: Ongoing work with the Reason to Reside Discharge Cell as a part of the ICAN Discharge long term project.
Reviewing target and consideration given to metrics relating to quality.
National guidance released at the end of August on discharge makes far reaching expectations that the Trust and the 'system' are currently developing locally

SPC Charts – Super Stranded patients (avg.) as a % of bed base

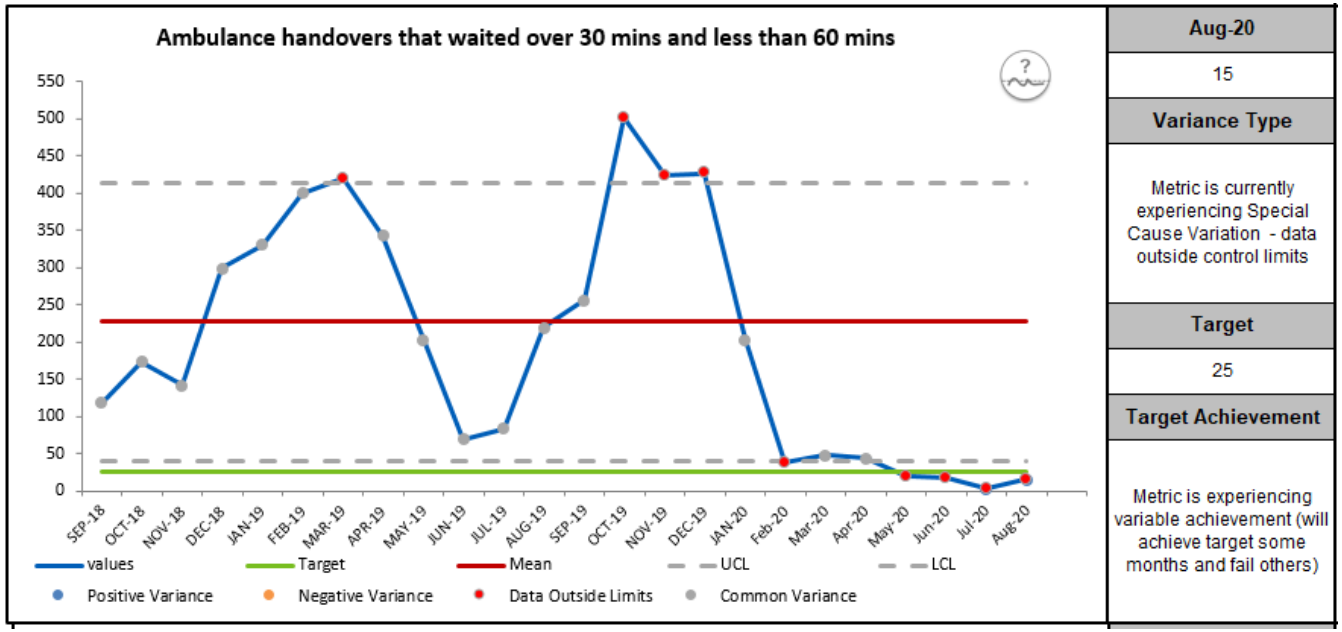


Aug-20
12.9%
Variance Type
Metric is currently experiencing Special Cause Variation - data outside control limits
Target
25%
Target Achievement
Metric is experiencing variable achievement (will achieve target some months and fail others)

Context: Super Stranded figures continue to increase slowly from the lowest ever figure during the pandemic when the hospital prepared to receive COVID patients. However the figure remains well below the previous years figures .

Actions: Ongoing work with the Reason to Reside Discharge Cell as a part of the ICAN Discharge long term project.
Reviewing target and consideration given to metrics relating to quality.
National guidance released at the end of August on discharge makes far reaching expectations that the Trust and the 'system' are currently developing locally

SPC Charts – Ambulance handovers that waited over 30 minutes and less than 60 minutes



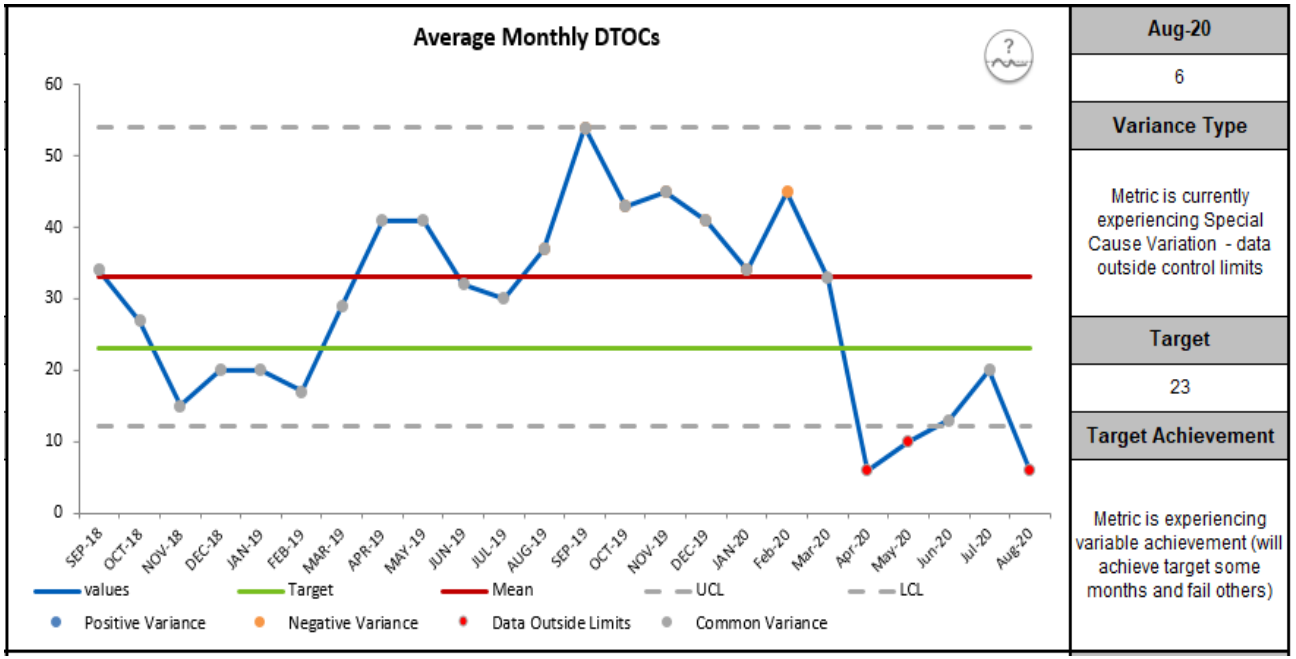
Aug-20
15
Variance Type
Metric is currently experiencing Special Cause Variation - data outside control limits
Target
25
Target Achievement
Metric is experiencing variable achievement (will achieve target some months and fail others)

Context: Ambulance handover figures continue to be 'best in class' in the Midlands. Aided by an efficient FIT process on arrival in ED and effective streaming of patients to other urgent care services in the Trust

.

Actions: Further winter development of Children's ED, 'talk before you walk' NHS111 new service that will go live at the end of September should help keep flow optimal into ED

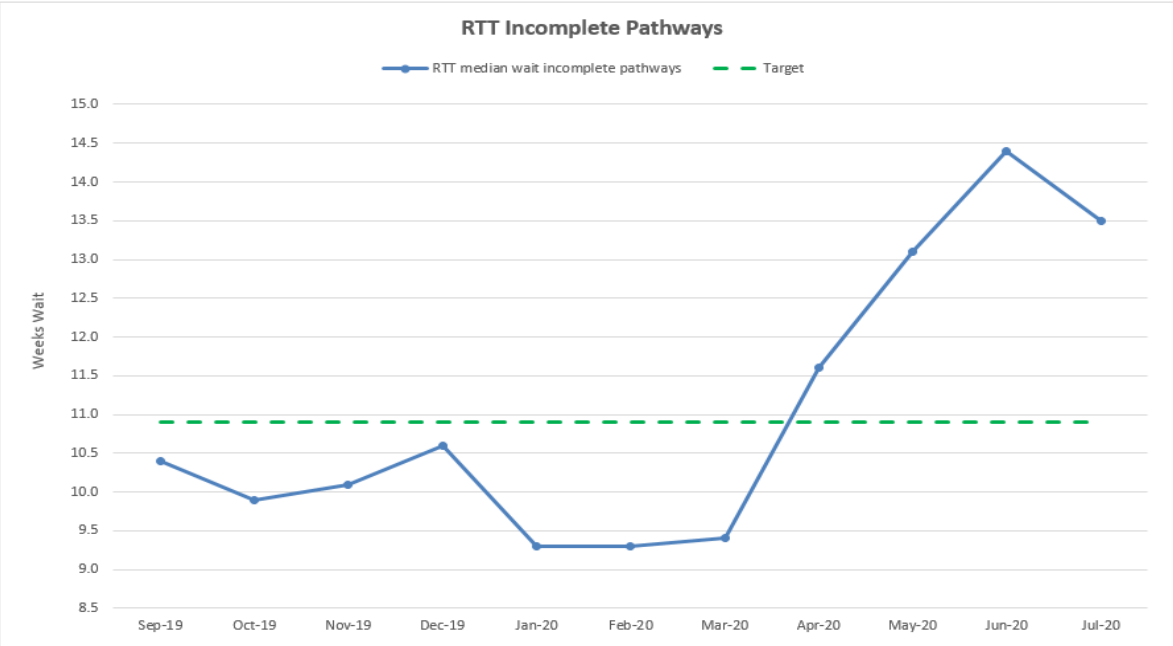
SPC Charts – Average monthly DTOCs



Context: Delayed Transfers of Care for patients needing a supported discharge which usually includes a package of care remain well below the figures this time last year

Actions: Ongoing work with the Reason to Reside Discharge Cell as a part of the ICAN Discharge long term project.
Reviewing target and consideration given to metrics relating to quality.
National guidance released at the end of August on discharge makes far reaching expectations that the Trust and the 'system' are currently developing locally.
National requirement for D2A (Discharge to Assess) for all patients needing a supported discharge will be a major challenge for our partners but the Trust and our patients will see a huge benefit when delivered.
The closure of the SPA (single point of access) handed the actions and the DTOC metric back to the acute unit to report.

Charts – RTT Average Wait Incomplete Pathways



Jul-20	Target
13.5	10.9

Actions:

• Phase 3 COVID repose letter issued by NHSEI on 31st July 2020 with expectation that RTT performance is back to 80% of Pre-COVID activity by September and 90% by October.

• All Divisions working on the 'additional ask' to see what else could improve the position if funding is made available

Context:

Whilst all routine outpatient activity was ceased from April to June 2020 due to covid-19 , the average waiting time has increased, whilst validation of the PTLs has taken place, the time waiting has increased significantly and currently sits at 13.5 Clinically urgent & cancer appointments take priority over routine procedures

• Elective recovery cell in place and continues to drive extra capacity from clinics and theatres covering weekends and evenings

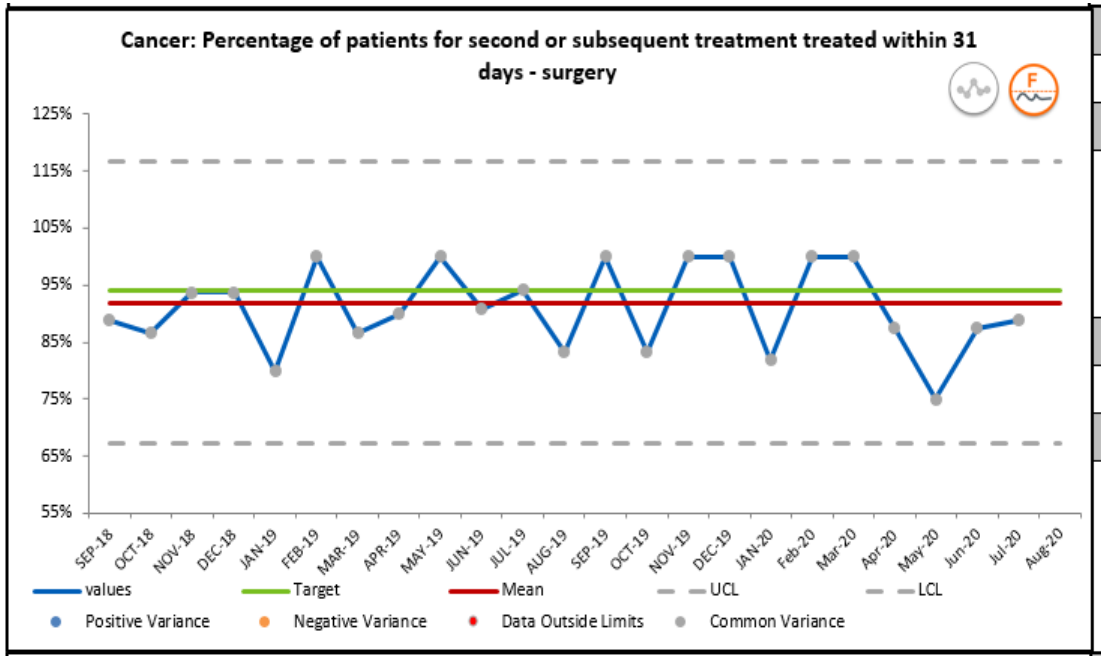
• Insourcing and Outsourcing of activity is taking place including weekends

• Trust continues to use Private sector for its elective surgery

• Virtual clinics and robust validation of lists in place to manage the waiting lists

• Blue COVID free wards will remain in Trust over winter to support the RTT recovery

SPC Charts – Cancer: Percentage of patients for second or subsequent treatment treated within 31 days - Surgery

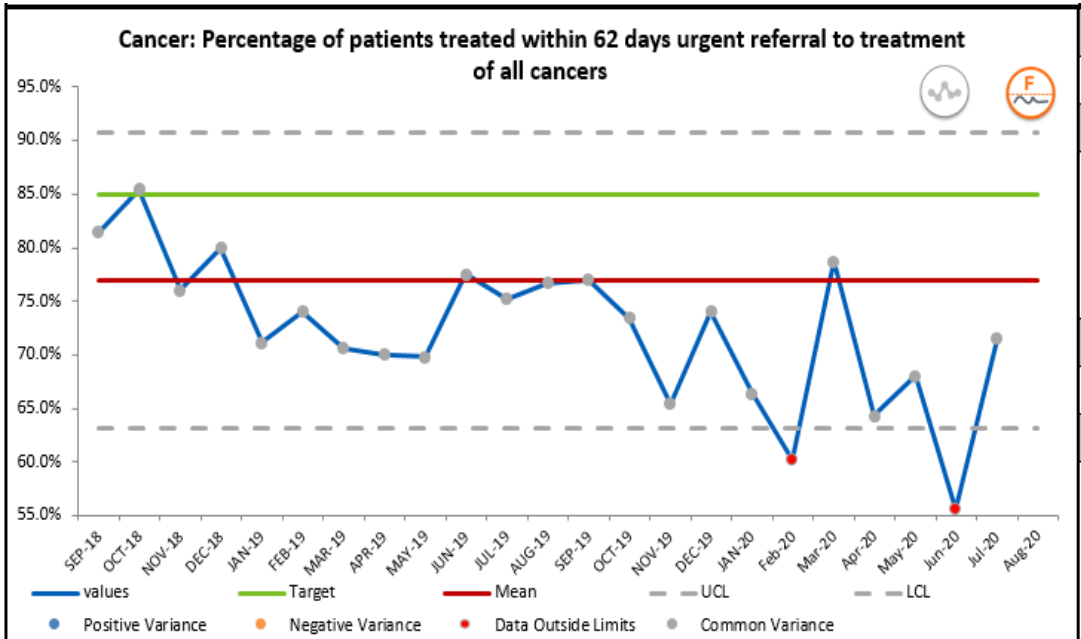


Jul-20
89%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
94%
Target Achievement
Metric is consistently failing the target

Context:
The trust did not achieve this standard achieving 88.9% against the 94% standard, failing by only 1 patient. This was due to surgical capacity and the requirement for patients to self isolate for 14 days

Actions:
All subsequent pathways are now on the main Patient Tracking List (PTL) list circulated daily. These are reviewed at site PTL meetings and once a week at the corporate PTL meeting.

SPC Charts – Cancer: Percentage of patients treated within 62 days



Jul-20
71.5%
Variance Type
Metric is currently experiencing Common Cause Variation
Target
85%
Target Achievement
Metric is consistently failing the target

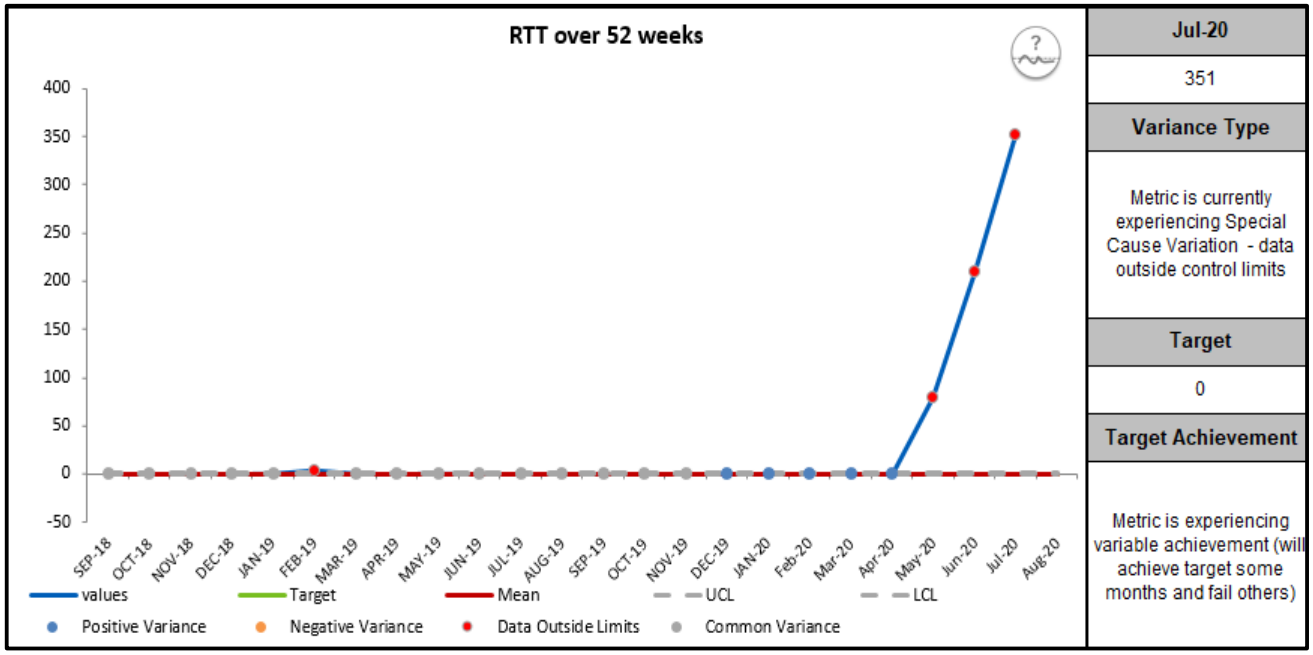
Context:
The Trust has not met the 62 day standard for July reaching 71.6% against the 85% standard. This is a 29% improvement on June. The effects on pathways due to covid are still being felt and will continue to do so for sometime.

Skin was the only site to achieve during July. The number of patients treated showed a decline on pre covid average months but is steadily improving.

Actions:
The diagnostic phase to any pathway is crucial to delivery of this standard as well as having only a small cohort of patients or less than 15% breached in any month to achieve the 62 day standard. Patients need to be seen by day 7 or sent straight to test and NGH are not achieving this for all sites.

A 2ww capacity and demand study has been undertaken to evidence and provide data for future planning . This month the 2ww endoscopy backlog has reduced considerably. All teams have been heavily focused on improving cancer, this is overseen by the cancer weekly reset meeting, the cancer board and corporate and site ptl meetings. All tumour sites have refreshed action plans and provide weekly progress against these.

Charts – RTT Incomplete Pathway 52 week breaches



Actions:

• Elective recovery cell in place and continues to drive extra capacity from clinics and theatres covering weekends and evenings

• Cancer surgery is taking precedence during the first part of the COVID recovery

• Phase 3 COVID response letter issued by NHSEI on 31st July 2020 with expectation that RTT performance is back to 80% of Pre-COVID activity by September and 90% by October. County wide response to this is being developed.

Context:

Whilst all routine outpatient activity was ceased from April to June 2020 due to covid-19, the number of patients waiting over 52 weeks has increased over the last 3 months

Clinically urgent & cancer appointments take priority over routine appointments and procedures.

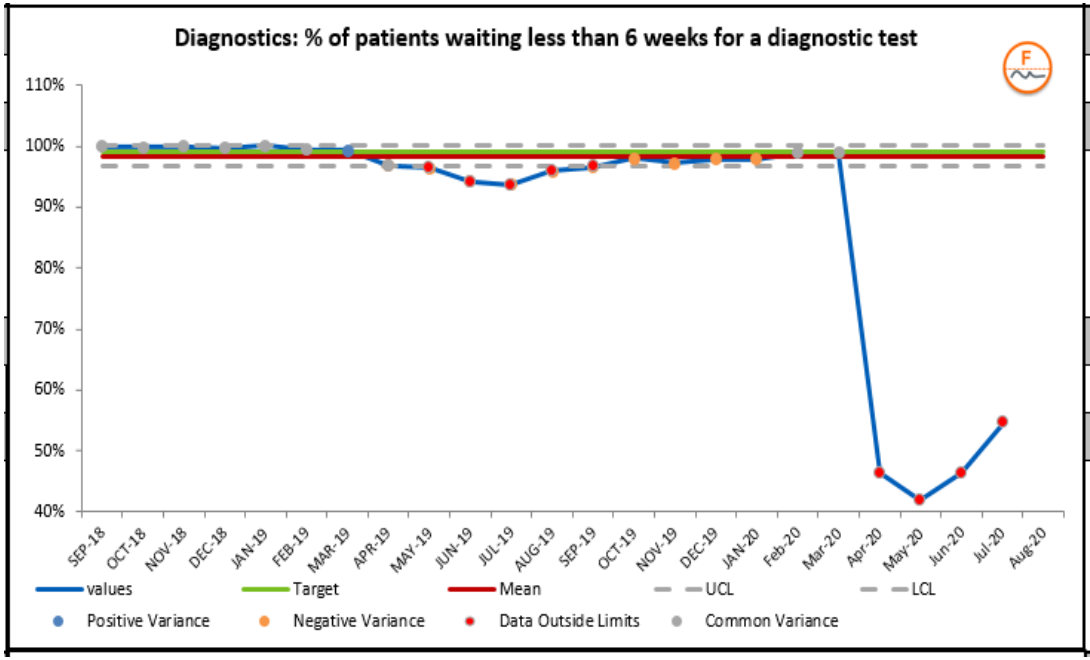
• Full validation of all 52 week breaches is undertaken

• Review of harm is being conducted on every 52 week breach

• Non elective patients are being reviewed in virtual (non face to face) clinics to clear the backlog
• Support of in and out sourcing providers are being commissioned to support the recovery

- Across the Midlands there are 14000 x52 week patient breaches as all trusts struggle to managed the elective backlog from the pandemic

Charts – Diagnostic 6 week waits



Jul-20
54.6%
Variance Type
Metric is currently experiencing Special Cause Variation - data outside control limits
Target
99%
Target Achievement
Metric is consistently failing the target

Context:

- As per national guidance to take down elective work during the pandemic we have seen a huge fall in the percentage of patients having their diagnostic test in 6 weeks from 98+ % to performance of around mid 40% (final validated figure not available at time of this report)

- Third Phase of the COVID response was released by NHSEI less than 2 weeks ago with the expectation that 90% of last year's activity is reinstated by September and 100% by October

Actions:

- Rectification plans developed in all specialties that now have significantly increased diagnostic waits

- Teams are using insourcing and outsourcing options with external providers as we have used in the past

- Additional lists are being provided in house where possible at weekends and evenings

- Full validation of all lists to ensure all breaches are accurate

Directors view – Director of Finance

The Trust ended the month August 2020 with a break-even financial position which includes £25.3m block funding, £4.0m top-up funding and £1.8m additional top-up funding to cover COVID spend. Year to date non-recurrent top-up funding is £27.5m.

COVID spend for the month is £1.2m (Month 4: £1.8m) and includes pay cost of £0.9m and non-pay cost of £0.3m.

Non-COVID operational activity continues to improve but still remains below pre-COVID planned levels resulting in a block funding gap of £5.5m. As a result of the increasing activity, non-pay spend has increased by 10% both from medical and surgical consumables and insourcing costs. Pay expenditure remains consistent with previous two months but with a shift from temporary to substantive pay costs when compared to July spend.

Agency spend is £1.6m and shows an improvement against July. £0.3m of the agency spend relates to COVID spend for sickness cover and additional shifts due to operational requirements. The agency control meetings have been reinstated to ensure that the reasons for the high level of usage are understood and can be reduced through recruitment plans and any other support required.

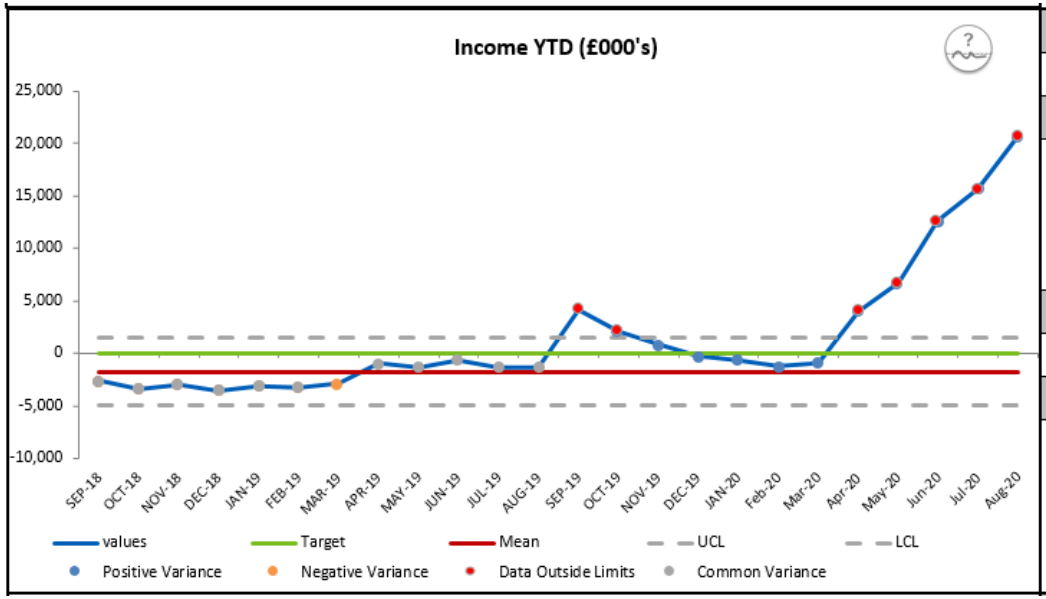
The current block funding and retrospective top-up arrangement is expected to continue to September and then revised as from October as part of the Phase 3 arrangements. This is being discussed with NHSE/I and the System to ensure that we can agree a realistic and deliverable budget that supports the increased operational trajectory requirement.

Other income is beginning to increase but is still down by £0.3m due to loss of catering, car parking and other income.

The Capital spend in the month is £4.9m mainly relating to Fire & the Critical Care building plus Information Technology.

Cash balance at the end of the month is £33.2m as NHSE/I currently provide additional funding for the following month in advance.

SPC Charts – Income YTD



Aug-20
20,675
Variance Type
Metric is currently experiencing Special Cause Variation - data outside control limits
Target
0
Target Achievement
Metric is experiencing variable achievement (will achieve target some months and fail others)

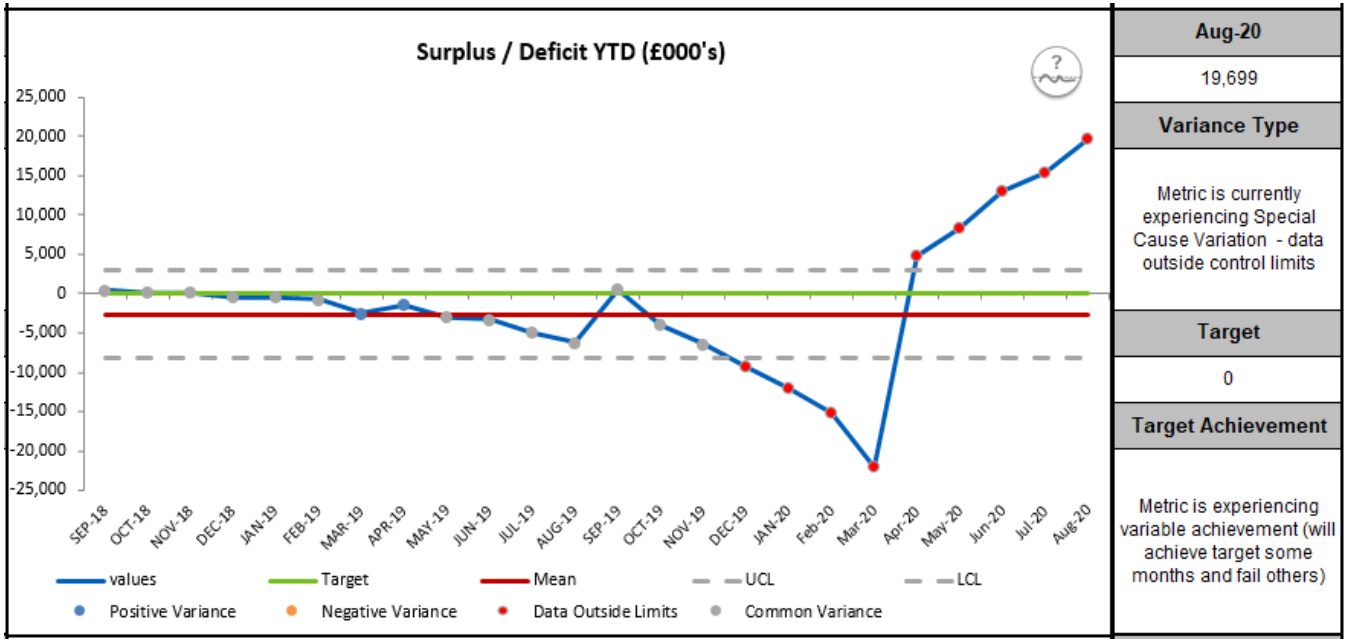
Context:

The Trust received block funding for its clinical income, in addition to top-up funding which means that it is able to break-even with a favourable variance to plan of £20.7m.

- A&E witnessed a continuation of increased attendances, with over 350 more attendances in August compared to July. Year to date this is 65% of the volume seen in 2019/20
- Planned activity continued to see recovery following the extremely low levels of April and May due to the impact of COVID-19 prioritisation.
- Day Case and Elective activity year-to-date is now achieving 54% of expected levels (previously 41%), with First Outpatient appointments at 44%
- Outpatient activity overall (Firsts, Follow-up and OPROCs) are 22% below plans, but 38% below PbR value as some activity has been converted to non-face-to-face.
- NEL discharges continued to increase. In August approximately 3 more per day compared to July, including over 1,000 in the penultimate week of August (the first time since early March), reflecting increased admissions.
- .

Actions:

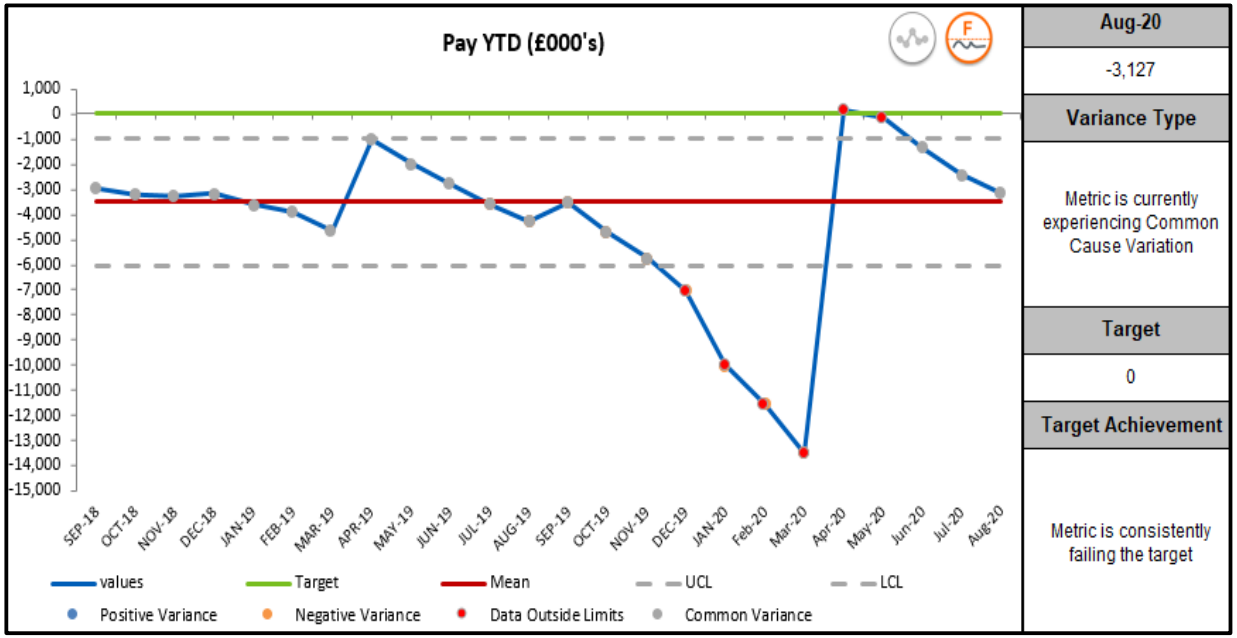
SPC Charts – Surplus/Deficit YTD



Aug-20
19,699
Variance Type
Metric is currently experiencing Special Cause Variation - data outside control limits
Target
0
Target Achievement
Metric is experiencing variable achievement (will achieve target some months and fail others)

As a result of the block funding and top-up funding, the Trust is able to achieve a break-even position of 19.7m (prior to donated assets adjustment of £0.8m).

SPC Charts – Pay YTD



Aug-20
-3,127
Variance Type
Metric is currently experiencing Common Cause Variation
Target
0
Target Achievement
Metric is consistently failing the target

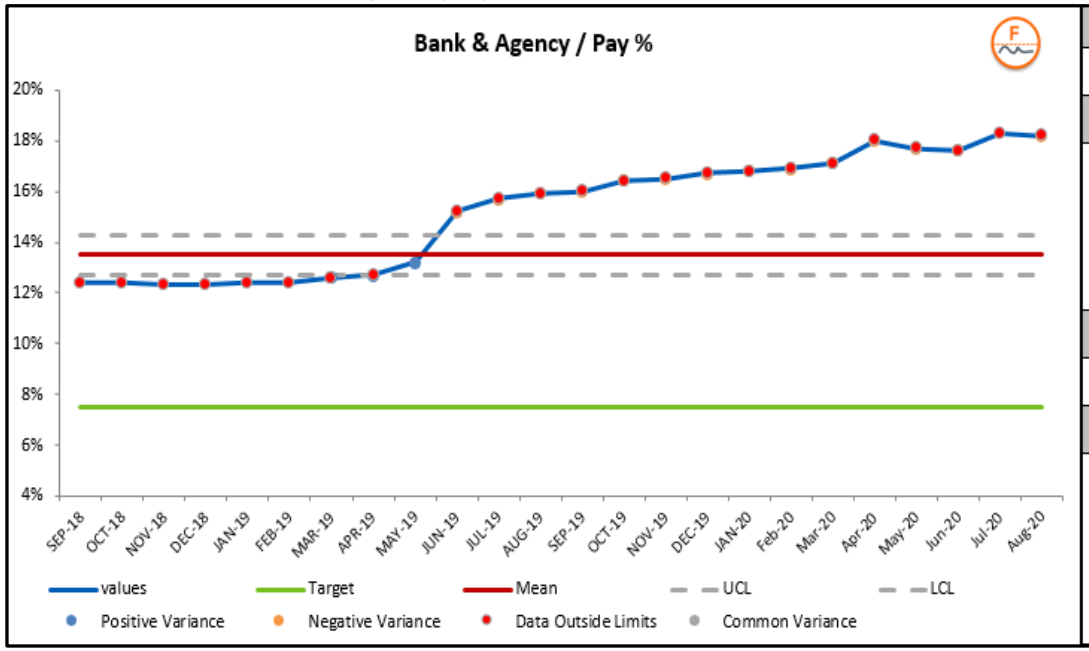
Actions:

Context:

Pay expenditure continues to remain above plan in year (£0.7m adverse to plan in month; £3.1m adverse to plan year to date).

- Year to date adverse position on pay is mainly due to COVID-19 related pay expenditure of £5.3m year to date. £0.84m of pay costs in Month 5 have been attributed to COVID-19 response including £0.73m of temporary staff costs for either as additional shifts due to operational requirements or backfill as shielding staff returned to work.
- Pay expenditure has reduced by £0.4m from the previous month due to COVID-19 related pay due to reducing COVID-19 directly related activity and staff returning to work following sickness and shielding.
- Excluding COVID related expenditure, medical and nursing staff groups continue to overspend against budget (£0.31m and £0.26m respectively). Medical pay mainly due to number of premium cost temporary staff who are employed to cover vacancies (16% WTE in August); whilst nursing staff numbers remain above budgeted establishment (100WTE).

SPC Charts – Bank & Agency spend



Aug-20
18.2%
Variance Type
Metric is currently experiencing Special Cause Variation - trend is showing a negative performance above the mean
Target
7.5%
Target Achievement
Metric is consistently failing the target

Context:

- In Month 5 Temporary Staff expenditure was £4.0m (previous month £4.6m)
- £0.72m of this spend has been attributed to COVID-19 related spend (£0.97m in Month 4). This includes payments to student nurses and medical students working at the Trust to support the COVID-19 response.
- NHS Improvement issued a maintained agency expenditure limit of £11.2m for the financial year 2020/21, against an exit run-rate (2019/20) of £18.6m. Year to date the Trust has spent £8.2m on agency.
- The non-COVID-19 part of the spend is on par with 19/20, albeit with a significantly lower level of service delivered in the first 5 months of 20/21.
- Agency Nursing has shown a clear reduction in number of shifts in August.
- Bank and ADH expenditure has also reduced in August compared to the previous month in particular in junior medical staff costs following the August rotation of medical trainees.

Actions:

- Initial agency meetings have taken place between the Director of HR, Finance and the Divisional leads to review the longest serving and highest paid locums to identify key issues and areas that require additional support; with a view to identifying actions to reduce agency usage going forward.

Directors view – Chief People Officer

Vacancy position

The overall Trust vacancy factor for August 2020 is 8.48% and is below the 9% target. The vacancy factor for medical staff is 10.37%, which is a increase on the figure of 10.21% reported for July 2020. There are a total of 46 medical candidates in clearance ranging from junior doctors through to consultant level. A resourcing plan to fill hard to recruit medical posts is in the early stages of being established. The nursing & midwifery vacancy factor for August 2020 is 6.88% which is the third consecutive monthly decrease and remains below the Trust target of 9%. In the early part of August a total of 28 overseas nurses arrived and a further 19 arrived on 4 September 2020. A further cohort of 36 are planned to arrive in October. Work health assessment screening - 157 new starter health clearance completed in August recognising the Junior Doctor Rotation which was successfully completed in August and reported to the August Workforce Committee, along with a robust Medical Education plan. Overall time to hire for August 2020 is an average of 11.6 weeks from advertisement to clearances received.

Attendance

The Trusts sickness absence rate for August 2020 as reported through ESR is 4.46%, which is an increase from July's figure of 4.38%. A proportion of this absence is due to Covid-19 and this absence is monitored and reported on daily basis via the Roster system. Sickness absence related to Covid-19 continues to reduce which is due in part to those members of staff who have been shielding being able to return to work. The management of sickness absence and Covid-19 absence is being supported by HR Business Partners and Occupational Health and ways of supporting staff back into work continue to be identified on a case by case basis. The top two reasons for non-Covid -19 related absence are Stress and Anxiety and Musculoskeletal. Health and Wellbeing activity this month has included:

- Trust wide Coke Zero, Fanta Zero and 7 Up zero distribution by Executive Team
- The launch of monthly virtual sessions to support those that have either recently returned from shielding or who still are shielding. These have been very well received and have become an opportunity for those that have returned to share experiences and support one another.
- 1:1 conversations supporting managers develop compassionate leadership
- A video of all the changes that have taken place to mitigate transmission was made and shown to those shielding as we recognise the hospital site is a very different place now compared to what it was when colleagues shielded in March
- 'Leading the way' webinars for managers have continued looking at topics such as supportively bringing people back to work, supporting blended teams, understanding the psychological impact of covid on your team, resilience when working at home and on site, leading through covid

Competence

The overall appraisal compliance percentage for the month of August 2020 is 69.41%, which is a decrease on the figure of 71.41% reported for July 2020. The overall statutory and mandatory training position for the month of August 2020 is 85.06%, which is an decrease on the figure of 85.51% reported for July 2020 and is marginally above the Trust target of 85%. All statutory and mandatory training continues to be available via e-learning and initial discussions are now underway regarding the re-provisioning of the other training delivery methods, which were temporarily suspended as part of the Covid response.

Medical Director's view

Overview

Building on the appointments of a chief registrar and BAME clinical fellow reported to the July board, I am delighted to announce several further appointments in support of the trust's ambitions in relation to becoming an outstanding place to work and train for our doctors, and as a partner in the acute care provider group and the system.

These include the appointment of an associate director of research, innovation and education, a head of academic programmes, an academic courses manager, an SAS tutor and 2 surgical college tutors.

Substantial progress on an academic strategy is covered in a separate report to board.

Incidents

The recovery in incident reporting has been sustained, with no change in the rates of moderate or severe harm incidents. There has been a notable cluster of maternity related clinical incidents declared over the last quarter (7 SI, 12 moderates). The medical director and director of nursing have met with the deputy director of midwifery and clinical and divisional directors responsible for the service and been assured, based on HSIB benchmarking, that the service is safe. A theme around staffing levels and volume of work was explored and some mitigations agreed.

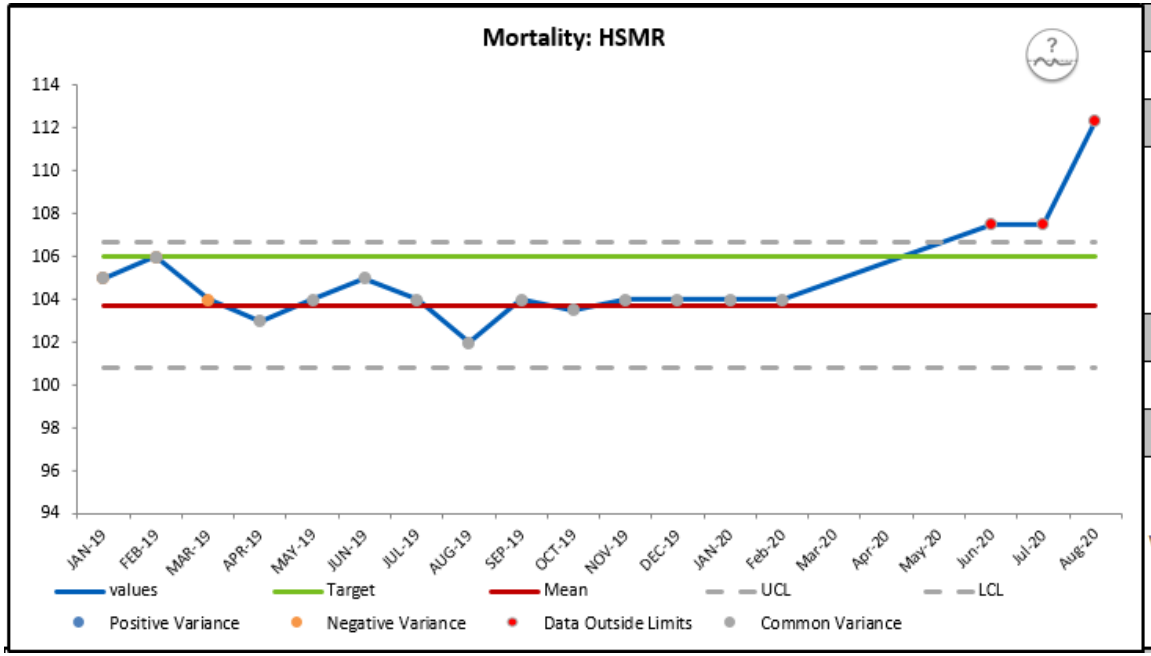
Mortality

HSMR has risen to 112.3, the increase due to the distortion of the covid effect (the comparison is with the previous 12 months expected values). SHMI, which is not subject to this distortion nor the linkage issue with Cynthia Spencer hospice, remains in as expected at 100.1. The trust is currently in discussions with Dr Foster around the hospice linkage distortion to HSMR as this is unhelpful in the analysis required to most effectively direct improvement activity.

VTE prophylaxis and ePMA

An ePMA project group with an executive oversight committee have been established to govern the re-introduction of the next ePMA upgrade and rigorous testing prior to go live during Q4. Interim improvement and assurance measures are in place during the paper based business continuity.

SPC Charts – Mortality: HSMR



Aug-20
112
Variance Type
Metric is currently experiencing Special Cause Variation - data outside control limits
Target
106
Target Achievement
Metric is experiencing variable achievement (will achieve target some months and fail others)

Context:

We anticipate HSMR is likely to remain elevated for a period of time due to the impact of both the December 2019 spike in Inpatient deaths, and the effects from Covid-19. With planning underway for a "2nd wave" of Covid-19 admissions, our HSMR may remain elevated for the foreseeable future.

The Mortality team are currently conducting a 100+ case note review of inpatient deaths in December 2019 ("Review 13"), using standard SJR methodology. All patients scored as "very poor care" or "poor care" will undergo a 2nd SJR.

The first 2nd SJR meeting was held on the 4th September; the review will be concluded following presentation of the remaining cases listed for SJR2 at the next meeting scheduled for November.

The aim of this review will be both to identify any gaps in care provided at NGH, and to identify the key feedback and learning themes.

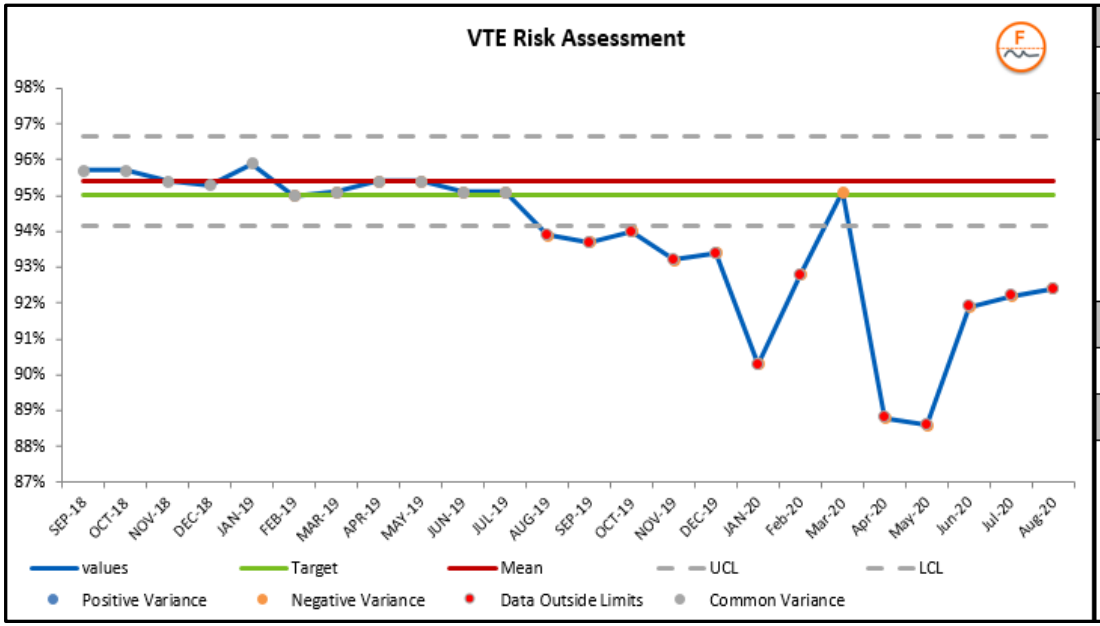
Actions:

Dr Foster will be providing NGH with a COVID-specific package with analysis report and 5 updates for review after 5th iteration so we can identify any future areas of concern as early as possible.

In September - October 2020 the Mortality team will conduct a trustwide review of all deaths identified with hospital acquired Covid-19 infection ("Review 14"), that have been referred for SJR by the Medical Examiner Team. These reviews will be conducted as part of the routine M&M process, and we aim to have the final report available to highlight key learning themes from the Covid-19 outbreak as soon as achievably possible.

Going forward, increased resources and support for patients in the community will result in decreased hospital admissions, and therefore decreased in-hospital mortality. We have invited a CCG representative to our next Mortality Review Group to discuss the situation further.

SPC Charts – VTE Risk Assessment



Aug-20
92.4%
Variance Type
Metric is currently experiencing Special Cause Variation - data outside control limits
Target
95%
Target Achievement
Metric is consistently failing the target

Context:

Lack of functioning ePMA combined with covid IPC movement restrictions have made significantly inhibited both monitoring and improvement actions.

Indirect assurance of compliance is drawn from a spot audit conducted by ward pharmacists confirming that 98% of patients had appropriate and timely prophylaxis prescribed.

Actions:

- New prescription charts with integrated assesssment forms printed and launched this month. Regular spot audits and feedback to practitioners near real time.
- ePMA project group and oversight exec committee established for re-introduction of further upgrade.

UNIVERSITY OF LEICESTER
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NHS Trust

Report To	**Trust Board**
Date of Meeting	**24th September 2020**

Title of the Report	**NGH Improvement Plan**
Agenda item	**9**
Presenter of Report	Ms Claire Campbell, Director of Corporate Development, Governance and Assurance
Author(s) of Report	Ms Jemma Moody, Compliance Governance Manager

This paper is for:

□ Note	□ Assurance
For the intelligence of the Board without the in-depth discussion as above	To reassure the Board that controls and assurances are in place

Executive summary

- Further to publication of the final reports, the Trust has developed an improvement plan to address the 'must' and 'should' actions listed in the reports.
- The Trust received three requirements notices. Two in relation to the proper and safe use of medicines (Medicine and Maternity) and one in relation to receiving and acting on complaints (Maternity).
- All actions have been completed for the three requirement notices and the supporting evidence of completion is in place.
- 25 out of the 39 actions in the Improvement Plan have been fully completed with supporting evidence, (Actions 1,2,3,4,5,6,7,10,11,12,13,18,19,20,21,22,25,26,27,28,30,32,34,37,and 38).
- 24 sub-actions have been closed since July 2020 (Last Trust Board Meeting)
- 15 sub-actions are outstanding, 6 of these are overdue.
- 6 actions have been signed off as complete but the evidence of completion is required.

Related strategic pledge	Which strategic pledge does this paper relate to? 1. *We will put quality and safety at the centre of everything we do* 2. *Deliver year on year improvements in patient and staff feedback* 3. *Create a sustainable future supported by new technology* 4. *Strengthen and integrate local clinical services particularly with Kettering General Hospital* 5. *Create a great place to work, learn and care to enable excellence through our people*
Risk and assurance	Does the content of the report present any risks to the Trust or consequently provide assurances on risks: **Yes** Failure to meet statutory requirements can lead to improvement

	notices, and prosecution and in extremes withdrawal of Trust services
Related Board Assurance Framework entries	All
Equality Analysis	Is there potential for, or evidence that, the proposed decision / document will not promote equality of opportunity for all or promote good relations between different groups? **No** Is there potential, for or evidence that, the proposed decision / document will affect different protected groups/characteristics differently (including possibly discriminating against certain groups/protected characteristics)? **No**
Financial Implications	Some actions will require additional funds e.g. business cases and capital projects. Failure to meet requirements can lead to fines.
Legal implications / regulatory requirements	Are there any legal/regulatory implications of the paper: **Yes** **CQC Fundamental Standards** The Trust has been issued with three requirement notice following the CQC inspection. Two in relation to Regulation 12 (2) (g): The proper and safe use of medicines. One in relation to Regulation 16 (2): Receiving and acting on complaints.

Actions required by the Trust Board:

The Board is asked to:

- Accept this report as part of the assurance process, showing the Trust has and is taking action to address the concerns raised in the CQC reports and undertakings requirements.
- Challenge any areas of concern or where it is felt that progress is not occurring in a timely manner, or evidence of completed action is not forthcoming.

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NGH Improvement Plan

1. Introduction

The CQC completed a Use of Resources, Core Service and Well-Led inspection of the Trust on 4th June 2019, 11th -13th June 2019 and 24th -25th July 2019 respectively. Three services were reviewed as part of the core service inspections, Urgent and Emergency Service, Medical Care (including older people's care) and Maternity. This was the first time the Trust had a Use of Resources inspection as part of the updated CQC inspection methodology.

The final reports were published on 24th October 2019. Three reports were published:

- Provider report
- Evidence appendix (to support the provider report)
- Use of Resources report

The reports are available on the CQC website https://www.cqc.org.uk/provider/RNS/reports

2. Progress against actions

2.1 NGH Improvement Plan (Update)

Following the publication of the reports, the 'must' and 'should' actions from the reports, have been transposed and used to form the detail of the NGH Improvement Plan. The Trust was issued with three requirement notices. The current version of the plan is provided in *Appendix A*. Actions have been provided, to show how the Trust will complete each of the 'must' and 'should' concerns raised in the reports. A deadline date, evidence of completion and a score for the likelihood of completion are also included. Only outstanding actions are included in the Appendix.

The likelihood score is rated from 1 (rare- not going to happen) to 5 (almost certain) to mirror the likelihood scoring within the Trusts risk assessment processes. Only one action was scored as unlikely (15.3) due to the lack of available capital funding, to make the necessary changes to the paediatric ED layout, however, funding has subsequently been received.

The improvement plan was approved at Public Trust Board on 28th November 2019. The process for confirming closure of actions is for the Lead Executive to 'sign off' on receipt of the required evidence and for the Executive team to ratify prior to the monthly Quality Governance Committee meeting. An update will also be provided to Public Trust Board on a bi-monthly basis.

Report Month	Total actions remaining	Number closed in month	Number outstanding (on track)	Number outstanding (overdue)
November 2019	126	30	96	0
December 2019	96	17	79	0
January 2020	79	24	55	0
February 2020	55	5	50	0
March 2020	50	6	44	0
June 2020	54	5 since March 2020	43	0
July 2020	45 (12 for evidence)	9	33	0
August	36 (8 for	9	21	7

2020	evidence)			
September 2020	21 (6 for evidence)	15	9	6

2.2 List of actions closed in month
Detail is provided in the NGH Improvement Plan (see Appendix A)

2.3 Actions which are overdue

Action number	Action	Deadline
14.1	**Request an internal audit review and address weaknesses**	**01/09/2020**
16.2	**Include process in revised Medicines Management Policy**	**30/07/2020**
29.1	**To monitor stroke service VTE compliance via thrombosis committee and implement actions if compliance has not improved**	**30/07/2020**
31.1	**Develop audit proforma for delayed/cancelled IOL and elective caesarean sections**	**01/08/2020**
33.2	**Review medical recruitment strategy**	**30/08/2020**
36.1	**Cancer recovery plan in place**	**30/07/2020**

2.6 Updates from external reporting to CQC/ NHSE/I

No updates to report since July 2020 in relation to feedback from CQC or NHSE/I.

3. Agreed governance reporting framework

The Improvement Plan will be presented to Executive meetings and the Quality Governance Committee on a monthly basis. Bi-monthly updates will be presented at Public Trust Board.

The process for confirming closure of actions will be for the Lead Executive to sign off on receipt of the required evidence and for the Executive team to ratify prior to the Quality Governance Committee.

Following presentation of progress to the Quality Committee next month, it is hoped that we will be in the position to close down the improvement plan moving any final outstanding items into other governance processes to monitor and follow up to completion as there should be minimal actions remaining outstanding.

4. Recommendations

The Board is asked to:

- Accept this report as part of the assurance process, showing the Trust has and is taking action to address the concerns raised in the CQC reports
- Challenge any areas of concern or where it is felt that progress is not occurring in a timely manner, or evidence of completed action is not forthcoming.

NGH Improvement Plan
(Incorporating CQC Inspection Report outcomes published October 2019/ NHSE/I Undertakings actions)

27/08/2020
V10

16/09/2020

No	Concern: Trustwide Quality "Should" actions Undertakings Section 4	Exec Owner	Action Owner(s)	Action	Deadline	Date completed	Evidence of completion	Likelihood of completion	Progress/ Comments
8	a) The trust should review the effectiveness of its audit committee b) The trust should consider the observations in relation to the audit committee to ensure that only realistic and deliverable internal audit recommendations are agreed in future, and that internal audit recommendations, as far as is practicable, are implemented within agreed timescales.	Claire Campbell	Claire Campbell	8.8 Closure of salary overpayment issue via audit committee (Cross reference with action no 14.)	18/12/2019	18/12/2019	8.8 Minutes of December 2019 meeting	3 - Possible	20/12/2019 Exec email- discussed at Audit Committee and Finance and Performance. Require final version of minutes from Audit meeting (will be available after March 2020 meeting)
No	**Concern: Trustwide Quality "Should" actions Undertakings Section 4**	**Exec Owner**	**Action Owner(s)**	**Action**	**Deadline**	**Date completed**	**Evidence of completion**	**Likelihood of completion**	**Progress/ Comments**
9	The trust should consider an external review of its governance structure and systems	Claire Campbell	Claire Campbell	9.2 Identify basic specification of need	29/02/2020	27/02/2020	9.2 Specification document	4- Likely	03/03/2020 Discussed at Board of Directors on 27/02/2020. Evidence of completion required. 12/02/2020 Postponed from January 2020 Board meeting as ran out of time. To now take place in Feb 2020. Date changed from 30/01/2020 to 29/02/2020. All other actions to be moved back one month. 20/12/2019 Exec email- actions relating to 9.1 and 9.2 postponed as Dec 2019 Board overran. To now take place in Jan 2020 (changed from 19/12/2019). All other actions to be moved back one month.
		Claire Campbell	Claire Campbell	9.3 Commission external review via competitive quotes	30/11/2020		9.3 Supplier engaged	4- Likely	9/9/20 - these will be completed within the calendar year. 06/08/2020 - Extended deadline to November 2020 due to competing priorities due to group model work. 08/06/20 - 4 month extension to deadline due to COVID-19. 12/02/2020 See action 9.1- date for completion changed to 31/03/2020 (from 29/02/2020) 20/12/2019 See action 9.1- date for completion changed to 29/02/2020 (from 31/01/2020)
		Claire Campbell	Claire Campbell	9.4 Undertake governance review	30/11/2020		9.4 Governance review completed	4- Likely	9/9/20 - these will be completed within the calendar year. 06/08/2020 - Extended deadline to November 2020 due to competing priorities due to group model work. 08/06/20 - 4 month extension to deadline due to COVID-19. 12/02/2020 See action 9.1- date for completion changed to 31/05/2020 (from 30/04/2020) 20/12/2020 See action 9.1- date for completion changed to 30/04/2020 (from 31/03/2020)
		Claire Campbell	Claire Campbell	9.5 Provide evidence to NHSE/I	31/12/2020		9.5 Outcome evidence	4- Likely	9/9/20 - these will be completed within the calendar year. 06/08/2020 - Extended deadline to December 2020 due to competing priorities due to group model work. 08/06/20 - 4 month extension to deadline due to COVID-19. 12/02/2020 See action 9.1- date for completion changed to 31/05/2020 (from 30/04/2020) 20/12/2020 See action 9.1- date for completion changed to 30/04/2020 (from 31/03/2020)
No	**Concern: Trustwide Quality "Should" actions Undertakings Section 4**	**Exec Owner**	**Action Owner(s)**	**Action**	**Deadline**	**Date completed**	**Evidence of completion**	**Likelihood of completion**	**Progress/ Comments**
14	The trust has plans to introduce an electronic solution between the human resources function and payroll to seek to address the issue of staff overpayments. The trust should consider requesting an internal audit function	Mark Smith	Adam Cragg	14.1 Request an internal audit review and address weaknesses	01/09/2020		14.1 Internal audit report and action plan	4 - Likely	12/08/2020 - update that there will be a change in the software solution that will assist in meeting this requirement. We do have a new tool in place (robotic process automation) that could help with this. 06/08/2020 - There was a solution devised by IT using a system called

No	Concern: Urgent and Emergency Services Quality "Should" actions	Exec Owner	Action Owner(s)	Action	Deadline	Date completed	Evidence of completion	Likelihood of completion	Progress/ Comments
15	Undertakings Section 4 The service should continue to re-assess the layout of the paediatric emergency department to ensure it meets the Children and Young People in Emergency Care Settings 2012 standards	Carl Holland	Tristan Dyer/ Owen Cooper	15.4 Review pathways for use of PAU and increased activity	31/12/2019	31/12/2019	15.4 PAU pathways reviewed and evidence of improved patient flow.	4- Likely	16/07/2020 - wording for evidence required changed from increased activity to improved patient flow to reflect reflect the excellent work that is on-going via our liaison with the Paediatricians to make sure that the right patients are going as rapidly as possible to PAU/the ward. 09/03/2020 Remains outstanding due to annual leave 14/02/2020 SB liaise with DN PA to try and resolve issues around closure of action
16	Undertakings Section 4 The service should make arrangements so patient group	Matthew Metcalfe	Rachel Westwood	16.2 Include process in revised Medicines Management Policy	30/07/2020		16.2 Revised Medicines Management Policy	5- Almost certain	06/08/20 - update requested. 08/06/20 - 4 month extension to deadline due to COVID-19. 07/02/2020 Process for PGDs will be included in review of Medicines
17	Undertakings Section 4 The service should take action so medical staff are compliant with the trust target for safeguarding children level three training	Mark Smith	Tristan Dyer	17.3 The Safeguarding Team provide regular updates of who needs to completed training and this will be monitored for medical staff who are not completing the training and are repeatedly on the list	01/10/2020		17.3 Training information over 3 months and identification of medical staff on the list more than once	4 - Likely	14/07/20 - 1 month evidence received for those needing to do training, deadline therefore amended to 1st October 2020. 08/06/20 - 4 month extension to deadline due to COVID-19. 09/03/2020 Plan to achieve by deadline date 13/02/2020 Joint working between QI and L&D to identify non-
No	**Concern: Medical Care Quality "Should" actions** **Undertakings Section 4**	**Exec Owner**	**Action Owner(s)**	**Action**	**Deadline**	**Date completed**	**Evidence of completion**	**Likelihood of completion**	**Progress/ Comments**
23		Carl Holland	Divisional Director for Medicine	23.1 Inpatients cared for on outlying wards have a designated medical team to review patients. This is monitored and audited twice weekly by reviewing the medical plans in the patient's medical records	29/02/2020	10/02/2020	23.1 Twice weekly audits	5- Almost certain	10/9/20 - National reason to reside weekly review has been commenced alongside specific review of when was the patients last consultant review, do they have a clear medical plan. At this stage ibox does not hold the reason to reside information it is currently a paper based audit. 10/02/2020 Completed and in place. Evidence of completion required. 06/01/2020 Email from D. Needham. Each outlying ward has nominated consultant. Audits completed within the division by the management team. Date of completion amended to 29/02/2020 (from 31/12/2019). Not yet signed off by exec lead. 31/12/2019 Review date of 31/12/2019
24	The service should consider how it manages private and NHS patients for cardiology procedures to ensure equity of access	Matthew Metcalfe	Mary Visser	24.2 Action plan developed linking multiple reports/ workstreams in Cardiology	13/09/2020		24.2 Action plan	5- Almost certain	15/06/2020 - E-mail reply from MV - Can you please extend it a further three months to allow us to work through reset and then we may have already addressed some of these actions? 09/06/20 - Mary Visser e-mailed for update 08/06/20 - 3 month extension to deadline due to COVID-19.
29	The stroke services to consider improving compliance with completion of VTE assessments	Matthew Metcalfe	Amanda Bisset	29.1 To monitor stroke service VTE compliance via thrombosis committee and implement actions if compliance has not improved	30/07/2020		29.1 Copy of meeting minutes and associated actions (if relevant)	4- Likely	06/08/2020 - update requested from action owners. 08/06/20 - 4 month extension to deadline due to COVID-19. 10/02/2020 Action owner confirmed data is captured by ward. Will provide for relevant wards related to stroke service.

No	Concern: Maternity Services Quality "Should" actions Undertakings Section 4	Exec Owner	Action Owner(s)	Action	Deadline	Date completed	Evidence of completion	Likelihood of completion	Progress/ Comments
		Sheran Oke	Trish Ryan	31.1 Develop audit proforma for delayed/cancelled IOL and elective caesarean sections	01/08/2020		31.1 Audit proforma	5- Almost certain	08/09/2020 - In progress, IOL delays at 13% Forecasted deliveries discussed at Divisional Board meeting 88 more bookings this quarter compared to last year's quarter 06/08/2020 - update requested from action owners. 08/06/20 - 4 month extension to deadline due to COVID-19. 01/03/2020 Audit proforma is being used, sections are now datixed and are reported on the huddle sheets. Figures to be reported as below 13/02/2020 Cancelled electives being monitored through Datix and IOL though audit . Figures to be included in Risk Management report and

31	The service should formally monitor delayed discharges and how frequently induction of labours or elective caesarean sections are delayed (or cancelled) so the service can analyse and monitor trends to inform future plans	Sheran Oke	Trish Ryan	31.2 Reasons for delayed discharges discussed and documented at the Maternity Safety Huddle	01/08/2020	08/09/2020	31.2 Maternity Safety Huddle sheets	5- Almost certain	08/09/2020 - requesting evidence to be sent that the action is being completed, no delayed discharges, improvements made during Covid-19. 06/08/2020 - update requested from action owners 08/06/20 - 4 month extension to deadline due to COVID-19. 01/03/2020 As per 31.1. Audit proforma being used 13/02/2020 Maternity huddle sheets being used daily and well embedded in service 05/12/2019 This is currently under development and on track to deliver by stated deadline
		Sheran Oke	Trish Ryan	31.3 Monthly report to Directorate Governance Group and Divisional Governance Group	01/08/2020	08/09/2020	31.3 Monthly reports / Minutes of Directorate / Divisional Governance Group	5- Almost certain	08/09/2020 -providing a monthly report to Directorate Governance group, this is already provided and should be green. 06/08/2020 - update requested from action owners 08/06/20 - 4 month extension to deadline due to COVID-19. 01/03/2020 Results of Feb 2020 audit will be presented at March 2020 Maternity governance meeting 13/02/2020 Monitoring and reporting as outlined and concerns escalated as needed 05/12/2019 To commence Feb 2020

No	Concern: Use of resources 'Should' Actions	Exec Owner	Action Owner(s)	Action	Deadline	Date completed	Evidence of completion	Likelihood of completion	Progress/ Comments
33	**Undertakings Section 4** The NHS trust should continue working to ensure optimisation of its substantive medical workforce and reduce reliance on agency staff.	Mark Smith	Tracy Robson	33.2 Review medical recruitment strategy	30/08/2020		33.2 Strategy in place	4 - Likely	06/08/2020 - Update requested. 08/06/20 - 3 month extension to deadline due to COVID-19. 09/03/2020 Project initiated to determine correct medical establishment. Date amended from 03/04/2020 to 31/05/2020 to progress the medical establishment review 13/02/2020 Senior level review meeting in place concerned with agency cost reduction, substantive recruitment and shift to Bank where possible
35	**Undertakings Section 4** The NHS trust should continue focusing on building internal capacity and capability to deliver trust wide workforce and service productivity improvements	Mark Smith	Bronwen Curtis	35.3 Introduce talent management	31/12/2020		35.3 Talent Management rollout plan	4 - Likely	13/08/2020 - Talent management process will be updated to reflect the learning from Covid and incorporate the guidance from the People Plan. Target completion date will be December 2020 Evidence of completion will be issuing of revised process by end December 2020. Rollout to commence January 2021. Deadline amended due to update. 08/06/20 - extension to deadline due to COVID-19. 08/06/20 - BC - 35. 3 was paused due to Covid19 but will be revised shortly to reflect current position Completion date can be revised to 31/8/20 09/03/2020 Rollout to other divisions launched as well as pipeline
36	**Undertakings Section 1** The NHS trust should ensure the improvements that they make in pathways results in achieving better performance against constitutional operational standards	Carl Holland	Owen Cooper	36.1 Cancer recovery plan in place	30/07/2020		36.1 Most recent version of recovery plan	3- Possible	10/08/20 Weekly cancer reset meetings continue reviewing individual tumour site and support function improvement plans, and overseen by the monthly cancer board. A 62 day trajectory is in place with further trajectories for 2ww, 28 Faster Diagnosis Standard and 31 day complete within the week. Transformation support and areas of focus agreed. 06/08/2020 - Update requested. 08/06/20 - 4 month extension to deadline due to COVID-19. 10/03/2020 Intensive support team (IST) have been working with us for 3 weeks now with very positive feedback on our cancer board, processes and cancer PTL structure. They are going to support us with some
		Carl Holland	Carl Holland Sheran Oke Matthew Metcalfe Claire Dannatt Owen Cooper	36.2 AE plan in place as per actions 18 and 23	30/10/2020		36.2 AE plan	3- Possible	12/08/2020 - Only 18.3 outstanding. Deadline amended to 30/10/2020 accordingly. 06/08/2020 - Update requested. 20/07/2020 - The work has now been taken over by the internal discharge and system discharge work. 08/06/20 - 4 month extension to deadline due to COVID-19. Link in with 18 & 23. 10/02/2020 New work streams agreed and being led by COO/MD/DoN 09/01/2020 Email from D.Needham. Recovery plan is in place. Completion date amended to 31/03/2020 (from 31/12/2019) Action not yet signed off.
	Undertakings Section 4	Stuart Finn	James Stewart	39.2 Implementation of new CMMS (computer maintenance management system)	31/10/2020		39.2 Confirmation email new CMMS in place and in use	5- Almost certain	7 Aug 20 - Independent review has been completed and confirmed system is operational. The report made a number of recommendations and a 3 month implementation plan has been put in place to deliver by end of October 2020. Deadline date amended accordingly. 04/06/2020 Review completed which supports the use of the existing system. Progress has been delayed due to vacancies but new interim Dep Dir of E&F has been tasked to complete implementation. Target date of Aug 20 will not be achievable and a new date will be set following further meetings in June 10/03/20 Independent review completed which confirmed existing system is fit for purpose. A number of recommendations were made as part of the report which are being reviewed. 06/01/2020 Independent review starting 7 Jan 20 04/12/2019 An independent review of the existing system has been arranged. This will include recommendations and action plan to implement the system and utilise the reporting function. Date of review TBC

39	The NHS trust should progress implementation of its five-year estates maintenance plan.	Stuart Finn	James Stewart	39.3 Development of key maintenance compliance reports from CMMS to be presented at Facilities Governance committee	31/12/2020		39.3 Maintenance compliance reports and copy of meeting minutes	5- Almost certain	7 Aug 20 - Independent review has been completed and confirmed system is operational. The report made a number of recommendations and a 3 month implementation plan has been put in place to deliver by end of October 2020. Completion of recomendations will allow acuarate maintenance reports to be run - these will be due Nov/Dec 20. Deadline date amended accordingly. 04/06/2020 Review completed which supports the use of the existing system. Progress has been delayed due to vacancies but new interim Dep Dir of E&F has been tasked to complete implementation. Target date of Aug 20 will not be achievable and a new date will be set following further meetings in June 10/03/20 Independent review completed which confirmed existing system is fit for purpose. A number of recommendations which included reporting were made as part of the report which are being reviewed. 06/01/2020 Independent review starting 7 Jan 20 04/12/2019 An independent review of the existing system has been arranged. This will include recommendations and action plan to implement the system and utilise the reporting function. Date of review TBC

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Report To	**Trust Board**
Date of Meeting	**24th September 2020**

Title of the Report	Infection Prevention Update and Northampton General Hospital Infection Prevention Control Board Assurance Framework
Agenda item	**10**
Presenter of Report	Sheran Oke, Director of Nursing, Midwifery & Patient Services/Director of Infection Prevention & Control
Author(s) of Report	Graham Pike, Interim Matron Infection Prevention & Control Ms Jemma Moody, Compliance Governance Manager

This paper is for:

☐ Note	☐ Assurance
For the intelligence of the Board without the in-depth discussion as above	To reassure the Board that controls and assurances are in place

Executive summary

This paper provides an update on the actions undertaken by the Infection Prevention & Control Team following the Covid 19 Outbreaks and the next steps that are required to support the Trust proactively manage Infection Prevention and Control. The paper also provides an overview of the Infection Prevention Control Board Assurance Framework (IPC BAF) for Northampton General Hospital.

Related strategic pledge	Which strategic pledge does this paper relate to? 1. *We will put quality and safety at the centre of everything we do* 2. *Deliver year on year improvements in patient and staff feedback* 3. *Create a great place to work, learn and care to enable excellence through our people*
Risk and assurance	Does the content of the report present any risks to the Trust or consequently provide assurances on risks: **Yes** Failure to meet statutory requirements can lead to improvement notices, and prosecution and in extremes withdrawal of Trust services
Related Board Assurance Framework entries	All
Equality Analysis	Is there potential for, or evidence that, the proposed decision / document will not promote equality of opportunity for all or promote good relations between different groups? **No** Is there potential, for or evidence that, the proposed decision / document will affect different protected groups/characteristics differently (including possibly discriminating against certain groups/protected characteristics)? **No**

Financial Implications	Some key lines of enquiry will require additional funds to gain assurance
Legal implications / regulatory requirements	Are there any legal/regulatory implications of the paper: **No**

Actions required by the Trust Board:

The Board is asked to:

- Accept this report as part of the assurance process.
- Challenge any areas of concern.
- Support the on-going IPC improvement agenda

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Northampton General Hospital IPC BAF

1. Introduction

In February 2020 the increasing international incidence of Covid 19 was noted, at this time the Trust began to consider and enact their approach to managing a probable outbreak in the community. The Major Incident Plan was put into place with Gold Silver and Bronze cells meetings in situ to manage the emerging situation working from an incident room hub.

At the beginning of March three Silver teams were established; each led by the Chief Operating Officer, Medical Director and Director of Nursing respectively supported by designated Executive Directors and Divisional Managers. Each team was based in the Incident Control Room and would rotate every 7 days, thereby ensuring continuity of leadership and communication. Each day would commence with a Silver call and with a site overview being provided, all bronze call leads including site, infection prevention and procurement would update on their position, support as identified was provided. At the peak of the pandemic Gold meetings were occurring also on a daily basis chaired by the Chief Executive. The Silver commander would also link into the incident control room at the CCH and with colleagues from Public Health and NHSE/I. There was also a strong professional link to both the Chief Nurse and Medical Director for both the Region and to NHSE/I making the optimal of networking using the virtual meeting options.

From the outset, the establishment of the Infection Prevention Bronze call has been key in planning and reacting to the changing situations. The IPC team adopted from the outset flexibility in their working practices, providing a seven day week service, increasing their visibility, training and supporting the workforce and keeping our patients and staff safe. The IPC bronze cell continue to meet each day to address those issues that require specialist input from our Microbiologist, IPC Nurses or Director of Infection Prevention & Control (DIPC).

2. Outbreak - Lessons Learnt

Since March 2020 there have been three outbreaks of COVID-19. Two were amongst patients on Abington Ward and Brampton Ward, and a staff outbreak was on Collingtree Ward. Although the formal investigation of these incidents by the Governance team is still ongoing, the IPC team have identified the following learning points from their internal investigations at the time of the outbreaks.

<u>Poor compliance with IPC protocols</u>
Poor Personal Protective Equipment (PPE) practice, hand-hygiene and social-distancing is thought to have contributed to spread of COVID-19 to both staff and patients and thus contributed to all three outbreaks.

Although PPE guidance was sent to all areas and IPC visited all wards, on a daily, speaking to staff and explaining correct procedures, there was no formal training or record of training at this time. Following the outbreaks the IPC team have focused on re-training all relevant staff, either directly or with the support of a “train the trainer”, with attendance records fed back to Learning and Development where a central record of PPE training is held. Non-compliance with IPC practices is now dealt with through an escalation process which was developed with the support of HR. Improving results are being seen in the audits of PPE and hand hygiene practice performed by the IPC team.

Poor adherence to national social-distancing guidelines, both at work and outside of work, was noted by the IPC team. This was particularly evident in staffrooms, MDT rooms and around nursing stations. A social-distancing audit tool has been implemented by the IPC team, which has helped to identify problem areas on individual wards. Improvements have been supported by new posters and guidance from the Communications team, as well as good engagement from clinical teams on finding different ways to work (e.g. remote board rounds) and using

space in a new way (staggering breaks, identifying different areas for staff use when on breaks).

Asymptomatic carriage of COVID-19 by staff potentially puts our most vulnerable patients at risk.
Weekly screening is now in place for those staff who work with our most vulnerable patients, i.e. those on elderly care wards, those who are immunosuppressed (oncology/haematology/renal) and those who have isolated prior to a procedure.

Early identification of outbreaks
The PHE criterion for defining a COVID-19 outbreak is now clear: two cases within 28 days where a patient tests positive for COVID-19 more than 7 days after admission. A staff outbreak would similarly be two cases within 28 days where there is evidence of transmission through contact at work. Additionally a protocol for regular swabbing of inpatients is now in place which will help to ensure that asymptomatically positive patients are detected sooner. Daily outbreak meetings will thus be implemented sooner, leading to a coordinated and cohesive response.

Early closure of affected areas, clearly communicated to all staff involved in patient movements
Any bay in which a positive patient is identified is immediately closed. The potentially exposed patients are quarantined – either together or in single rooms – and a list of all exposed patients is maintained by the IPC team and shared with the Site Team on a daily basis, or whenever changes are made. Although bay closure was in place prior to the outbreaks, there were some lapses due to communication breakdowns. This enhanced communication between the IPC team and Site team will ensure this does not occur.

Minimising movement of patients will minimise the chances of COVID-19 being spread between wards
The cohorting together of patients who have been exposed to COVID-19 in different locations, which might be appropriate in a norovirus outbreak for example, appears to have increased the chance of further patients acquiring COVID-19. This practice was in place prior to the outbreaks but is no longer the case.
Patients who are thought to have recovered from COVID-19, due to clinical improvement and negative swab result after 14 days, have been noted to subsequently test positive for COVID-19. Whether this is due to reinfection, relapse or detection of non-infectious particles of virus is not yet known. It would thus be prudent to avoid moving such patients to outbreak locations in future. Current practice is now to keep previously COVID-19 positive patients on their cohort wards until discharge, to avoid unnecessary patient moves (unless there is a clinical need to move the patient such as dialysis or ITU).

The wider zoning project, which divides the whole hospital site into coloured zones based on patients' risk of having COVID, will support ensure that patients are not exposed to COVID-19 or moved between wards when it is not appropriate to do so.

3. **Next Steps**
Aside from continuing to support the above learning, the following issues remain a priority:

Streaming patients in ED according to their risk of carrying COVID-19
As we learn more about the virus and how patients affected by it may present to hospital, there is the need to constantly refine our algorithms for identifying those at risk of being infectious. Getting this right minimises the risks of cross-infection to a previously unaffected patient. The IPC Matron and IPC Consultant are working closely with the Site Team, ED Matrons and ED Clinical Director to fine tune, clarify and develop existing processes.

Identifying patients who are due for routine COVID-19 swabs

Patients are now tested on day 1 in the hospital, day 3 (if symptomatic but negative on admission), day 5 and then every seven days. It is a challenge for ward teams to identify which patients are due a swab each day, leading to the possibility of swabs being missed. The IPC team are working with IT with the aim of this task appearing automatically on iBox, the Trust's electronic whiteboard system.

Environmental cleaning

The IPC Board Assurance Framework, authored by NHS England in response to the pandemic, recommends an enhanced frequency of cleaning across all clinical areas, with additional changes in COVID cohort areas. IPC have advised how these changes will affect existing ward cleaning schedules, however meeting this additional requirement necessitates recruitment of more cleaning staff – both to fill existing vacancies and to meet the increased need. The Domestic team are actively recruiting to achieve this.

Lack of IT system supporting IPC

The Trust IPC team rely on paper-based systems, together with much cross-referencing in different electronic systems, in order to identify and manage potential infection risks and outbreaks. This is time-consuming and inefficient, and is not robust when compared with an electronic system such as ICNET (used at Kettering, for example). Discussions on the possible implementation of ICNET continue between IPC, IT and Finance.

4. IPC Board Assurance Framework

In an attempt to provide Trust Boards' with assurance that Infection Control practices were optimal and being addressed, the national Board Assurance Framework was published in May 2020. Our team populated the document and brought this to the Board that same month May, articulating this as being an evolving piece of work. This has developed and is brought to the Board today following discussion at the Quality Governance Committee in August 2020.

This summarises the work undertaken during the COVID-19 pandemic with regard to infection prevention. The trusts progress with the IPC BAF is detailed in appendix 1.

5. Actions

There is a comprehensive improvement plan in place for the areas of the IPC BAF that are not fully compliant; this is monitored through the Infection Prevention Steering Group Meeting.

6. Agreed governance reporting framework

The IPC BAF will be reviewed at the monthly Infection Prevention Steering Group Meeting.

The process for confirming assurance of key lines of enquiry will be for the designated lead to sign off on receipt of the required evidence and for the Infection Prevention Steering Group to ratify the IPC BAF. This will then feed into the reports for Quality Governance Committee to highlight any areas of concern.

7. Recommendations

The Board is asked to:

- Accept this report as part of the assurance process.
- Challenge any areas of concern.
- Support the on-going agenda

Northampton General Hospital NHS Trust

Infection Prevention and Control Board Assurance Framework

Key areas of priority are currently:

- To ratification of the Trust wide ‘Zoning’ Policy
- To continue our training programme which includes Fit testing and PPE training for all relevant staff and central record keeping system
- To support our Head of Domestic Services & IPC Lead to continue our scope of the current cleaning schedules against the forthcoming national guidance that will determine the frequency and level of cleaning across the clinical & non clinical services
- To support the increase the resource and ability of Domestic Services to meet the current cleaning schedules and the foreseeable increase of requirements based on our internal review and forthcoming national guidance
- To recruitment of Pharmacy staff & Microbiologists

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Infection Prevention and Control (IPC) Board Assurance Framework

Reference	Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Risk(s) associated that are on Risk Register – Risk ID and title	Led By Whom	Assurance Rating
1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users							
1.1	Systems and processes are in place to ensure: • Infection risk is assessed at the front door and this is documented in patient notes	• Patients are split into two streams in the Emergency Department: those with signs and symptoms suggestive of COVID and those who are not suspected of having COVID-19. • All patients admitted non-electively are swabbed for COVID-19 using a swab which is processed in-house in a matter of hours		.	2359, 2287, 2393, 2336, 2313	IPC Matron Consultant Microbiologist Lead Consultant, Emergency Department Deputy Director of Nursing	
1.2	• Patients with possible or confirmed COVID-19 are not moved unless this is essential to their care or reduces the risk of transmission	• Those suspected of COVID-19 are moved from ED to Quinton Ward to await the results of their swab. Patients are bedded in bays with doors and en-suite facilities to minimise the number of other patients they are exposed to. If positive they are then moved to a COVID-positive cohort ward. If negative, following guidance from the Royal College of Pathology (13/05/2020), they are required to be swabbed again in 48 hours to reduce the risk of false negatives before they can be moved to a negative ward. Once the second swab result is known these patients are moved to a COVID-positive or COVID-negative ward as appropriate. • The Trust is currently developing its 'zoning' policy that will proactively support the patient journey and appropriate staffing.	Zoning policy is in final draft (planned for PDG Oct 2020)	Identified green zone wards – zoning practice going on whilst not written/ratified document	2359, 2287, 2393, 2336, 2313	IPC Matron Consultant Microbiologist Lead Consultant, Emergency Department Deputy Director of Nursing	
1.3	• Compliance with the national guidance around discharge or transfer of COVID-19 positive patients	• Patients are de-isolated from isolation or cohorting following both PHE and RCP guidance. Patients being discharged to other healthcare settings are swabbed for COVID-19 using same-day in-house testing. Patients being transferred to care homes as part of their on-going care are being screened for Covid 19. Due to the rapid change of COVID-19 guidance, this has been kept abreast through the trust IRR, the HETCG, regional NHSEI IRR and internally from IRR updates through silver meetings and twice daily trust wide briefings.			2359, 2287, 2393, 2336, 2313	IPC Matron Consultant Microbiologist Lead Consultant, Emergency Department Deputy Director of Nursing	

1.4	• 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	• PPE is used as per PHE guidance. We have tailored the PHE poster to each clinical area and we have had no supply issues with PPE. • We have fit-tested staff for FFP3 masks in all areas where aerosol-generating procedures (as defined by PHE) are undertaken and we have a good stock of unused, reusable FFP3 masks. • On-ward training in PPE has, and continues to be, delivered by the IPC team, as well as updates going out via the daily bulletin. The Team also provides a Frequently Asked Questions on PPE section on the Trust intranet. • Initial PPE audit complete • PPE audits are undertaken across the Trust by IPC monthly and twice a month in high-risk Covid 19 areas. • The IPCT have developed a set of competencies for Senior Staff to use to provide assurance staff understand PPE use in the Trust. • The IPCT have re-instated weekly Matron walk rounds. If results are not adequate these are repeated. Results are sent to the Deputy Director of Nursing and Associate Director of Nursing. • The trust has developed an extended 'Assessment & Accreditation' audit – Enhanced IPC compliance audit tool, for both general & Out-patient areas. This has been trialled and is now being 'rolled out' across the trust • Videos on PPE donning and doffing are available on trust intranet. Regular reminders and updates in daily briefings	Not all staff have had relevant PPE training.	The IPC team visit wards daily and clarify any misconceptions, providing reassurance regarding the appropriate use of PPE. IPC team to continue training of staff that is recorded monitored by L&D Ongoing auditing of PPE use and training is supported by the IPC Team	2359	IPC Matron Consultant Microbiologist Lead Consultant, Emergency Department Deputy Director of Nursing	
1.5	• National IPC guidance is regularly checked for updates and any changes are effectively communicated to staff in a timely way	• Any updates in national guidance have been incorporated into local guidance and communicated to clinical teams. • IPC guidance is reviewed at the Trust 'Bronze' cell meetings and escalated through our Silver to Gold as required.			2359	IPC Matron Consultant Microbiologist Lead Consultant, Emergency Department	

		• Regular updates are included in the daily briefings. Information is also available on the Trust intranet.				Deputy Director of Nursing	
1.6	• Changes to guidance are brought to the attention of boards and any risks and mitigating actions are highlighted	• Flowcharts showing above processes have been shared with all wards and embedded, by e-mail and via hard copy, as well as being distributed via the daily bulletin from the Trust's Comms. team. The most up-to-date guidance is also accessible via the Trust intranet page. • Changes to the guidance are bought to the attention of the executives on the boards through the daily silver and gold calls, and the non-executives having weekly briefings from the CEO. • IPC Board Assurance v1 report made to Trust Board (28th May 2020). • Board assurance update v3 to be taken Sept 2020 QGC/Board.			2359	IPC Matron Consultant Microbiologist Lead Consultant, Emergency Department Deputy Director of Nursing	
1.7	• Risks are reflected in risk registers and the Board Assurance Framework where appropriate	• Risks are added to the Infection Control risk register and escalated to corporate level if necessary (dependent on level of risk after mitigation). Risks are summarised in section 1.7 of the Board Assurance Framework. This did not exist prior to the CQC ESF Review during COVID-19. • IPC Risk Register updated and to be approved August 2020.			2359	IPC Matron Consultant Microbiologist Lead Consultant, Emergency Department Deputy Director of Nursing	
1.8	• Robust IPC risk assessment processes and practices are in place for non COVID-19 infections and pathogens	• Patients who are not suspected of COVID-19 are following pre-COVID pathways, with only minor changes: ○ they are swabbed in ED using same-day in-house testing, ○ Medical patients move to Walter Tull Assessment Unit ○ Speciality patients (e.g. Surgery, T&O) do not move to their Speciality ward, until their swab result is known to be negative. ○ Should patient require specific specialist care, they will be admitted to Specialty ward but nursed in a side-room			2336, 2359	IPC Matron Consultant Microbiologist Lead Consultant, Emergency Department Deputy Director of Nursing	
Reference	**Key lines of enquiry**	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	**Risk(s) associated that are on Risk Register – Risk ID and title**	**Led By Whom**	**Date completed / RAG**
2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections							

2.1	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	• As above regarding training given to ward staff. • Staff have been given training and updated with posters and leaflets. Increase in IPC Team to provide additional resource to support all services.			2359, 2387	IPC Matron Hotel Services Manager Deputy Director of Nursing	
2.2	• Designated cleaning teams with appropriate training in required techniques and use of PPE, are assigned to COVID-19 isolation or cohort areas.	• Designated and trained staff in place to undertake isolation and deep cleaning. SOP's incorporated as part of 'zoning' plan.			2359, 2387	IPC Matron Hotel Services Manager Deputy Director of Nursing	
2.3	• Decontamination and terminal decontamination of isolation rooms or cohort areas is carried out in line with PHE and other national guidance	• Isolation cleans (terminal) are performed for bed spaces vacated by suspected and confirmed cases of COVID-19, as well as for other infections with alert organisms (in line with national guidance.			2359, 2387	IPC Matron Hotel Services Manager Deputy Director of Nursing	
2.4	• Increased frequency, at least twice daily, of cleaning in areas that have higher environmental contamination rates as set out in the PHE and other national guidance	• Areas are identified for increased frequency cleaning. Vacancy factor high with limited temporary staffing cover available. • Presentation on cleaning	Advertising for additional staff and fill staffing vacancies	A complete review of cleaning frequencies and schedule will be undertaken to meet the new National Standards of Cleanliness due shortly.	2359, 2387	IPC Matron Hotel Services Manager Deputy Director of Nursing	
2.5	• 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	• Chlor-clean (1,000ppm available chlorine) is in use on all wards with confirmed or suspected Covid cases. This is made up and used daily. • In place and forms part of the services COSHH risk assessments and staff training • In place and forms part of the services COSHH risk assessments and staff training.				IPC Matron Hotel Services Manager Deputy Director of Nursing	

	• Manufacturers' guidance and recommended product 'contact time' must be followed for all cleaning/ disinfectant solutions/products	• Commodes are cleaned with Chlor-clean. • Other patient / nursing equipment are decontaminated with Clinell disinfectant wipes. Guidance has been sought from Clinell that these wipes are effective against Coronaviruses. https://gamahealthcare.com/latest/clinell-efficacy-against-coronavirus-covid-19					
2.6	• As per national guidance: '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	• The Domestic team are trained to focus on 'frequently touched' surfaces.	Not undertaken as frequently as per national guidance. Additional staff sought via recruitment and agency	A full cleaning services review is currently in progress and will be managed against the awaited National Standards of Cleaning and incorporating PHE guidance.	2359, 2387	IPC Matron Hotel Services Manager Deputy Director of Nursing	
	• Electronic equipment, e.g. mobile phones, desk phones, tablets, desktops and keyboards should be cleaned at least twice daily	• Patient / Nursing equipment is cleaned after every use and is labelled with Clinell green tape or stickers to denote this.					
	• Rooms/areas where PPE is removed must be decontaminated, timed to coincide with periods immediately after PPE removal by groups of staff (at least twice daily)	• Desks, keyboards, phones and tablets are cleaned every 2 hours in clinical areas reminders have been sent to Communications dept., Wards and Ward Clerks to highlight the importance of this					
2.7	• Linen from possible and confirmed COVID-19 patients is managed in line with PHE and other national guidance and the appropriate precautions are taken	• Correct procedures are in place for safe handling and removal of linen confirmed as COVID 19 possible contamination, using correct water soluble inner bag and correct outer bag. External laundry services provider confirmed their procedures for handling and washing, complies with the national guidance provided to them.			2359, 2387	IPC Matron Hotel Services Manager Deputy Director of Nursing	
		• Managed in line with PHE and laundry contractors' guidance.					
2.8	• Single use items are used where possible and according to Single Use Policy	• This includes cleaning cloths, mops, gowns, gloves, masks, and isolation materials / chemicals used. • This is present in the IPC Decontamination policy (NGH PC -870)			2359, 2387	IPC Matron Hotel Services Manager Deputy Director of Nursing	
2.9	• Reusable equipment is appropriately decontaminated in line with local and PHE and other national policy	• Equipment and plastic equipment including signage are all decontaminated using appropriate decontamination supplies.			2359, 2387	IPC Matron Hotel Services Manager Deputy Director of Nursing	

2.10	• Ensure the dilution of air with good ventilation e.g. open windows in admission and waiting areas to assist the dilution of air	• Individual risk assessments have been completed for all areas that have air conditioning units without mechanically supplied fresh air. The risk assessments include that the units must not be used without fresh air via opening windows. • Additional mechanical ventilation has been installed in a number of clinical areas to ensure sufficient air change rates. • Existing ventilation systems in clinical areas and theatre suites have been modified where required (with IPC guidance) to ensure the correct pressure regimes. • Risk assessments have been performed in conjunction with the Estates Manager and the Consultant Microbiologist for Ventilation			2359, 2387	IPC Matron Hotel Services Manager Deputy Director of Nursing	
Reference	**Key lines of enquiry**	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	**Risk(s) associated that are on Risk Register – Risk ID and title**	**Led By Whom**	**Date completed / RAG**
3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance							
3.1	Systems and process are in place to ensure: • Arrangements around antimicrobial stewardship are maintained	• An evidence based guideline has been published on the trust intranet: COVID-19 guideline: antibiotics for pneumonia in adults in hospital. In addition healthcare professionals are encouraged to promote the use of the 'Start Smart, then Focus' when prescribing antimicrobials.	Pharmacy cover is inconsistent across wards. Dedicated ward pharmacy service pilot on two wards showed benefit to antimicrobial stewardship [reducing course length;	Microbiology is available to be contacted regarding any stewardship advice. Current vacancies in	2359	Acting Chief Pharmacist	

		• Pharmacy provides a service on wards to offer antimicrobial stewardship advice [signposting to guidelines; advice on starting and stopping antimicrobials] to the multidisciplinary team. They are also contactable out of hours via the on-call system.	appropriate choice]; business case being submitted to support roll out to all wards. Only one Consultant Microbiologist	Pharmacy Antimicrobial team are being recruited to. Antimicrobial stewardship rounds are with a pharmacist only. Pharmacist is on the ward but contact via phone calls to the Consultant microbiologist. e-Referral available to Consultant microbiologist via the Infection Guidance page on intranet			
		• There are weekly C Diff Ward rounds with IPC Nurse and Antimicrobial Pharmacist and a Stewardship round with the antimicrobial Pharmacist and Consultant Microbiologist via phone support. These weekly ward rounds are shared by 3 antimicrobial Pharmacists to help maintain cover • Stewardship e-learning now mandatory training for all prescribers, nurses and pharmacists • IV to Oral antibiotic guidelines being produced to support antimicrobial stewardship					
	• Mandatory reporting requirements are adhered to and boards continue to maintain oversight	• All Covid results are automatically reported to PHE directly from the lab					
		• Antimicrobial Stewardship Group meets quarterly to review Stewardship, antimicrobial usage, governance issues and audit data					
Reference	**Key lines of enquiry**	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	**Risk(s) associated that are on Risk Register – Risk ID and title**	**Led By Whom**	**Date completed / RAG**
4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion							
4.1	Systems and processes are in place to ensure: • Implementation of national guidance on visiting patients in a care setting	• Visitors are not permitted aside from the exceptions in the national guidance; however we have deviated slightly in that we allow two visitors in cases of end-of-life care, as we felt it was important for the person visiting to have someone to support them. Guidance on this has been jointly written by the Trust's Palliative Care and IPC teams and PPE is provided as indicated.			2359, 2313	IPC Matron Deputy Director of Nursing Associate Director of Communications	

4.2	• Areas in which suspected or confirmed COVID-19 patients are where possible being treated in areas clearly marked with appropriate signage and have restricted access	• We are treating all patients as potentially positive so the above restrictions apply to all areas within the Trust.			2359, 2313	IPC Matron Deputy Director of Nursing Associate Director of Communications	
4.3	• Information and guidance on COVID-19 is available on all Trust websites with easy read versions	• Banner on home page of website with key links for information; separate sections for general advice; how we are re-opening services and media updates. Links to accessible advice made available by Sense around Coronavirus and links to Government website • On The Street, the trust's intranet, there is a clear link (red box) to information about coronavirus, including FAQs, processes, flowcharts, end of life care, basic and advanced life support; advice from the medical director; key contact numbers; links to health and wellbeing support; HR support; PPE; UK cases and latest figures; advice for NHS organisations and clinicians and healthcare worker guidance; also a document library. • Information & guidance available on the website with easy read versions • Signage for visitors is available at all hospital entrances and also at department entrances. This is also available on the trust intranet and face book page. • Visitors for exceptional circumstances are informed to wear a face covering to the ward and will be met at the ward entrance and given an advice sheet and a surgical mask (see above attachment)			2359, 2313	IPC Matron Deputy Director of Nursing Associate Director of Communications	
4.4	• Infection status is communicated to the receiving organisation or department when a possible or confirmed COVID-19 patient needs to be moved	• The Site team oversee all internal transfers between wards. COVID-19 results are sent directly to the Site team from the Microbiology department. These results are used to inform patient moves. • For external transfers the COVID status is reported to the receiving location e.g. care home.			2359, 2313	IPC Matron Deputy Director of Nursing Associate Director of Communications	
Reference	**Key lines of enquiry**	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	**Risk(s) associated that are on Risk Register – Risk ID and title**	**Led By Whom**	**Date completed / RAG**
5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people							

5.1	Systems and processes are in place to ensure: • 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	See answers in Section 1			2359, 2287, 2412, 2399, 2387, 2336, 2313	IPC Matron Consultant Microbiologist Lead Consultant, Emergency Department	
5.2	• Mask usage is emphasized for suspected individuals	• All clinical are required to wear a surgical mask at all times in the clinical environment. • Inpatients that are suspected or confirmed of having Covid are asked to wear a mask if they can tolerate this. • ED and OPD patients are all asked to wear a mask. • Advice on mask wearing for patients attending the hospital site available on trust website and at all entrances			2359, 2287, 2412, 2399, 2387, 2336, 2313	IPC Matron Consultant Microbiologist Lead Consultant, Emergency Department	
5.3	• Ideally segregation should be with separate spaces, but there is potential to use screens, e.g. to protect reception staff	• Outpatient departments have been reviewed by a Senior Member of the Estates team who has coordinated the fitting of Perspex screens to protect staff and ensure floor markings are in place throughout the trust. This has been done in areas such as outpatients, pharmacy, radiology, canteen, café.			2359, 2287, 2412, 2399, 2387, 2336, 2313, 2362	IPC Matron Consultant Microbiologist Lead Consultant, Emergency Department	
5.4	• For patients with new onset symptoms, it is important to achieve isolation and investigation of contact tracing as soon as possible	• Any patient who tests positive in the trust will be moved immediately into an isolation room or a cohorted bay. The contacts of that patient will be reviewed by the IPCT with the Consultant Microbiologist, to monitor for signs and symptoms and be re-swabbed after 7 and 14 days, to ensure they do not have the virus. • We check with the staff contacts that they have been PPE complaint and so not required to self-isolate for 14 days if have been complaint. • PHE will be automatically notified of all patient results and will commence track and trace.			2359, 2287, 2412, 2399, 2387, 2336, 2313	IPC Matron Consultant Microbiologist Lead Consultant, Emergency Department	

5.5	• Patients with suspected COVID-19 are tested promptly	See answers in Section 1 • We are committed to getting in-house covid testing up and running asap to protect all our patients and staff, and aim to confirm covid status within 3-7 hours.			2359, 2287, 2412, 2399, 2387, 2336, 2313	IPC Matron Consultant Microbiologist Lead Consultant, Emergency Department	
5.6	• Patients that test negative but display or go on to develop symptoms of COVID-19 are segregated and promptly re-tested and contacts traced	• An algorithm based on both PHE and RCP guidance has been developed and shared with clinical and site teams. This shows the processes to follow regarding patient isolation and testing when this situation arises. In summary, patients are promptly isolated and tested.			2359, 2287, 2412, 2399, 2387, 2336, 2313	IPC Matron Consultant Microbiologist Lead Consultant, Emergency Department	
5.7	• Patients that attend for routine appointments who display symptoms of COVID-19 are managed appropriately	• Patients are advised in their appointment letters not to attend if they have symptoms of COVID-19. Patients attending have their temperatures checked and are asked if they have any symptoms. Patients who display symptoms are advised to isolate at home as per national guidance. The Trust has continued with a number of Outpatient clinics 'virtually' as appropriate.			2359, 2287, 2412, 2399, 2387, 2336, 2313	IPC Matron Consultant Microbiologist Lead Consultant, Emergency Department	
Reference	**Key lines of enquiry**	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	**Risk(s) associated that are on Risk Register – Risk ID and title**	**Led By Whom**	**Date completed / RAG**
6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection							
6.1	Systems and processes are in place to ensure: • All staff (clinical and non-clinical) have appropriate training, in line with latest PHE	See answers in Section 1.4	Not all staff have had relevant training.	The IPC team visit wards daily and clarify any misconceptions, providing reassurance	2359, 2287, 2300	IPC Matron Specialist Engineering Maintenance Manager Learning &	

	and other guidance, to ensure their personal safety and working environment is safe	• As part of the Trust management of the pandemic there has been proactive support for staff to 'Work from Home' and are preparing 'Social Distancing' guidance for staff working in the clinical & non-clinical environment.		regarding the appropriate use of PPE. IPC team to continue training of staff that is recorded monitored by L&D Ongoing auditing of PPE use and training is supported by the IPC Team		Development Manager Hotel Services Manager	
6.2	• All staff providing patient care are trained in the selection and use of PPE appropriate for the clinical situation and on how to safely don and doff	See answers in Section 1.4 • The IPCT has developed staff competencies for donning and doffing PPE and is currently rolling this out across the Trust. • Donning and doffing video available on trust website; posters on how to wear masks provided; information promoted via daily briefings	Not all staff have had relevant training.	The IPC team visit wards daily and clarify any misconceptions, providing reassurance regarding the appropriate use of PPE. IPC team to continue training of staff that is recorded monitored by L&D Ongoing auditing of PPE use and training is supported by the IPC Team	2359, 2287, 2300	IPC Matron Specialist Engineering Maintenance Manager Learning & Development Manager Hotel Services Manager	
6.3	• A record of staff training is maintained	• Up to date record of annual training updates is maintained by HR. • Trust induction also covers PPE usage. • The IPCT have visited wards daily and given informal training and advice when improvements are required.			2359, 2287, 2300	IPC Matron Specialist Engineering Maintenance Manager Learning & Development Manager Hotel Services Manager	
6.4	• Appropriate arrangements are in place that any reuse of PPE in line with the CAS alert is properly monitored and managed	• The Trust has sufficient stock & supply of PPE so have not had to implement any re-use of PPE. We took a clear view that this guidance was not supported by the trust in relation to disposable items.			2359, 2287, 2300	IPC Matron Specialist Engineering Maintenance Manager Learning & Development Manager Hotel Services Manager	

6.5	• Any incidents relating to the re-use of PPE are monitored and appropriate action taken	• The Trust has sufficient stock of PPE so have not had to implement any re-use of PPE.			2359, 2287, 2300	IPC Matron Specialist Engineering Maintenance Manager Learning & Development Manager Hotel Services Manager	
6.6	• Adherence to PHE national guidance on the use of PPE is regularly audited	• PPE audits have been completed and inputted on an internal dashboard			2359, 2287, 2300	IPC Matron Specialist Engineering Maintenance Manager Learning & Development Manager Hotel Services Manager	
6.7	• Staff regularly undertake hand hygiene and observe standard infection control precautions	• Ward audits are submitted monthly. Validation audits are usually performed three-monthly by the IPC team, in high risk areas these are been performing twice monthly. The IPCT conducted hand hygiene audits in all wards in June. Feedback has been given to Ward Sisters and Managers.			2359, 2287, 2300	IPC Matron Specialist Engineering Maintenance Manager Learning & Development Manager Hotel Services Manager	
6.8	• 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 on hand hygiene, including drying, should be clearly displayed in all public toilet areas as well as staff areas	• All air hand driers have been electrically isolated by the Estates department and paper towel hand dispensers have been installed instead • The 6 steps of hand hygiene are displayed on all the soap and foaming sanitiser dispensers in all staff and Public areas • The tissue viability / infection prevention nurse has visited all wards, focusing on wards where FFP3 use is high, discussing hand and face care, advising on creams and methods of skin care.			2359, 2287, 2300	IPC Matron Specialist Engineering Maintenance Manager Learning & Development Manager Hotel Services Manager	

		• As part of the trust wide Assessment & Accreditation the IPC standard (standard 5) has been enhanced and is now in placed across the Trust where self and peer/leadership assessment is in place monthly. A joint review by trust A&A Lead & IPC was undertaken during June 2020, see section 1					
6.9	• Staff understand the requirements for uniform laundering where this is not provided for on site	• Those staff that laundered uniforms off site have been instructed of the necessary washing requirements. • The Trust has also received many donated linen bags for staff to use to transport their uniforms home to wash as advised. • This has been supported with advice and guidance for uniform laundering provided in daily briefing			2359, 2287, 2300	IPC Matron Specialist Engineering Maintenance Manager Learning & Development Manager Hotel Services Manager	
6.10	• 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 display any of the symptoms.	• Guidance sent to all staff via Communications team and displayed on Trust intranet. Frequently asked questions around this are listed and answered on the Trust intranet by our HR team and supported through the trust daily Communications Briefing. We also communicate this information to those without intranet facilities.			2359, 2287, 2300	IPC Matron Specialist Engineering Maintenance Manager Learning & Development Manager Hotel Services Manager	
Reference	**Key lines of enquiry**	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	**Risk(s) associated that are on Risk Register – Risk ID and title**	**Led By Whom**	**Date completed / RAG**
7. Provide or secure isolation facilities							

7.1	Systems and processes are in place to ensure: • Patients with suspected or confirmed COVID-19 are isolated in appropriate facilities or designated areas where appropriate • Areas used to cohort patients with suspected or confirmed COVID-19 are compliant with the environmental requirements set out in the current PHE national guidance • Patients with resistant/alert organisms are managed according to local IPC guidance, including ensuring appropriate patient placement	See answers to Section 1, section 2, section 5.4			2359, 2412, 2313	IPC Matron Specialist Engineering Maintenance Manager	
Reference	**Key lines of enquiry**	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	**Risk(s) associated that are on Risk Register – Risk ID and title**	**Led By Whom**	**Date completed / RAG**
8. Secure adequate access to laboratory support as adequate							
8.1	There are systems and processes in place to ensure: • Testing is undertaken by competent and trained individuals • Patient and staff COVID-19 testing is undertaken promptly and in line with PHE and other national guidance	• SARS-CoV-19 molecular testing is undertaken in-house by qualified Biomedical Scientist under the supervision of the Microbiology Consultants. • The Trust follow PHE guidance on testing all patients on admission (symptomatic and asymptomatic). • All inpatient suspected cases are tested. Any suspicion of other co-infections is tested as required	No gaps identified but microbiology service has been moved to 24/24 creating the need for more qualified biomedical scientist and plans are in place for recruiting more staff.		2359, 2287, 2385	Consultant Microbiologist	

	• Screening for other potential infections takes place	• We are isolating our patients with symptomatic infections, including c.diff; we are continuing our HOHA/COHA surveillance and post infection reviews. • Our isolation process has been challenging but the IPC team are working closely with the Site team to isolate patients promptly.					
Reference	**Key lines of enquiry**	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	**Risk(s) associated that are on Risk Register – Risk ID and title**	**Led By Whom**	**Date completed / RAG**
9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections							
9.1	Systems and processes are in place to ensure that: • Staff are supported in adhering to all IPC policies, including those for other alert organisms	• Policies are shared through various forums across the Trust and supported by IPC team to understand & implement. The Trust has 'NetConsent' on the intranet to enable staff to review each policy/guidance prior to accessing Outlook.			2359, 2287, 2444, 455	IPC Matron Hotel Services Manager Procurement	
	• Any changes to the PHE national guidance on PPE are quickly identified and effectively communicated to staff	• Comms. Daily briefing provide updates and are supported by different media methods. Daily briefings for staff include information about any changes in guidance; information also promoted via social media and trust closed Facebook community • This is re-enforced through the Bronze, Silver & Gold meetings.					
	• All clinical waste related to confirmed or suspected COVID-19 cases is handled, stored and managed in accordance with current national guidance	• Due to the increase of clinical waste additional facilities have been provided around the Trust that are monitored by the Domestic staff and supported by the IPC team.					

	• PPE stock is appropriately stored and accessible to staff who require it	• Update on all stores (PPE) are provided as part of the internal management of the pandemic (Silver Meeting update from Bronze work streams) • PPE stock is stored at department level and supplied from the Trusts' main bulk stock. PPE is replenished directly to clinical areas by the supplies team or on demand as required. An 'Out of Hours' store is maintained and accessible via the site team. Stock is checked daily and any risks are identified and escalated to Silver command as appropriate.					
Reference	**Key lines of enquiry**	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	**Risk(s) associated that are on Risk Register – Risk ID and title**	**Led By Whom**	**Date completed / RAG**
10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection							
10.1	Appropriate 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	• Covid Risk assessments currently being completed by managers – including BAME risk assessments. Managers contacting OH Department for support with mental wellbeing through referrals to Health Psychologist and for advice regarding workplace adjustments • Risk assessments sent to OH for records and priority or highlighted ones contacted to discuss further and to provide support and guidance • Having completed an initial self-assessment those staff that indicate that they wish to have a full risk assessment, have one carried out by their Manager following the HR guidelines. • Risk assessment forms are sent to OH department where they are screened by a qualified OH professional.	• Manager not completing the Risk Assessment and returning to OH • Some managers not addressing psychological impact of shielding on the employee. Expectations are not being met and the practical terms are only being addressed	• Numbers of staff within each directorate that have been approached by their manager in accordance with the At Risk guidelines are monitored and in the event of non-completion are followed up.	2359, 2287, 2412, 2405, 2336, 2387, 2313, 2386	Occupational Health Manager Deputy Director of Nursing IPC Matron	

10.2	• Staff required to wear FFP reusable respirators undergo training that is compliant with PHE national guidance and a record of this training is maintained	• IPC team provide training and maintain a record of those who have received training.			2359, 2287, 2412, 2405, 2336, 2387, 2313, 2386	Occupational Health Manager Deputy Director of Nursing IPC Matron	
10.3	• 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	• Telephone contact is made to determine the individual's health needs. Advice on workplace adjustments and or psychological support is provided. Advice is provided to the employees manager to support their return to work. • Access to the SOS help-line is also provided to staff (SOS leaflet and numbers of those that accessed the service attached) • Prioritised and at the request of manager due to volume received. • Reports are sent to HR on numbers of types of risk assessments received and reviewed.	• New staff are not routinely risk assessed in the way the guidance describes		2359, 2287, 2412, 2405, 2336, 2387, 2313, 2386	Occupational Health Manager Deputy Director of Nursing IPC Matron	
10.4	• All staff adhere to national guidance on social distancing (2 metres) wherever possible, particularly if not wearing a facemask and in non-clinical areas	• The Zoning policy and SOP for each area will explain and support the management of the staff across each 'zone'. There is clear criteria for how and when staff can be moved in exceptional circumstances. • Social distancing is reinforced through the use of floor markers, Comms bulletins and through good practice. Risk assessments (see section 5) are completed to assess risks and identify where improvements can be made, i.e. in staggering breaks to reduce numbers of staff in tea rooms. • New signage installed across the trust reminding people of 2 metre social distancing requirement; floor and wall markings in lifts and on tables in restaurant areas	Zoning policy is in final draft		2359, 2287, 2412, 2405, 2336, 2387, 2313, 2386	Occupational Health Manager Deputy Director of Nursing IPC Matron	
10.5	• Consideration is given to staggering staff breaks to limit the density of healthcare workers in specific areas	• Wards arrange breaks to manage social distancing in staff rooms. Some areas have additional staff rooms (day / visitors rooms).			2359, 2287, 2412, 2405, 2336, 2387, 2313, 2386	Occupational Health Manager Deputy Director of Nursing IPC Matron	
10.6	• Staff absence and well-being are monitored and staff who are self-isolating are supported and	• Daily reports are produced from rostering system to monitor numbers of staff that are absent due to a covid related reason.	Managers not recording absence correctly on the roster system		2359, 2287, 2412, 2405, 2336, 2387,	Occupational Health Manager	

	able to access testing	• Staff that are self-isolating due to being symptomatic are able to contact a swabbing team that arranges testing through the Occupational Health Department on a daily basis. • SOS is ongoing. This service is available to people returning to work. • OH contact all staff who have tested positive either through the internal swabbing system or the government route, and these staff are advised on self-care and return to work plans. • OH telephone support line set up for out of hours. OH has been manned over weekends for results and support. Self-isolating staff contacted by OH for welfare call on receipt of list from HR. The line-manager is also engaged to provide support to their individual staff.			2313, 2386	Deputy Director of Nursing IPC Matron	
10.7	• Staff that test positive have adequate information and support to aid their recovery and return to work.	• OH contacting positive staff with their results and advising on their return to work. Symptomatic staff also contacted to inform of result so return to work can take place if able and to provide suitable advice, guidance and support as required.			2359, 2287, 2412, 2405, 2336, 2387, 2313, 2386	Occupational Health Manager Deputy Director of Nursing IPC Matron	

The BAF management process

The Infection Prevention Steering Group (IPSG) is responsible for managing the IPC BAF.

The process for routine review and update of the IPC BAF is as follows:

- The IPC BAF improvement plan will be monitored through IPSG
- The corporate risk register is maintained, in accordance with the Risk Management Policy
- The IPC BAF is updated with any changes to those corporate risks recorded within it; the IPSG decides which corporate risks are significant enough to warrant inclusion on the IPC BAF.
- The IPSG identifies any gaps in primary controls or assurance and ensures there are appropriate plans in place to address them , through the improvement plan
- The IPSG decides on an assurance rating for each required outcome, based on evidence provided in identified sources of assurance

When deciding on the assurance rating for each outcome the following key should be used:

Red = **Not assured**. The Steering Group has reviewed the available evidence and is not satisfied that risks to this objective are being managed effectively
Amber = **Inconclusive**. There are gaps in assurance that prevent the Steering Group from determining whether or not risks to this objective are being managed effectively
Green = **Assured**. The Committee has reviewed t-1he available evidence and is satisfied that risks to this objective are being managed effectively

Report To	**Public Trust Board**
Date of Meeting	**24 September 2020**

Title of the Report	Developing an Academic Strategy-Progress Update
Agenda item	**12**
Presenter of Report	Mr Matthew Metcalfe Medical Director
Author(s) of Report	Karen Spellman Deputy Director of Strategy and Partnerships

This paper is for: (delete as appropriate)

☐ Approve	☐ Receive	x Note	☐ Assurance
To formally receive and discuss a report and approve its recommendations OR a particular course of action	To discuss, in depth, a report noting its implications for the Board or Trust without formally approving it	For the intelligence of the Board without the in-depth discussion as above	To reassure the Board that controls and assurances are in place

Executive summary

This paper summarises the progress to date in developing our Academic Strategy ahead of the finalised strategy being presented to Board in November 2020.

The Academic Strategy will be a key strategic initiative and programme of work to deliver the Group vision, values and goals. It will set out how we aim to become an exemplar education and training provider underpinned by excellence in research and innovation.

It is widely recognised that organisations with a reputation for providing excellence in education and research attract and retain high quality staff impacting positively on the delivery of patient care.

We plan to build on our existing capacity and capability and to develop the Group as University Teaching Hospitals. There are a number of requirements that have to be met in order to achieve this and a summary of these are included in the paper.

Related Strategic Pledge	Which strategic pledge does this paper relate to? 1. *We will put quality and safety at the centre of everything we do* 2. *Deliver year on year improvements in patient and staff feedback* 3. *Create a sustainable future supported by new technology* 4. *Strengthen and integrate local clinical services particularly with Kettering General Hospital* 5. *Create a great place to work, learn and care to enable*

	excellence through our people *6. Become a University Hospital by 2020 becoming a centre of excellence for education and research* *(Delete as applicable)*
Risk and assurance	Does the content of the report present any risks to the Trust or consequently provide assurances on risks:
Related Board Assurance Framework entries	BAF – please enter BAF number(s)
Equality Analysis	Is there potential for, or evidence that, the proposed decision / document will not promote equality of opportunity for all or promote good relations between different groups? If yes please give details and describe the current or planned activities to address the impact. Is there potential, for or evidence that, the proposed decision / document will affect different protected groups/characteristics differently (including possibly discriminating against certain groups/protected characteristics)? If yes please give details and describe the current or planned activities to address the impact.
Financial Implications	Listed within the paper
Legal implications / regulatory requirements	Are there any legal/regulatory implications of the paper: Compliance with the national planning framework and contribution to the system control total

Actions required by the Board

The Board is asked to:

- The Trust Board are asked to note the progress in developing a Group Academic and Research Strategy together with the requirements to be delivered to become a university teaching hospitals.

Developing an Academic Strategy
Progress Update

1 Introduction

The Academic Strategy will be a key strategic initiative and programme of work to deliver on the Group vision, values and goals. Through enhancing and developing our multi-disciplinary academic offer and increased research portfolio we aim to create an exemplar education and training system that is evidence based and underpinned by research and innovation. It is widely recognised that organisations with a reputation for providing excellence in education and research attract and retain high quality staff impacting positively on the delivery of patient care.

We plan to build on our existing capacity and capability and to develop the Group as University Teaching Hospitals. There are a number of requirements that have to be met in order to achieve this and progress against these is summarised in the paper. The Department of Health and University Hospital Association (UHA) specify that any NHS trusts seeking to include the word 'university' in its title will be required to have applied for UHA membership and for UHA to have agreed the terms of membership have been met. Whilst the governance for name changes is different for NHS foundation trusts it is recommended that the same standards as NHS trusts are applied.

This paper summarises the progress to date in developing our Academic Strategy ahead of the finalised strategy being presented to Board in November 2020.

2 Principles of developing an academic strategy

The strategy will set out how the academic departments will be strengthened and coordinated to support our ambition of becoming university teaching hospitals by ensuring we integrate research, innovation and education into multi-disciplinary training and education and invest in our staff and facilities.

The key principles of developing an academic strategy are to;

- Collaborate and co-operate between NGH, KGH, University of Leicester and University of Northampton and other research and education departments to develop Northants University Teaching Hospitals

- Strengthen existing partnerships to complement and further develop clinical education and health sciences research to support the needs of clinical medicine across the Trusts

- Develop the workforce to support the ambition to become university teaching hospitals to include associated professor posts in collaboration with University of Leicester and KGH/NGH

- Develop excellence in integrated multidisciplinary clinical education at undergraduate and postgraduate levels

- Facilitate the increase in medical student numbers within the School of Medicine by NGH and KGH providing additional undergraduate teaching

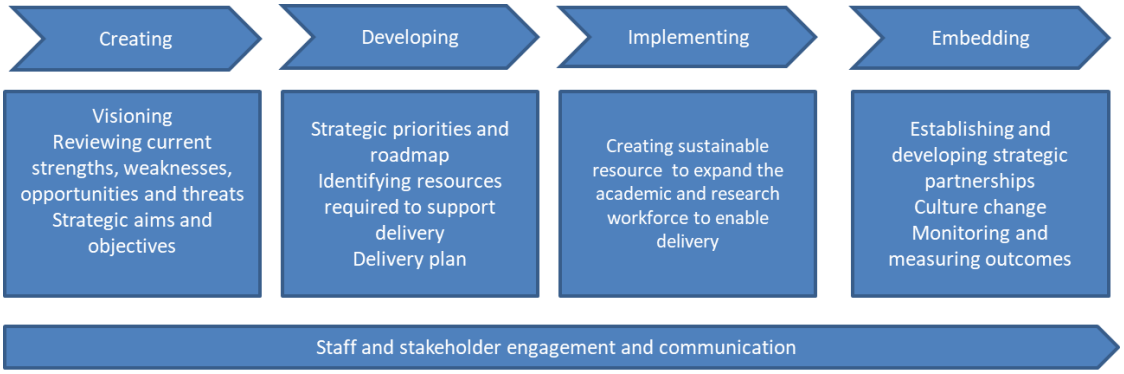
opportunities including significantly more ward based apprenticeship opportunities

- Improve student experience, new recruitment and retention of medical, nursing, allied health professions and scientific staff
- Maximise innovation and research opportunities by appointing a Senior Clinical Professor across the group
- Improved clinical outcomes associated with increased multidisciplinary clinical education and increased research activity

3 Engagement

We recognise that inclusive and meaningful stakeholder engagement is essential in order to embed a culture of multidisciplinary education supported by excellence in research and development. We have identified and mapped all relevant partners and stakeholders to ensure there is a continuous engagement programme and we have aligned priorities and policies.

Figure 1 sets out our pathway for delivering and implementing the strategy and ensuring ongoing stakeholder engagement and communication.



An initial visioning workshop was held with key stakeholders from KGH and NGH on the 11th September. Figure 2 below illustrates the key words suggested when thinking about a vision for the academic strategy.

Wider engagement in developing and finalising the vision will include a survey monkey to reach our internal and external stakeholders.

4 Benefits of delivering an Academic Strategy

There is a clear association between research, innovation and supporting education and training to improve clinical outcomes and patient experience. The strategy will set out our ambition to grow and develop a sustainable, flexible, multi-disciplinary work force delivering improved outcomes for our patients. The following summarises the some of the key benefits to developing and delivering an academic strategy.

Domain	Benefits
Patients	• Improved patient care and experience • Patient involvement in research leading to improved outcomes • Novel treatments in research delivered trials • Upskilled multi-disciplinary teams resulting in improved patient care • Development of specialised services • Centre of excellence locally delivered
Quality	• Enhanced patient safety and improved patient outcomes • Evidence based care delivery and outcomes • Access to alternative and cutting edge treatments • Promoting a culture of innovation and quality improvement • Research active organisation leading to improved patient care
Systems and Partnerships	• Enhanced reputation and system partnership working improving recruitment and retention across the system • Opportunities for developing specialist services and networks to deliver care locally in partnership with other centres • Multi-disciplinary education and research teams across the system
Sustainability	• Improved staff retention resulting in improved clinical and financial sustainability • Innovation attracting additional resources and funding • Reputational benefits • Increased participation in clinical trials leading to increased clinical reputation and sustainability
People	• Improved recruitment and retention of high calibre staff • Motivation, opportunities to develop and progress • Developing and building future leaders, succession planning and opportunity to expand roles • Pride in the organisation and ambition to provide

	excellence in research and education • Multi-disciplinary training building teams and relationships for the future

5 Key steps and progress to date

A work programme led by the Medical Directors of KGH and NGH has been established to ensure delivery at pace and scale. The following summarises the key actions to be implemented to date.

Work stream	Key actions (supported by detailed implementation plans)	Timescales	Progress
Governance	Establish governance structure for programme; Steering Group, Operational Group, programme management support and reporting	August 2020	In place
Academic Strategy	Complete Academic and Research Strategy to include framework for collaboration across the Group and the Universities.	November 2020	On track
Engagement	Stakeholder mapping, visioning and strategic priority engagement sessions to develop strategy. Ongoing engagement in implementation	November 2020	Visioning session carried out Further strategic priority and milestone planning session planned. Survey monkey planned
Partnerships	Develop partnerships and identify and establish leads from KGH/NGH/UoL/UoN Formalise partnership agreement and memorandum of understanding	December 2020	On track
Academic Posts	Review academic structure, agree and cost up new structure, appoint to new posts; Senior Academic Manager, Senior Clinical Professor, Associate Professors, Research Fellow, Clinical Fellows	August-April 2021	Academic Associate Director appointed AP JDs being agreed and finalised
Clinical Education	Review academic and teaching structures to include Medical, QI, Nursing, AHP and additional resource required to support development of Academic Hub. Develop plans to accelerate multi-disciplinary education programme. Develop clinical education prospectus and review opportunities to develop additional PG cert courses and advanced practitioner courses	September 2021	Head of Academic Programmes appointed
Research & Development	Stock take and review current portfolios and resources. Develop plans to expand research trials. Joint R&D programmes developed between the partners to increase breadth and depth of studies and associated income. Develop academic research framework and programme in collaboration with the universities	September 2021	On track

Facilities	Review existing R&D and academic estate across the two Trusts to develop Academic Hub to include branding and signage To include medical students/nursing accommodation block	September 2021	Plans to be prioritised as part of the strategy development

6 Financial investment

A key challenge and risk to delivery highlighted by stakeholders is the investment required. It has to be recognised that if we are to build our academic and research reputation and be successful at both pace and ambition, there will need to be significant investment in the programme. We will require a shift in mind set from assessing short term gains to longer term benefits and return on investment.

There will be a robust process of evaluation and benefits realisation monitoring of any investments made to ensure value for money and delivery of the anticipated benefits.

A full business case will be developed and presented to Board in November in order to support the strategy implementation.

7 University Hospital Association requirements

The University Hospital Association (UHA) is the unified voice of university hospitals. They are a national forum that brings together experts and organisations to share best practice and translate research, education and experience to shape government policy.

They recognise that identifying an NHS provider as having teaching and/or university status denotes it as an important national teaching and research resource and helps its ability to recruit and retain the best staff.

The UHA therefore sets out specific criteria that are to be met and evidenced in order for an NHS trust to consider including the word ‘university’ in its name. These requirements include formal governance arrangements with a partner university and a memorandum of understanding to include joint working, joint academic and research strategic plans and joint associate professor posts.

There will need to be evidence of significant research activity within the Trust much of which will involve collaboration with university staff. This is to include a core number of university principle investigators (minimum of 10 university staff with honorary contracts) to be based on site, REF returnable research and an average of at least £100k research capability funding over the previous two years.

The Trust will have to demonstrate to the university that it provides high quality clinical education that is evidenced.

Both Trusts have some considerable strengths in delivering the criteria and a full gap analysis and SWOT analysis is being completed as part of the strategy and supporting implementation plan development.

Detail of the criteria are in include din Appendix 1.

8 Recommendations

The Trust Board are asked to note the progress in developing a Group Academic Strategy together with the requirements to be delivered to become a university teaching hospitals.

Appendix 1 University Hospitals Association Registration and Compliance Requirements

Item	Requirement	Current Status
DOH Approval	• Written recommendation from the University confirming the Trust meets the key principles	• To be provided by University of Leicester and University of Northampton by June 21
Research	• Joint MOU with the University on Joint Working for Effective Clinical Governance. This shall need to be updated to include KGH. • Demonstration that the Trust shall work collaboratively and develop an agreed joint research strategy • Evidence of significant research activity within the Trust, involving collaboration with University staff, including a) a core number of University principal investigators (minimum of 10 University staff with honorary contracts) to be based on site • The research output to be REF returnable • An average Research Capability Funding of at least £100k average p.a. over the last 2 years	• MoU in place between NGH and UoL-to be updated to reflect Group Model and revised Academic Strategy to include an ambitious research programme. • Research programme to be developed to meet requirements. Research requirements currently not met • Job descriptions for 6 Associate Professor posts in development with the UoL
Strategic Links and working Relationship	• University representation on the Trust's Local Awards Committee for considering nominations for Clinical Excellence Awards • University representation on the Trust's Advisory Appointment Committee for consultant posts • Board membership of a Non-Executive Director from the Faculty • Trust's CEO to attend formal meetings with the Faculty Dean's Advisory Committee	• University representative on NGH Board, consultant interviews and CEA awards. To de developed across the Group model • CEO to attend formal meetings with Faculty Dean at UoL
University Practice Placements	• University placements should be in place for undergraduate medical students and students from at least one other profession	• In place across both NGH and KGH

IT & Teaching Facilities	• The Trust shall provide appropriate library facilities, IT facilities with internet access and teaching facilities	• In place
Lead Placement Contact	• The Trust shall have a Lead Placement Contact approved by the Faculty of Medicine to be responsible for medical education for all professions for which it provides placements.	• In place
High Quality Clinical Education	• Trust to demonstrate to the University that it provides high quality education regarding flexibility for changing needs of the Faculty	• Evidence of student satisfaction and quality of education to be assessed by DMEs
Human Resources	• Trust staff ability to deliver curriculum and assessments as per the requirements of the Faculty • Provision of appropriate human resources to include student supervision for a range of professions and grades • Participation by core Trust teaching staff in appropriate training	• Evidence across Group to be collated in collaboration with UoL
Collaborative Working Partnership	• Availability of Trust staff to provide teaching and supervision and respond to student queries in a timely manner. • Collaboration between University and Trust staff regarding curriculum development • Monitoring and evaluation of quality of education provision and to facilitate student evaluation • Trust to readily provide timely response to students and the Faculty • Evidence of action of Trust on Faculty quality assurance measures	• Evidence across Group to be collated in collaboration with UoL
Resources	• Provision of appropriate support staff, equipment and accommodation for Lead Placement Contracts • Access to lockers and appropriate facilities	• Evidence across Group to be collated. Facilities for clinical education and student accommodation to be developed further across both sites

English Trust Compliance Regulations	• Learning and Development between the Trust and Health Education England • Service Level Agreement between the Trust and Faculty	• Evidence across Group to be collated • SLA not in place
Miscellaneous	• Requirement to have a Non-Executive Director from the Medical School	• In place at NGH - Option to be extended to cover Group to be developed

Report To	**Public Trust Board**
Date of Meeting	**24th September 2020**

Title of the Report	**Safeguarding Annual Report 2019-2020**		
Agenda item	**13**		
Presenter of Report	Sheran Oke, Director of Nursing, Midwifery and Patient Services		
Author(s) of Report	Tracy Keats, Head of Safeguarding and Dementia		
This paper is for: (delete as appropriate)			
□ Approve	□ Receive	□ Note	X□ Assurance
To formally receive and discuss a report and approve its recommendations OR a particular course of action	To discuss, in depth, a report noting its implications for the Board or Trust without formally approving it	For the intelligence of the Board without the in-depth discussion as above	To reassure the Board that controls and assurances are in place

Executive summary

The purpose of the safeguarding annual report is to inform Trust board members of the progress with regard safeguarding responsibilities across the organisation. This report acknowledges safeguarding activity within the Trust, raises awareness of key issues affecting practice and service delivery, and identifies key priorities for the coming year (2020-2021).

Related Strategic Pledge	Which strategic pledge does this paper relate to? *1. We will put quality and safety at the centre of everything we do*
Risk and assurance	Assurance that there are safeguarding controls in place as per national guidance for NHS providers
Related Board Assurance Framework entries	BAF – 1.1, 1.2
Equality Analysis	Is there potential for, or evidence that, the proposed decision / document will not promote equality of opportunity for all or promote good relations between different groups? (N) If yes please give details and describe the current or planned

	activities to address the impact. Is there potential, for or evidence that, the proposed decision / document will affect different protected groups/characteristics differently (including possibly discriminating against certain groups/protected characteristics)? (N) If yes please give details and describe the current or planned activities to address the impact.
Financial Implications	Nil
Legal implications / regulatory requirements	Human Rights Act (1998) Equality Act (2010) Children's Act (2004) Care Act (2014) Mental Capacity Act (2005) Deprivation of Liberty Safeguards (2009)

Actions required by the Trust Board

The Board is asked to note the report

UNIVERSITY OF LEICESTER
Associate Teaching Hospital

NHS
Northampton General Hospital
NHS Trust

SAFEGUARDING ANNUAL REPORT

2019-2020

TRACY KEATS, HEAD OF SAFEGUARDING AND DEMENTIA
LORRAINE HUNT, NAMED NURSE FOR SAFEGUARDING ADULTS
SUE MCCRAE-SAMUEL, NAMED NURSE FOR SAFEGUARDING CHILDREN
RHEO SMITH, NAMED MIDWIFE

JULY 2020

UNIVERSITY OF LEICESTER
Associate Teaching Hospital

NHS
Northampton General Hospital
NHS Trust

CONTENTS

Executive Summary

1. Northampton General Hospital NHS Trust is committed to ensuring safeguarding is part of its core business and recognises that safeguarding children, young people and adults at risk is a shared responsibility with the need for effective joint working between partner agencies and professionals. This annual report outlines how the safeguarding service is performing and promoting best practice. The report provides an update on safeguarding priorities during 2019/20 and identifies safeguarding key issues, risks and priorities for 2020/21.

2. The Safeguarding Assurance Group (SAG) is a strategic meeting responsible for disseminating and monitoring information from Northamptonshire Safeguarding Adult's Board (NSAB) and Northamptonshire Safeguarding Children's Partnership (NSCP). In turn as a partner agency, the Trust provides challenge and scrutiny to both the NSAB and the NSCP via the Clinical Commissioning Group (CCG) as one of the statutory partners, as this is an essential part of working together to keep children, young people and adults at risk safe.

3. There are three safeguarding 'active' risks on the Trust risk register which relate to: general governance processes in line with adult and children safeguarding external to the Trust, unauthorised Deprivation of Liberty Safeguards (DoLS) applications and safeguarding training compliance.

4. Safeguarding training meets the national standards as identified in the revised children's and adult's Intercollegiate Guidance.

5. There has been two Safeguarding Adult Reviews (SARs) and three Safeguarding Children Practice Reviews (SCPR's) published within this reporting period. NGH have completed Individual Management Reports (IMR's) to all reviews apart from one which was focussed in the north of the county. All requests for information or to become panel members have been responded to in a timely manner.

6. There is a statutory duty for the Trust to comply with Domestic Homicide Reviews (DHR's). There has been one DHR published during the reporting period. There are three reviews awaiting final ratification from the Home Office. The Trust contributed to the published review. All requests for information to potential DHRs have been completed in a timely manner.

7. The was not brought, approved visitors, children's safeguarding supervision and missing patients policies have been revised during the reporting period.

8. Deprivation of Liberty Safeguards (DoLS) applications in the Trust increased in 2019/20. There have been 560 DoLS applications in the Trust during the reporting period against 455 in 2019/20.

9. 2019-20 has been a challenging time for the safeguarding team. The maternity safeguarding team in particular has had to concentrate on working with Northamptonshire children's services to ensure that the appropriate level of intervention/support was obtained for women and their families.

1.0 Introduction

1.1 This annual report reflects the arrangements to safeguard and promote the welfare of children, young people and adults at risk within Northampton General Hospital NHS Trust for the period of April 2019 to March 2020. The report concentrates on the key safeguarding activity and risks within the organisation. In doing so, the Trust discharges part of its responsibility for Board-level assurance, scrutiny and challenge of safeguarding practice within the Trust, in line with the statutory requirements of section 11 Children Act (2004), Working Together to Safeguard Children (2018), the Mental Capacity Act 2005 and the Care Act 2014.

1.2 In addition to the requirements of the Children's Act 2004, the Trust, as a registered provider with the Care Quality Commission (CQC), must have regard for the Regulations as established under the Health and Social Care Act (2008). In relation to Safeguarding, including but not limited to, Regulation 13 and Regulation 17, relating to protecting service users from abuse and robust governance, respectively.

1.3 The Accountability and Assurance Framework (NHS England 2019) sets out the safeguarding roles, duties and responsibilities for all NHS organisations and this report reflects the integrated safeguarding portfolio. The report is arranged sequentially under safeguarding adults, safeguarding children and safeguarding within maternity services.

2.0 National

2.1 Safeguarding is a complex area of practice. The potential patient group is wide ranging from people able to self-care to those who are experiencing a short term illness or a long term disability. Abuse can happen in any context and takes many forms, some of which may not be obvious. Therefore it is essential that the Trust continues to promote the importance of safeguarding for our patients and community.

2.2 Child exploitation/sexual exploitation, modern slavery, gangs and Prevent have continued to be priority work streams highlighted either by central government or by national publication. The safeguarding team have revised their training programmes to highlight these themes for frontline staff and this has included a range of external speakers.

3.0 Local Context

3.1 Northampton General Hospital is a key partner agency for safeguarding within the county. This is achieved by:

- A strong robust safeguarding team across the whole organisation including maternity, paediatrics and adults. This is further complimented by the Mental Health and Mental Capacity Lead Practitioner, the Dementia Liaison Nurse and the Learning Disability Liaison Nurse as part of the wider team covering key vulnerable groups.
- Membership of Northamptonshire Safeguarding Adults Board (NSAB) and sub-groups of both the NSAB and the Northamptonshire Safeguarding Children's Partnership (NSCP)
- Membership of the Northamptonshire Strategic Health Safeguarding Forum
- Participation of the multi-agency audits from both the NSAB and NSCP and ensuring that internal audits are in place to respond to national and local trends
- Active contribution to Safeguarding Adult Reviews (SAR's) and Safeguarding Children Practice Reviews (SCPR's)
- Active contribution to Domestic Homicide Reviews (DHR's) with the associated Community Safety Partnership

- Active participation at complex safeguarding meetings and arranging discharge planning meetings with multi-agency participation
- Attendance and dissemination of information at the Multi-Agency Risk Assessment Conference (MARAC) when appropriate
- Dissemination of domestic abuse notifications from the police regarding pregnant women
- Attendance to support the Prevent agenda and the Channel panel in Northamptonshire
- Close liaison and dissemination of information with and from the children's Multi Agency Safeguarding Hub (MASH)
- Paediatric Liaison Nurse in post who scrutinises the Emergency Department (ED) lists on a daily basis and shares information between hospitals and community services which enables children and their families to receive appropriate care and support post discharge.

4.0 Safeguarding Governance

4.1 Named Safeguarding Roles

4.2 Northampton General Hospital is accountable for ensuring that its own safeguarding structure and processes meet the required statutory requirements of the Children's Act 2004, the Care Act 2014 and other statutory and national guidance. The safeguarding roles, duties and responsibilities of all organisations in the National Health Service (NHS) including the Trust, are laid out in the NHS England 'Accountability and Assurance Framework' (2019).

4.3 The Trust is highly committed to safeguarding with a strong culture of safeguarding vulnerable individuals of any age that have contact with services – either as patients, visitors or staff. Therefore robust governance processes are in place to ensure that services delivered are keeping people of all ages safe.

4.4 The Trust is statutorily required to maintain certain posts and roles within the organisation in relation to safeguarding. These have been fulfilled and enhanced throughout 2019/20.

4.5 The Director of Nursing, Midwifery and Patient Services is the executive lead for safeguarding and represents the Trust externally at the NSAB and the bi-annual NSCP meetings. The executive lead also acts as Named Senior Officer for allegations made against staff.

4.6 The Head of Safeguarding and Dementia provides strategic direction for adult, children's and maternity safeguarding and supports the Director of Nursing in the executive role. The role of Named Senior Manager for allegations against staff is fulfilled by the Head of Safeguarding and Dementia, who also attends the NSAB Delivery Board.

4.7 The Named Professionals provide the organisation with operational advice, support and input. The professionals are committed to supporting the workforce in understanding safeguarding, embedding it into 'everyday business' and improving outcomes.

4.8 The aims of the safeguarding service are to:

- To provide visible and professional safeguarding leadership for all aspects of safeguarding adults, children and young people and midwifery to ensure that day to day advice, support and expertise is available to all staff in the hospital. This includes the responsibility of the implementation, maintenance and development of effective and efficient systems for the detection, prevention, surveillance, investigation and control of harm and abuse
- To provide challenge and scrutiny of safeguarding practice including the interface with statutory agencies

- Facilitate safeguarding training sessions across the hospital to ensure that learning, skills set and knowledge of staff is provided as per statutory and mandatory training requirements. This includes all matter of communication across the hospital to ensure that the local needs and risks of children, young people and adults are understood and dealt with to a degree by the frontline staff using lessons learnt from national and local case reviews, best practice and research. Ethical concerns, legislative processes and reporting processes are part of this training as per hospital staff's roles and responsibilities.
- Contribute to the development of appropriate systems including audit, governance policies and procedures to ensure safe practice in relation to the delivery of an effective safeguarding service across the hospital
- Provide guidance and advice to the Human Resources Department in staff investigations including disciplinary, related to vulnerable adults, children and young adults.
- Work in partnership with key internal and external stakeholders to deliver a comprehensive, cohesive, safe and effective safeguarding service for the hospital. This includes engagement with at risk patients, relatives and advocates in order to gain feedback in order to ensure services and service improvements are patient centred and enhance equality and parity of esteem.

4.9 The expected outcomes of the service are to:

- Facilitate the development of a confident, informed workforce in relation to their role and responsibility to children, young people and adult welfare and safeguarding matters
- Improved outcomes for children, young people and adults
- A reduction in risk to children, young people, adults, visitors and staff
- Safe discharge from hospital

4.10 The Named Professional Team comprises of:

- 1.0 Full Time Named Nurse (Children)
- 1.0 Full Time Named Midwife (Children and Vulnerable Women)
- 1.0 Full Time Named Nurse (Adults)
- 2.0 sessions a week Named Doctor (Children)
- 1.0 sessions a week Named Doctor (Adults)

4.11 The Named Nurses are each individually supported by a 1.0 WTE safeguarding practitioner, who provide advice, support and training to all staff within the Trust about the management of safeguarding and vulnerability issues. A full-time paediatric liaison nurse is also in post. Two safeguarding administrators provide general assistance and support to the teams on a daily basis, including handling sensitive, emotive and confidential information.

5.0 Safeguarding Assurance Group (SAG)

5.1 The SAG has been in place since 2015 and is chaired by the Director of Nursing, Midwifery and Patient Services. Highlights from this meeting are cascaded to senior managers via the Clinical Quality Effectiveness Group (CQEG) on a quarterly basis.

6.0 Safeguarding Dashboards

6.1 Following the discontinuation of the Safeguarding Operational Group in March 2019, divisional safeguarding dashboards have been introduced to ensure that safeguarding and learning from safeguarding incidents are embedded into the organisation.

7.0 Safeguarding Strategy 2019-2022

7.1 The safeguarding strategy was approved by the Safeguarding Assurance group (SAG) in October 2019. The safeguarding strategy sets out the strategic approach to ensure safe and effective services for safeguarding adults and children are in place for the next three years. The main objectives are to encourage continuous improvement in compliance with national and local policies, developing and implementing systems for quality monitoring that are robust, auditable and effective and raising the awareness of safeguarding making it 'everyone's business.'

8.0 Disclosure and Barring Service (DBS)

8.1 Disclosure and Barring Service (DBS) regulations are in place for the Trust. All new employees and volunteers are checked as part of the employment/volunteer process. Safer recruitment processes are followed and the safeguarding team work closely with Human Resources when concerns are raised.

9.0 Safeguarding Concerns

9.1 Safeguarding concerns in the Trust are monitored by the safeguarding team. Some concerns are managed at ward level by the ward sister/department head and some are more complex which require reporting externally as per national legislation and local policy and procedures. The safeguarding team are involved in providing safeguarding expertise and concerns are analysed to detect trends and themes and to improve safeguarding. The Head of Safeguarding and Dementia is a member of the Trust's Review of Harm Group, which meets on a weekly basis.

10.0 Quality Schedule

10.1 The Clinical Commissioning Groups (CCG) Quality Schedule (2019/20) has been completed for both safeguarding adults and children. All key performance indicators were successfully completed and successful quality visits undertaken.

10.2 Business meetings take place with the Governance Team, the Deputy Director of Nursing, Midwifery and Patient Services and the CCG to ensure that there are agreed strategies in place to meet key performance indicators (KPIs). The 2020/2021 KPIs have been revised in consultation with the health providers across the county.

11.0 Care Quality Commission

11.1 The Care Quality Commission (CQC) visited and inspected the Trust in July 2019 and rated as requires improvement. The inspection team found that staff understood how to protect patients from abuse and services work well with other agencies to do this. However not all staff had training on how to recognise and report abuse. This was particularly highlighted for medical staffing.

12.0 Partnership Working

12.1 The Trust is committed to working with partners to improve outcomes for adults at risk, young people and children. Part of that commitment takes the form of attendance at, and active participation in, the NSAB and NSCP.

12.2 The table below highlights the attendance of the safeguarding team at the external NSAB and NSCP and subgroups. Commitment to these subgroups is substantial, not only in terms of attendance, but also with active participation and contribution to work streams:

Meeting	Frequency	Role
Northamptonshire Safeguarding Adults Delivery Board	Quarterly	Director of Nursing/Head of Safeguarding and Dementia
Learning and Development Committee (NSAB)	Quarterly	Named Nurse for Safeguarding Adults
Quality Assurance Sub Group (NSAB)	Quarterly	Named Nurse for Safeguarding Adults
Safeguarding Adults Review Subgroup (SAR)	Quarterly	Head of Safeguarding and Dementia
Named and Designated Nurses Meeting	Monthly	Named Nurse for Safeguarding Adults
Northamptonshire Safeguarding Children's Partnership (NSCP)	Bi-annually	Director of Nursing / Head of Safeguarding and Dementia
Child Death Overview Panel	Monthly	Named Doctor (Chair) Named Midwife
Child Sexual Exploitation Sub Group	Monthly	Named Nurse for Safeguarding Children
Learning and Development Committee	Quarterly	Named Midwife
Quality Sub-Group (NSCP)	Bi-monthly	Named Nurse for Safeguarding Children
Multi-Agency Safeguarding Development and Innovation Group (MASDIG)	Bi-monthly	Named Nurse for Safeguarding Children
Learning Review Subgroup	Quarterly	Head of Safeguarding and Dementia
Named and Designated Nurses Meeting	Monthly	Named Nurse Children and Named Midwife
Safeguarding Health Strategic Forum	Quarterly	Director of Nursing/ Head of Safeguarding and Dementia

12.3 There has been two SAR's completed within this reporting period. There also has been three SCPR's. NGH have completed Individual Management Reports (IMR's) as requested to all of these reviews. These reviews take place after an adult or a child dies or is seriously injured, and abuse or neglect is thought to be involved. The reviews look at lessons that can help prevent similar incidents from happening in the future.

12.4 Domestic Homicide Reviews (DHRs) were established on a statutory basis under Section 9 of the Domestic Violence, Crime and Victim Act 2004. The Trust has contributed to one review, which was published in the reporting period. There are three reviews awaiting final ratification from the Home Office.

Safeguarding Adults

13.0 National Context

13.1 The Safeguarding Adults Collection (SAC) Annual Report 2018-19 published by NHS Digital in November 2019 presents information about adults at risk for whom safeguarding enquiries were opened during the reporting period 1 April 2018 to 31 March 2019. A safeguarding concern is where a local authority is notified about a risk of abuse, follows up the notification with information gathering, and if appropriate, instigates an investigation (enquiry) under the local safeguarding procedures. The report highlighted:

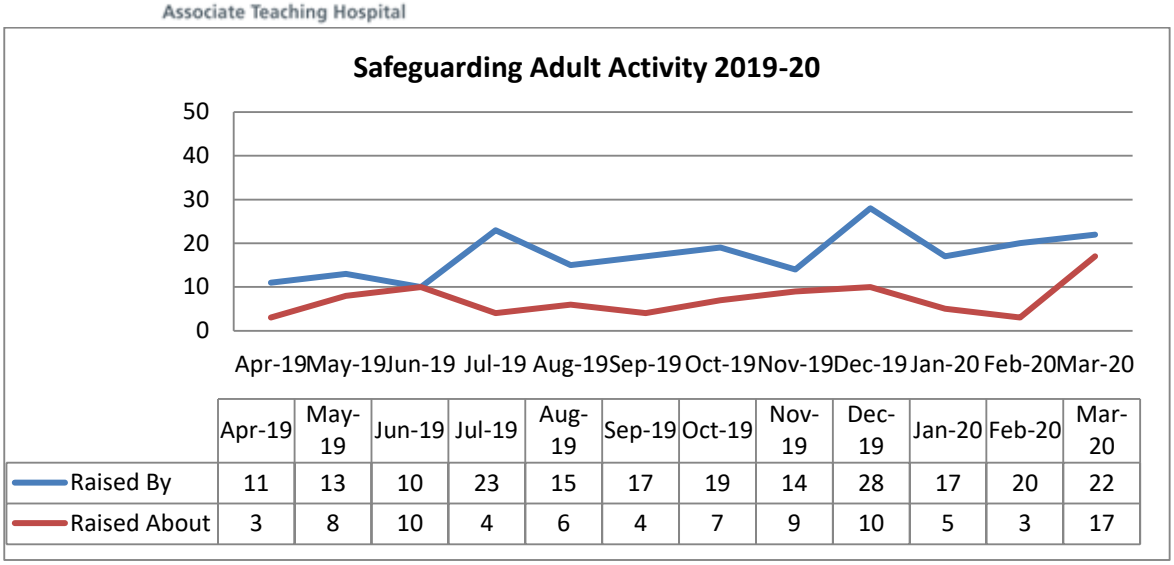
- There were 415,050 concerns of abuse raised during 2018-19 which is an increase of 5.2% on the previous year
- There were 143,390 individuals that were the subject of a safeguarding enquiry under Section 42 of the Care Act that started within the year. This is an increase of 8.7% per cent on 2017-18.
- Older people are much more likely to be the subject of a Section 42 enquiry; one in 43 adults aged 85 and above compared to one in 862 adults aged 18-64
- The most common type of risk in Section 42 enquiries that concluded in the year was neglect and acts of omission which accounted for 31.4% of risks
- The most common location of the risk was the person's own home (44.8%).

14.0 NGH Activity

14.1 There were 209 Safeguarding Adults referrals made by Trust staff during the reporting period which is a decrease compared to the same reporting period for 2018/2019 (283).

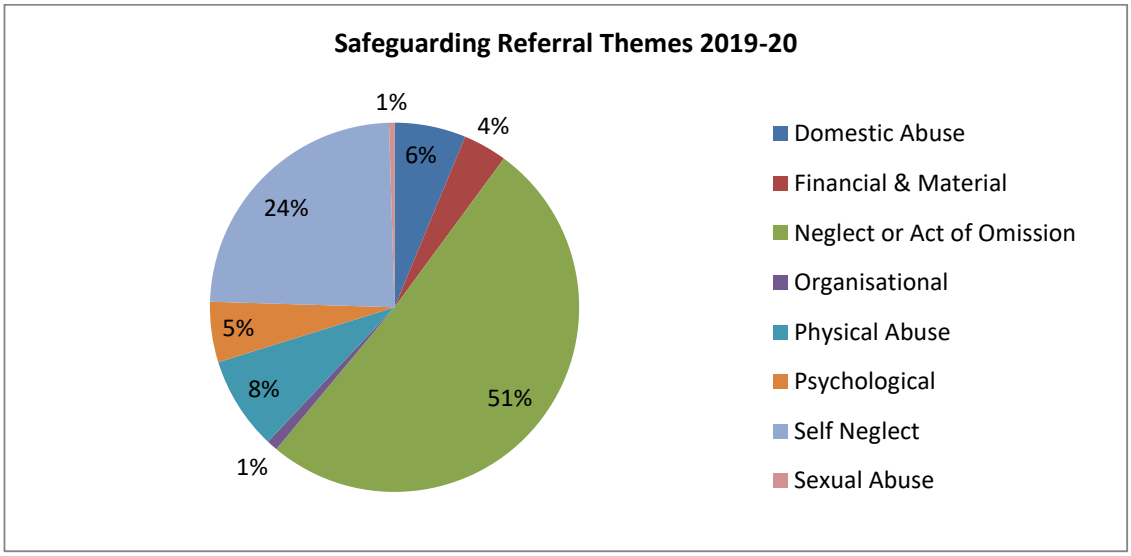
14.2 The majority of referrals were generated by the Emergency and Urgent Care Departments. These areas are often where initial assessments are undertaken prior to admission to the Trust in-patient wards.

14.3 The chart below shows the number of safeguarding referrals that were made about and by the Trust for 2019-20. There were 86 safeguarding referrals raised about the Trust which saw a decrease of 26.5% in comparison to 2018-19.



	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Raised By	11	13	10	23	15	17	19	14	28	17	20	22
Raised About	3	8	10	4	6	4	7	9	10	5	3	17

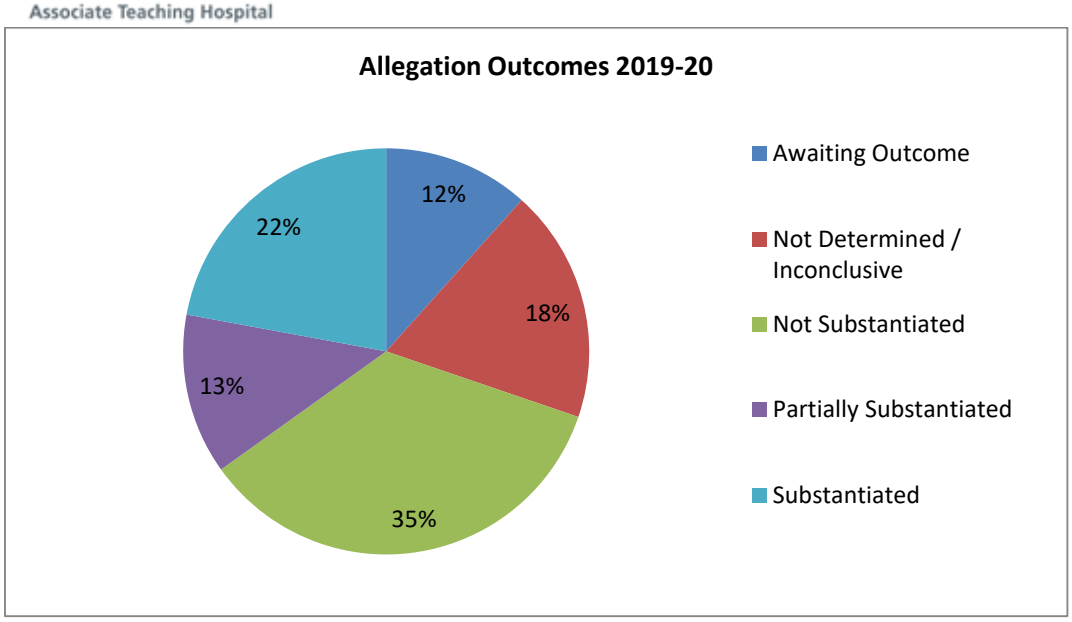
14.4 The chart overleaf highlights the themes of referrals made by the Trust during this reporting period. Neglect/or act of omission has been the highest level of safeguarding adult concern in terms of both referrals made by the Trust or about the Trust.



14.5 Safeguarding Adults investigations run on a 28 day timeline by the Local Authority. The Trust has contributed and completed within this timeframe for the majority of investigations.

14.6 The outcome of the investigations are as follows and illustrated in the chart overleaf:

- 19 Substantiated
- 11 Partially substantiated
- 30 Not substantiated
- 16 Not determined / Inconclusive
- 10 Awaiting Outcome



14.7 The themes of the allegations raised about the Trust predominantly refer to discharge arrangements in terms of timeliness, completeness of arrangements (i.e. home care package) and communication with carers and families prior to discharge.

14.8 The outcome of safeguarding investigations have been was shared with staff members via ward / department meetings to review and instigate processes/clinical practice to prevent similar incidents from occuring.

15.0 Allegations Against Staff

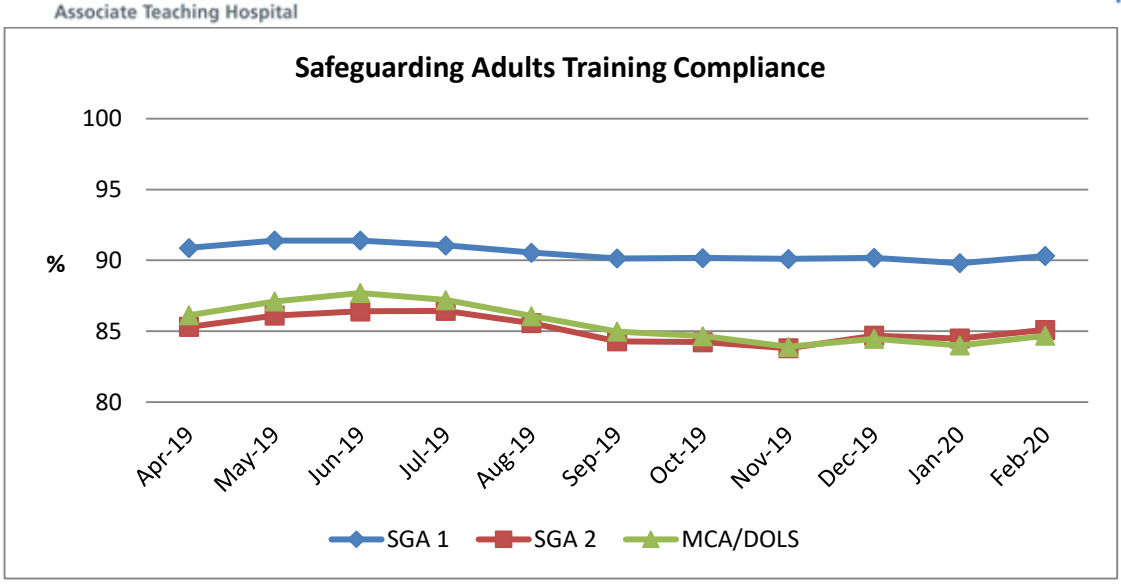
15.1 As part of the overarching safeguarding legilsative framework, the Trust has a statutory responsibility with regards to managing allegations against staff and there is a policy in place to support this. During 2019/20 there were 28 allegations made against staff which were investigated accordingly with outcomes of no further action, supportive frameworks or discplinary measures such as dismissal.

16.0 Safeguarding Adult Reviews (SAR's)

16.1 During the reporting period there were two SAR's published. The Trust contributed to both reviews as the Trust had contact with both individuals. Recommendations from the reviews are monitored on a quarterly basis at the Safeguarding Assurance Group.

17.0 Training

17.1 The safeguarding teams are committed to training and education which are fundamental to develop staff confidence and skills in relation to safeguarding. The chart overleaf highlights the safeguarding adult training compliance over the year of 2019-20.



17.2 Safeguarding adult level 1 training has continued to remain above the expected compliance level. However safeguarding adult level 2 and MCA/DoLS dipped marginally just under compliance for four months during the reporting period. Training was paused in March 2020 due to the Covid-19 pandemic.

17.3 The safeguarding team will continue to provide training for all staff groups. However in light of Covid-19, an alternative safeguarding training offer will need to be in place rather than an over reliance on face to face training.

The feedback from the training delivered has been highly positive. This has included:

18.0 Mental Capacity Act

18.1 The Mental Capacity Act (MCA) came into force in October 2007. The MCA provides a legal framework for assessing capacity and making decisions about the care and treatment of adults who lack capacity. This could be due to a mental health condition, a severe learning disability, a brain injury, a stroke or unconsciousness, etc. The MCA protects and empowers individuals who

are unable to make all or some decisions for themselves. The MCA applies to everyone working in health and social care providing support, care or treatment to people aged 16 and over who live in England and Wales.

18.2 The safeguarding team has undertaken quarterly audits regarding the compliance and application of the MCA in practice, which have been presented to the SAG. The audit also forms part of the Trust quality schedule, which reports to the CCG.

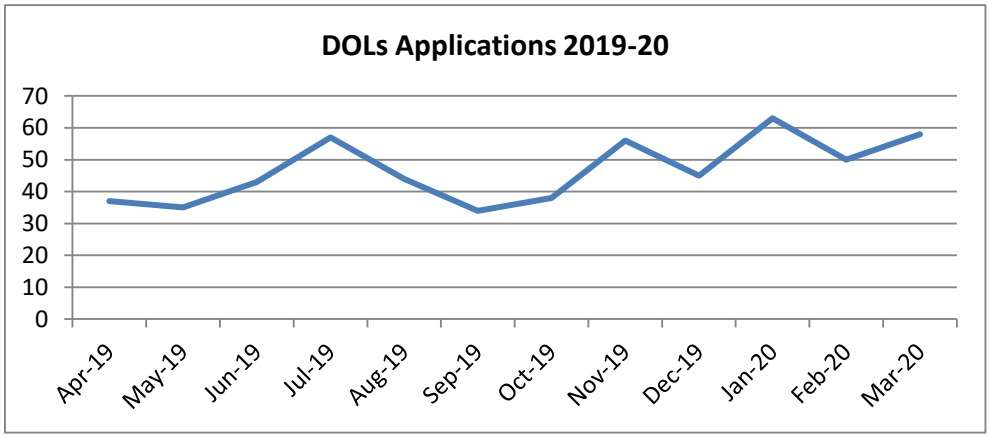
18.3 The audit results over this reporting period have demonstrated that professionals had a good understanding of the decision specific nature of assessments and often utilised the support of the specialist Learning Disability or Dementia Liaison nurses which aided the process. However the consistent application of the principles of the Mental Capacity Act when making assessments was not always clear in the cases audited. Also record keeping and information sharing in relation to assessments and best interest's decisions was variable.

18.4 An Independent Mental Capacity Advocate (IMCA) supports people when they are assessed to lack capacity to make a best interest decision and they do not have family or friends appropriate to consult about the decision. During the reporting period the Trust made 19 referrals for an IMCA compared to 16 in 2018/19.

19.0 Deprivation of Liberty Safeguards (DoLS)

19.1 The Deprivation of Liberty Safeguards (DoLS) was introduced in 2009. They are part of the Mental Capacity Act 2005. They are used to protect the rights of people who lack the ability (mental capacity) to make certain decisions for themselves. The DoLS are set firmly within the empowering ethos of the MCA. They encourage all health and social care providers to put liberty and autonomy at the heart of care planning, to avoid wherever possible the need to deprive people of their liberty.

19.2 Deprivation of Liberty Safeguards (DoLS) applications in the Trust increased in 2019/20. There were 560 DoLS applications in the Trust during the reporting period against 455 in 2019/20.



19.3 The Trust continues to request Best Interest Assessments from the County Council under the legislative framework. However only three assessments have been carried out in the reporting period due to capacity issues associated with the Supreme Court ruling and there are over 3,500 outstanding Best Interest Assessments outstanding for the county. This concern is captured on the risk register within Patient and Nursing Services.

19.4 The Mental Capacity (Amendment Bill) Act 2019 received Royal Assent on 16th May 2019. The Liberty Protection Safeguards (LPS) will replace the current DoLS and was due to come into force on 1st October 2020. However due to Covid-19 this has been suspended. No further implementation date has been announced by the central government.

19.5 The safeguarding team will continue to attend both the countywide and health LPS steering groups to ensure there is consistent implementation across the county.

20.0 Court of Protection

20.1 The Trust made one application to the Court of Protection in this reporting period.
The application related to a patient with mental health problems that require ongoing medical treatment. The Court agreed with the proposal that the patient could be treated under the scope of the Mental Health Act.

21.0 Prevent

21.1 Prevent forms part of the Counter Terrorism and Security Act, 2015 and is concerned with preventing children and vulnerable adults becoming radicalised into terrorism. NHS Trusts are required to train staff to have knowledge of Prevent and radicalisation and to spot the vulnerabilities that may lead to a person becoming radicalised.

21.2 The purpose of Prevent is for staff to identify and report concerns where they believe young people or adults may be vulnerable to radicalisation or exploiting others for the purposes of radicalisation. The Named Nurse for Safeguarding Adults is the Prevent lead for the Trust.

21.3 The Named Nurse will make referrals where appropriate and attends the Local Authority Channel panel. This multi-agency panel discusses the risk posed by vulnerable people who are referred for multi-agency support.

21.4 All NHS Trusts and Foundations Trust are required to submit Prevent data to NHS England and NHS Improvement. This is submitted on a quarterly basis.

21.5 All staff are required to receive basic awareness Prevent training and the Trust has achieved 90% compliance and this training is delivered on Trust induction. Level 3 training (Workshop to Raise Awareness of Prevent – WRAP) is above compliance trajectory at 92%

22.0 Modern Slavery

22.1 Despite slavery being banned in the majority of countries for over a hundred and fifty years, modern slavery takes many forms. Forced labour, people trafficking, debt bondage and child marriage are all forms of modern day slavery that affects the world's most vulnerable people. It is estimated that there are over 13,000 people in modern slavery in the United Kingdom.

22.2 Modern slavery is incorporated within the safeguarding children and adult mandatory training from levels 1 -3, which applies to all staff employed by the Trust. Also the Trust's procurement department makes an annual statement in terms of systems and processes that are in place across the commissioning cycle.

22.3 The safeguarding team raise concerns and referrals with either the National Helpline or the National Referral Mechanism when appropriate. In light of Covid-19 and worldwide lockdowns this has created a significant reduction in opportunities to travel across borders.

23.0 Achievements in 2019/20

- Revision of the quarterly Mental Capacity audit to ensure that wards receive individual feedback
- Appointment of a Mental Health and Mental Capacity Lead Practitioner to work alongside the Named Nurse and the Dementia and Learning Disability Liaison Nurses
- Completion of the NSAB Safeguarding Assurance Framework with limited remedial actions
- Contribution to the safeguarding strategy
- Named Nurse shortlisted in the 'safety' category at the Trust's best possible care awards

24.0 **Priorities for 2020/21**

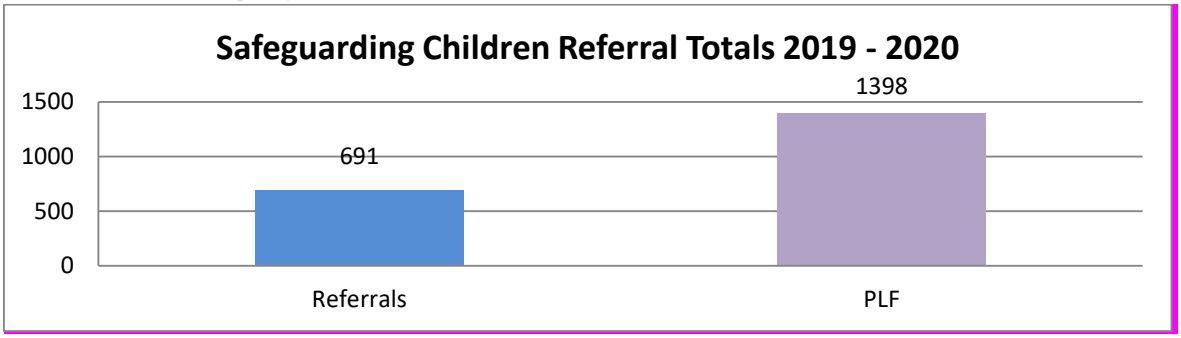
- Appointment and induction of Named Nurse for Safeguarding Adults following the retirement of the previous post holder
- Attendance at the Countywide and Health LPS meetings to ensure that a robust and a consistent approach is in place to introduce and embed the new legislation within the Trust
- Introduction of a wider safeguarding training offer for Trust staff other than face to face training in light of Covid-19
- Introduction of Level Three safeguarding training in light of the recommendations from the intercollegiate training guidance for adult safeguarding
- Review MCA file audit which will be carried out on a quarterly basis to inform areas of learning across the Trust
- Review current safeguarding data management processes to produce more meaningful information and inform learning

25.0 <u>Safeguarding Children</u>

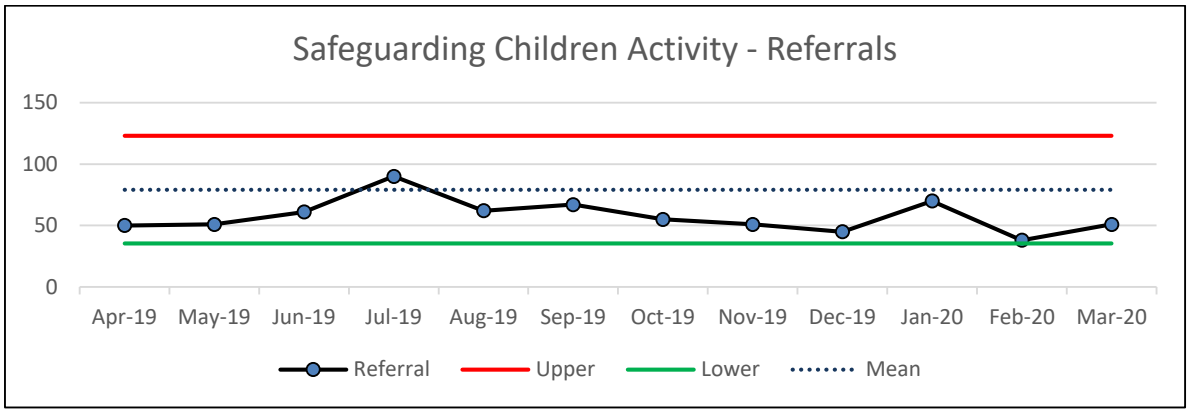
25.1 The Safeguarding Children's team are committed to safeguarding and promoting the health and wellbeing of all children and young people attending the Emergency Department (ED), as outpatient's or, those admitted to the paediatric wards, the Paediatric Assessment Unit (PAU), or any adult wards where 16 year olds and over have requested this. The Trust also have a 'duty of care' toward 'unseen' children whose parents have been admitted, or, have attended ED where there may be safeguarding concerns, for example, presenting with alcohol and drug misuse, suicidal ideation or in a mental health crisis.

26.0 Activity

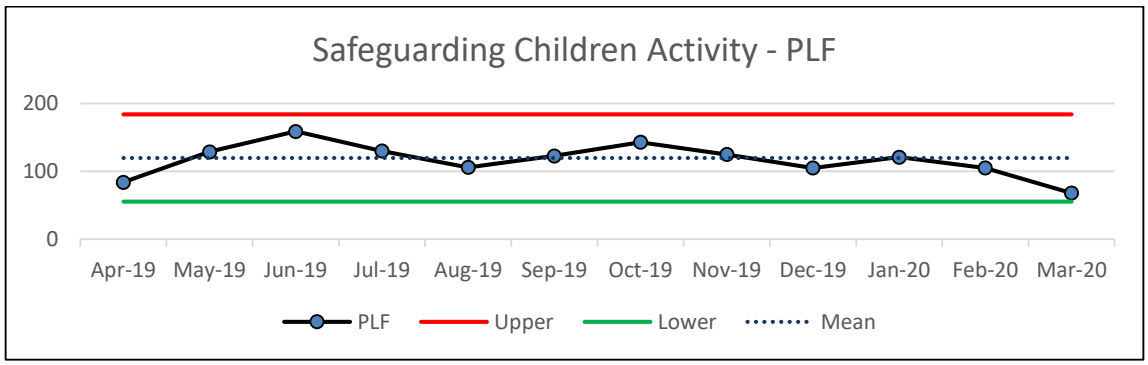
26.1 There have been a total of 691 Multi-Agency Safeguarding Hub (MASH) referrals during 2019/2020 which is significant decrease than the previous year (956). This is partially attributed to the Covid-19 pandemic which saw a drastic reduction in the attendances and admissions of children and young people.



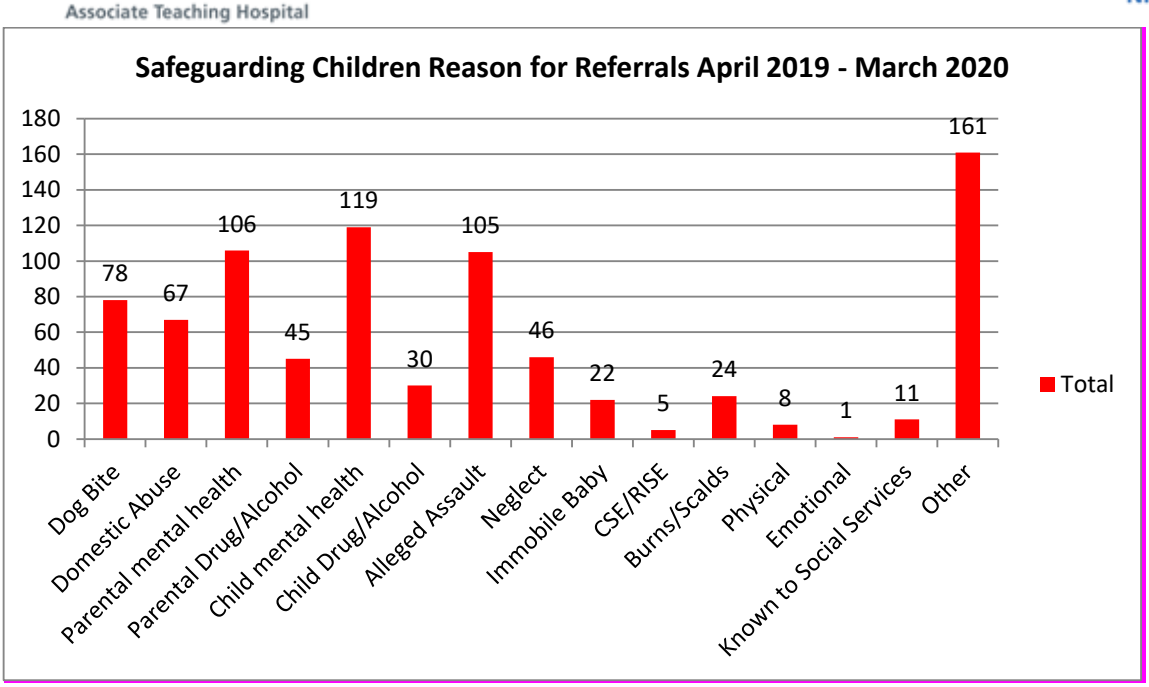
26.2 The charts below presents the safeguarding activity across the reporting period.



26.3 There was 1398 paediatric liaison forms (PLF's) completed which highlights only a minimal decrease compared to last year when 1421 were raised. This evidences good practice in terms of timely information and liaison with external health colleagues such as GP's, health visitors and school nurses. This liaison work was highlighted as good practice within Laming recommendations in 2003 and Working Together (2018) in terms of the ethos of collaborative partnership working.



26.4 The bar chart overleaf presents the primary reason for MASH referrals by the Trust. Referrals are recorded by 'primary reason'. However there will often be multiple concerns or reasons for statutory intervention.



26.5 Referrals for 'unseen children' equate to 22.17% of all MASH referrals made in the reporting period due to domestic abuse, parental mental health, parental drug and/or alcohol misuse.

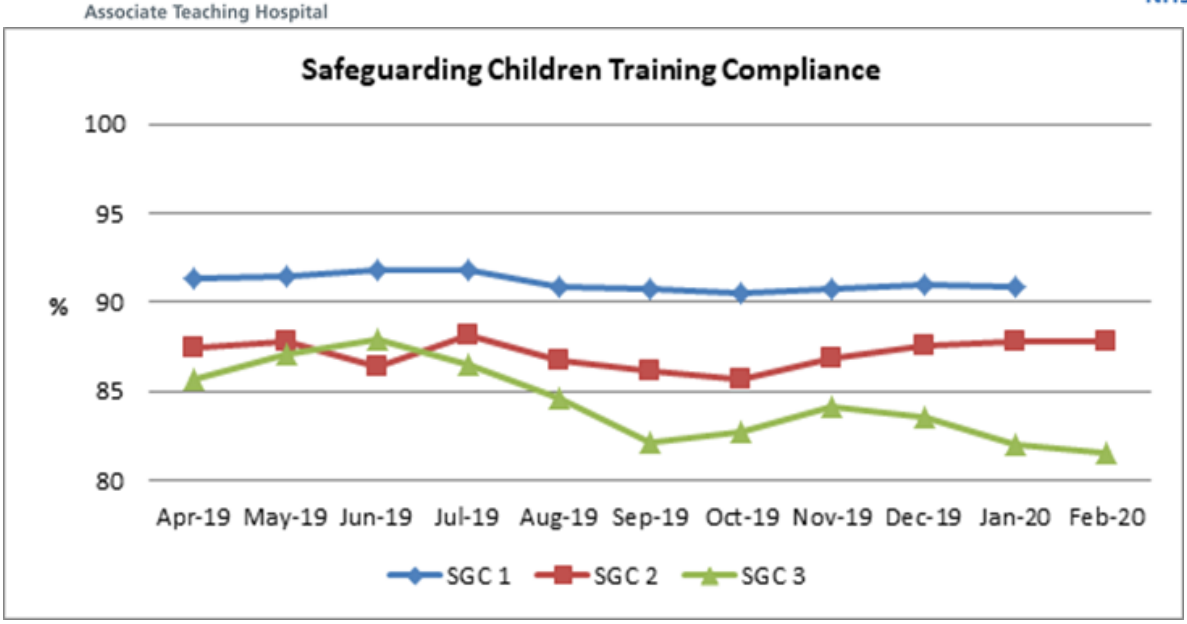
26.6 Alleged assaults equate to 15.4% of all MASH referrals and is an escalating concern due to increasing county lines and gang activity reported within the county. However this is difficult to evidence due to non-identification of the perpetrators by their victims where known, resulting in a no further action outcome of the safeguarding referral. The ED will encourage referrals to CIRV by way of supporting victims of assaults where gang related assaults are suspected.

26.7 There were 22 MASH referrals were completed for bruising/injury/non-accidental injury to non-mobile babies which compares to half the figure last year.

26.8 Dog bites equate to 11% of ED presentations and with the introduction of lockdown in March 2019 increased the risk to children and young people due to prolonged periods of time in the household rather than being in a school environment.

27.0 Safeguarding Children Training

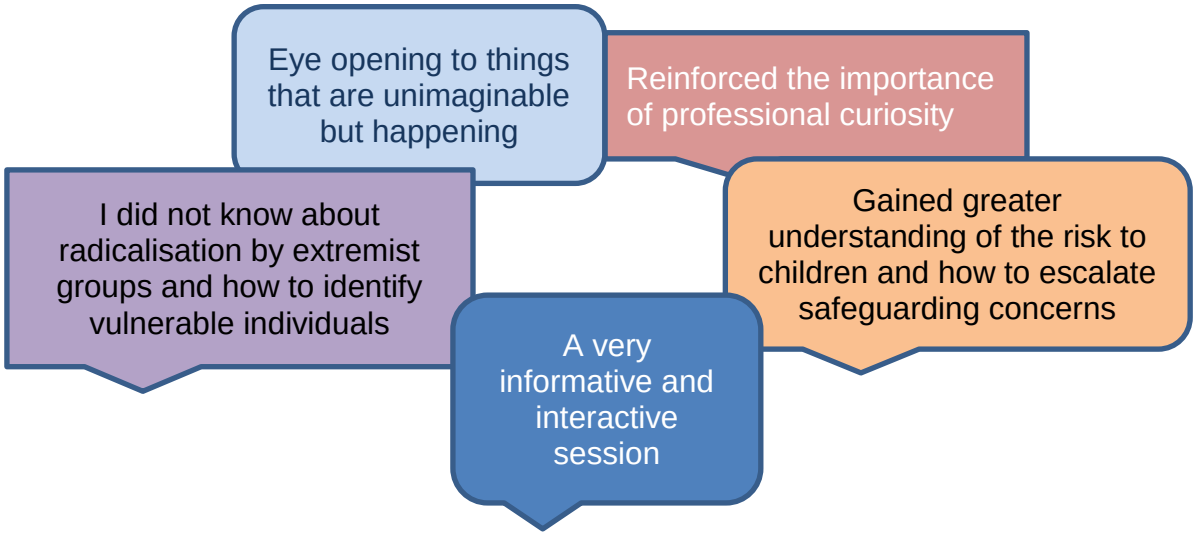
27.1 Considerable focus has been given to safeguarding training within the clinical divisions, particularly at Level 3 during the last year. Winter pressures saw a reduction in training attendance and staff compliance reduced as a result as evidenced in the graph presented below:



27.2 Level 1 and Level 2 safeguarding children training remained above the trajectory of 85% throughout the reporting period facilitated by e-learning, work books and face to face training.

27.3 The safeguarding children's team has offered 'bespoke' sessions to teams/departments to enhance training compliance. In addition external speakers have been invited to deliver alternative Level 3 training as an opportunity for frontline staff in domestic abuse, online safety and child sexual exploitation (CSE)

27.3 The feedback from the training delivered has been highly positive. This has included:



28.0 Early Help Referrals

28.1 Early help is vital in offering children support which will increase their outcomes. The Early Help Assessment (EHA) is a way to help identify needs of children and families and make a plan to meet them. The EHA is a shared tool used by all agencies in Northamptonshire to inform a co-ordinated response.

28.2 There has been an increased awareness through safeguarding training and supervision as to the early help process for staff within the Trust.

28.3 Through PLF's external health colleagues have been requested to consider completing EHA with families on their caseloads whom have attended the hospital.

28.0 Paediatric Liaison Nurse (PLN)

29.1 The Paediatric Liaison Nurse (PLN) is the vital link between the Trust and community health services and social care colleagues ensuring pertinent and timely information about children aged 0-19 years (and beyond, for example, children with disabilities, looked after children) are shared and exchanged with the professionals in the community to enhance continuity of care and inform safeguarding and promoting the welfare of children and young people.

29.2 The role of the PLN ensures that the ED child attendance lists are scrutinised on a daily basis to ensure MASH referrals and PLF's are raised appropriately to other professionals involved in the child's care.

29.3 The role of the PLN ensures that the ED lists are scrutinised on a daily basis to ensure MASH referrals and Paediatric Liaison forms are raised as appropriate to escalate safeguarding concerns and share information in a timely manner to enhance continuity of care, wellbeing and safeguarding. The role includes scrutinising the ED lists on a daily basis and carrying out internal audits such as presentations of babies under twelve weeks to the department.

30.0 Safeguarding Nurse Advisor (SNA)

30.1 The Safeguarding Nurse Advisor (SNA) commenced with the Trust on 1st April 2019. The role and responsibilities of the SNA ensures frontline staff in ED, urgent care, paediatric and adult wards receive support on a daily basis to ensure safeguarding is prioritised to babies, children and young people.

31.0 Designated Officer (LADO)

31.1 The Designated Officer (formerly known as the Local Authority Designated Officer or LADO) at Northamptonshire County Council is informed by the Trust of all cases in which it is alleged that a person who works with children has behaved in a way that has harmed, or may have harmed a child or behaved in a way that indicated they may pose a risk to children. There have been three LADO enquiries received from the Designated Officer during the reporting period.

32.0 Child Safeguarding Practice Reviews (formerly Serious Case reviews)

32.1 There has been three child safeguarding practice reviews completed during the reporting period

32.2 The Trust has actively participated with all reviews in terms of panel members and Individual Management Report (IMR) reports.

33.0 Child Protection Information System (CP-IS)

33.1 Data relating to children (including unborn children) with a child protection plan, or with looked after status, is securely transferred to and stored on CP-IS on the NHS Spine and is presented as a flag indicating the patient is a vulnerable child to all frontline practitioners.

33.2 By sharing data across regional boundaries CP-IS helps health care professionals build up a picture of a child's visits to unscheduled care settings supporting early help detection and

intervention in cases of potential or actual abuse. It also enables information as to ED/PAU attendance to children's services and health colleagues in the community accessing this system.

34.0 Achievements in 2019/2020

- Successful recruitment to the safeguarding children's administrator
- Successful induction of the safeguarding children's advisor and the paediatric liaison nurse
- Relocation of the children's safeguarding team to co-locate with the wider safeguarding team
- 2018/2019 dog bite audit invited to be presented at the paediatric and child health conference in Liverpool (sadly cancelled due to the pandemic)
- Audit activity both internally and externally has been completed in the form of multi-agency case audits to ensure that safeguarding activity within the Trust reflects good practice. Internal audits have included: babies presenting to ED, children and young people leaving ED prior to being seen, quality of MASH referral forms, parental details of minors attending ED, alleged assaults, prevalence of children to ED due to self-harm by ligature
- Contribution to the safeguarding strategy
- Paediatric safeguarding quality visit by the CCG with positive feedback
- Ongoing pre-arranged, ad hoc safeguarding supervision to paediatric wards, teams and departments.

35.0 Priorities for 2020/2021

- Introduction of a wider safeguarding training offer for Trust staff other than face to face training in light of Covid-19
- Support the ongoing induction of the newly appointed safeguarding children's team administrator
- Safeguarding training compliance to be maintained as per the CCG quality schedule
- Revise all levels of safeguarding children's training to update according to national and local changes in policy, and lessons learnt from recent CSPR's and thematic reviews.

36.0 <u>Safeguarding Within Maternity Services</u>

36.1 The Named Midwife for Safeguarding is supported in her role by two Band 6 Safeguarding Midwives, one 0.6WTE and the other 0.4WTE. The Maternity Safeguarding Team supports both hospital and community based staff, and ensures that safeguarding is embedded into practice.

36.2 The central midwifery team has three full time and two part-time midwives in post. An additional full time midwife became part of the team as a response to the Covid-19 pandemic. The midwives support women who have currently children's services involvement, or cases which are being escalated by the Named Midwife when children's services have determined that the case is closed. The midwives provide continuity of care for vulnerable women and families across Northampton, Daventry and Towcester. The team work alongside a multitude of professionals, such as social workers, police and other health sectors to support the women and their families.

36.3 The maternity safeguarding team provides safeguarding supervision to each central team member team on a monthly basis or where an individual case requires more frequent focus. A safeguarding supervision plan has been devised and this is documented within the woman's records and recorded on the maternity safeguarding team database. The Named Midwife also provides bespoke training sessions on themes and concerns that have become apparent in the midwifery/child protection cases. Further training such as substance misuse understanding has been facilitated.

36.4 The central team represent the Trust at safeguarding meetings, such as strategy discussions, child protection conferences, core meetings and child in need meetings. The central team will feedback to the maternity safeguarding team when issues arise, such as drift in adhering to the agreed Northamptonshire Safeguarding Children Partnership (NSCP) pre-birth pathway.

36.5 The Named Midwife for Safeguarding commenced in post in July 2019 with the main objective to develop a working relationship with Northamptonshire children's services as a number of

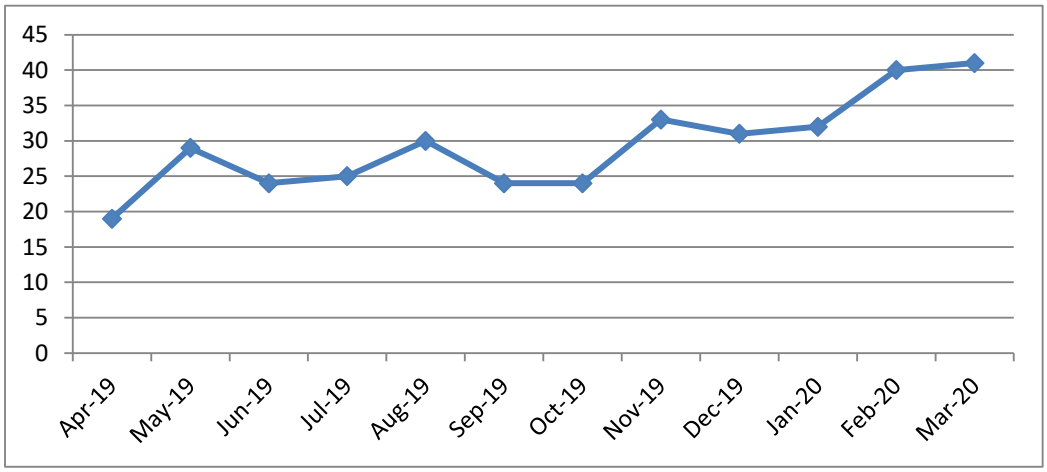
maternity safeguarding cases had identified the absence of pre-birth assessments and the cases being held at a lower safeguarding threshold, such as children in need. A service manager at children's services has been allocated as the single point of contact for the maternity safeguarding team. Midwives are still encouraged to raise their concerns with the allocated social worker, in accordance with the NSCP escalation procedure. When issues/concerns are not resolved through liaison with the social worker and team manager, concerns are then shared with the service manager, who explores these further.

36.6 During the period between November 2019 and March 2020, 258 cases were shared by the Named Midwife with the service manager. These cases were often only discussed once or on several occasions. Themes identified at this meeting were inappropriate threshold levels, drift in cases, transient workforce and 'risky' male partners. To mitigate these risks, the Trust's risk register was increased to critical in October 2019.

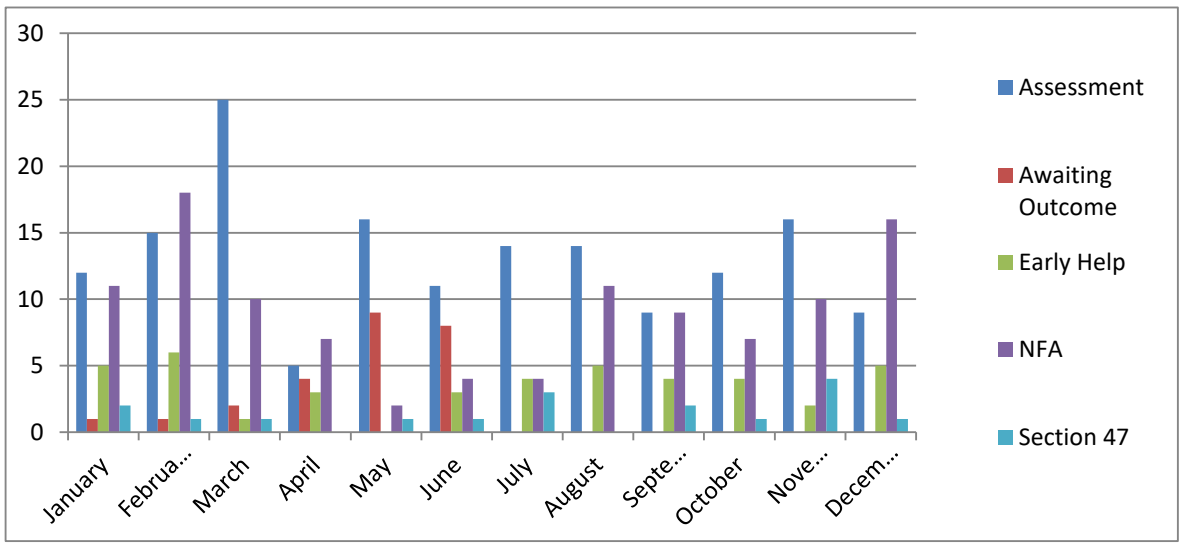
36.7 In addition the maternity safeguarding team systematically reviews all bookings for women who have current or previous children's services involvement or has a learning disability. From September 2019, 113 women have been identified as having current or previous children's services involvement and 8 women have been identified as having a learning disability. By reviewing the records, a multi-agency safeguarding referral (MASH) is often required and this is then discussed and completed by the allocated midwife. This process has been educational for midwives and most importantly, relevant safeguarding referrals have been generated and shared with the local authority.

37.0 Maternity Activity

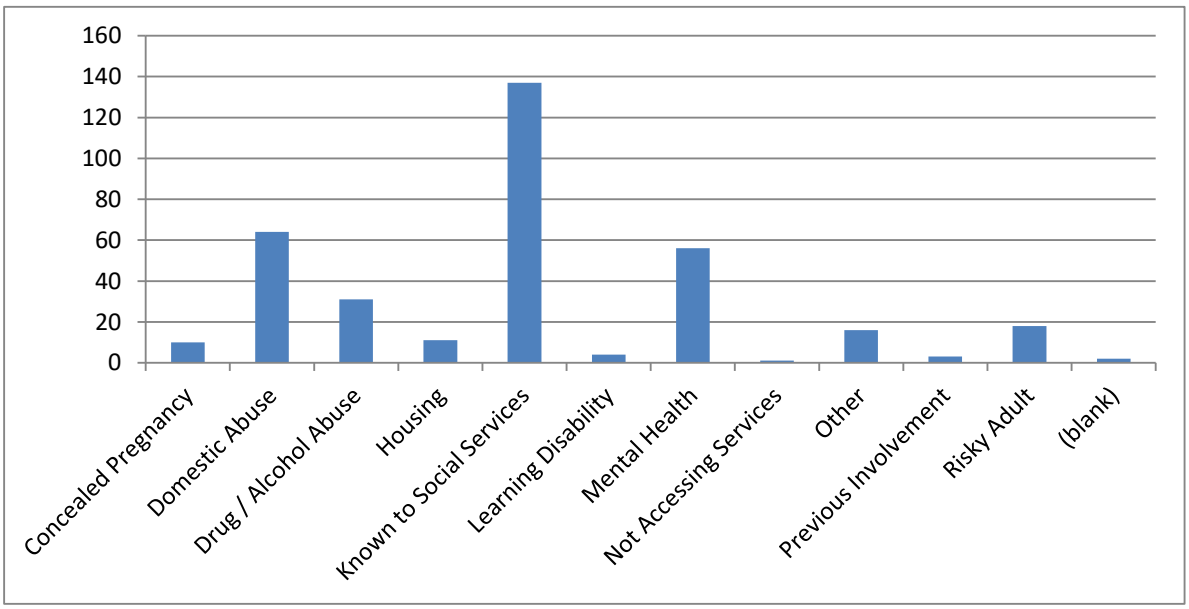
37.1 The total number of referrals made to the MASH during 2019/20 was 353, which is a 34% increase from 2018/19 (264). On average during 2019/2020, the number of referrals made to social care each month has increased which is displayed in the chart below:



37.2 Each referral that is sent to MASH is forwarded to the maternity safeguarding team, who will review the referral and MASH outcomes are followed up on a weekly basis to ensure that appropriate plans are in place. When necessary, if the case is closed by MASH, the outcome will be challenged by the Named Midwife to ensure that the correct plans and provisions are in place for the family. One hundred and fifty eight assessments were completed by children's services in 2019/2020 following MASH referrals being raised by maternity services. This is compared to 69 in 2018/19. This demonstrates that midwives are informed about what they need to refer, able to articulate the needs of vulnerable women and their unborn and where no further action is an outcome, this is challenged early by the maternity safeguarding team. The outcome of these referrals can be seen in the chart below:



37.3 Every safeguarding referral received by the maternity safeguarding team is screened to establish the primary reason for the concerns being raised. A number of maternity cases will have a number of complicating factors, which include the trilogy of risk – domestic abuse, substance misuse and poor parental mental health. The primary leading cause for MASH referrals being completed in maternity services continues to be due to the mother/family already being known to children's services. This is demonstrated in the graph below



38.0 Training

38.1 The current training figures for Obstetrics and Gynaecology is 82.8%. Throughout the year a number of bespoke internal training events have been organised with a range of internal and external speakers. The Named Midwife developed a Female Genital Mutilation (FGM) bespoke level three safeguarding training for Trust staff to attend, following changes made to the FGM guidelines. In addition Trust staff are able to attend training provided by the NSCP which includes face to face or e-learning. The Named Midwife attends the NSCP Learning and

Development subgroup, which has noted that the Trust has the highest uptake of the e-learning offered to health and social care staff across the county.

39.0 Female Genital Mutilation (FGM)

39.1 Female Genital Mutilation (FGM) is illegal in England and Wales under the FGM Act (2003). It is a form of child abuse and violence against women. FGM comprises of all procedures involving partial or total removal of the external female genitalia for non-medical reasons.

39.2 Section 5B of the 2003 Act introduces a mandatory reporting duty which requires regulated health and social care professionals and teachers in England and Wales to report 'known' or potential risk of FGM in under 18s to the Police. The duty came into force on 31st October 2015. During the reporting duty the Trust did not refer any children to the Police under this framework. However statistical information is gathered regarding women who have had FGM and present to the Trust. During 2019/2020 there were 59 women identified as having FGM when booking their pregnancy with the Trust. The majority of these ladies were from Somalia. Other countries cited were Sudan, Djibouti, Tanzania, Kenya, Yemen, Iraq, Nigeria, Ethiopia and Liberia.

39.3 The Female Genital Mutilation Risk Information System (FGM-RIS) is a national information technology system that supports the early intervention and ongoing safeguarding of girls, under the age of 18, who are potentially at risk of FGM.

39.4 This system was launched by the Department of Health and NHS England in July 2014 which enables recording the potential risk of FGM on a girl's health record. This is particular pertinent to maternity services as the most likely point for identifying that a girl is potentially at risk of FGM is when she is born to a mother with FGM. Eighteen infant females had FGM-RIS alerts added onto the NHS summary care records as per guidance by NHS England and NHS Improvement.

39.5 A FGM audit was completed by the maternity safeguarding team in December 2019. The audit identified the inconsistent management of FGM by maternity services. Compliance with standards was varied and therefore guidance was amended accordingly to articulate the mandatory duties health professionals must adhere to when FGM is disclosed. A flowchart was devised and circulated across maternity services and Level 3 FGM training was developed and facilitated to enhance professionals' skills set and knowledge.

40.0 <u>Domestic Abuse</u>

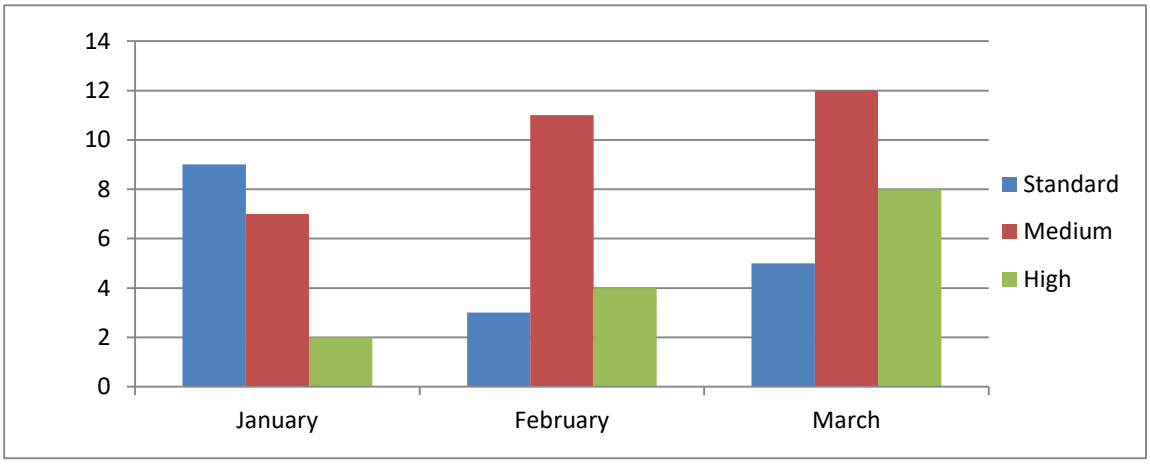
40.1 The Hospital Independent Domestic Violence Advisor (HIDVA) role at the Trust was decommissioned in March 2020. Prior to this, the IDVA would support staff in offering advice, safety planning and support to staff and patients experiencing domestic abuse. The hospital remains in liaison with the Sunflower Centre (voluntary domestic abuse support services), who continue to support the organisation and provide domestic abuse training to professionals.

40.2 All midwives are required to routinely ask every woman about domestic abuse at least twice during the woman's pregnancy, as well as adopting a target approach where signs or indicators of domestic abuse are observed at any time throughout maternity services – during the antenatal or the post-natal period.

40.3 The maternity safeguarding team receives Police Protection Notifications (PPN's) from Northamptonshire Police on a weekly basis regarding domestic abuse incidents involving pregnant women. The maternity safeguarding administrator will alert maternity services of the notification by uploading the information onto the woman's maternity electronic records. In addition, the allocated midwife will receive an email alerting them to the notification and prompting them to discuss domestic abuse at each contact where possible. This is an

opportunity for a referral to domestic abuse support services such as Victim or the Sunflower Centre

40.4 From January 2020, the maternity safeguarding team have analysed the PPN's received from Northamptonshire Police in terms of the different levels of risk. The information shared is categorised into three levels of risk: standard (no significant current indicators); medium (identifiable indicators of harm) and high (indefinable indicators of risk of serious harm). During this period 61 PNN's have been received by the team and the variation of risks received for pregnant women is illustrated in the graph below:



41.0 Domestic Homicide Reviews

41.1 There was one Domestic Homicide Review (DHR) published during the reporting period and there are three reviews awaiting final ratification from the Home Office. The Trust contributed to the published review. Action plans from the reviews are reviewed and monitored at the Safeguarding Assurance Group on a quarterly basis.

42.0 Achievements during 2019/2020

- A single point of contact has been established with children's services to share and escalate concerns
- Domestic abuse notifications have been amended to include a plan of care for the woman
- Increase and quality of MASH referrals during the reporting period
- Contribution to the safeguarding strategy

43.0 Priorities for 2020/21

- Introduction of a wider safeguarding training offer for Trust staff other than face to face training in light of Covid-19
- Safeguarding training compliance to be achieved as per quality schedule.
- Escalation of safeguarding cases to children's services when concerns that the appropriate threshold of intervention has not been met
- Monitoring of the unborn tracker meeting which was established in April 2020 with children's services and the health visiting service to track progression of cases of concern which have been escalated by the maternity safeguarding team
- Maternity safeguarding policy to be developed and embedded
- Safeguarding quality visit by the CCG to maternity services which received positive feedback

44.0 Covid-19

44.1 In the middle of March and then into subsequent months, Covid-19 became a national issue which impacted upon the safeguarding and vulnerability agendas. Some processes were streamlined

and some delayed whilst the safeguarding team focused on the safety and wellbeing of all patients attending the Trust.

References and Further Reading

- Adult Safeguarding : Roles and Competencies for Health Care Staff (2018) London: Royal College of Nursing
- Care Act (2014)
- Children's Act (2004)
- Counter Terrorism and Security Act (2015)
- Deprivation of Liberty Safeguards (2009)
- Domestic Violence, Crime and Victims Act (2004)
- Female Genital Mutilation Act (2003)
- Health and Social Care Act 2008
- Laming (2003)
- Mental Capacity Act (2005)
- NHS England (2019) 'Safeguarding Vulnerable People in the NHS – Accountability and Assurance Framework' HMSO: Department of Health
- Northamptonshire Safeguarding Adult Board Procedures
- Northamptonshire Safeguarding Children Board Procedures
- Safeguarding Children and Young People Intercollegiate Guidance (2019) HMSO: Department of Health
- Supreme Court (2014) http://www.supremecourt.uk/decidedcases/docs/UKSC_2012_0068_Judgment.pdf
- Working Together to Safeguard Children and Young People Intercollegiate Guidance (2018)

Report To	**Public Trust Board**
Date of Meeting	**24 September 2020**

Title of the Report	**Infection Prevention & Control 2019/20 Annual Report**
Agenda item	**14**
Presenter of Report	Sheran Oke - Director of Nursing, Midwifery & Patient Services and Director of Infection Prevention & Control
Authors of Report	Sheran Oke - Director of Nursing, Midwifery & Patient Services and Director of Infection Prevention & Control Ros Pounds - Infection Prevention & Control Clinical Nurse Specialist Graham Pike – Interim IPC Matron Claire Brown- Occupational Health Manager/Specialist Community Public Health Nurse Mark Duggan - Decontamination Lead Shamsul Hoque - Antimicrobial Pharmacist
Purpose	Assurance
Executive summary This annual report provides a summary of the performance and developments related to Infection Prevention and Control (IPC) during 2019/20 and the broad plan of work for 2020/21	
Related strategic aim and corporate objective	Corporate Objective 1 – Focus on Quality & Safety
Risk and assurance	Provides assurance on risks
Related Board Assurance Framework entries	BAF – 1.1, 1.2, 1.3
Equality Analysis	There is no potential for, or evidence that, this document will not promote equality of opportunity for all or promote good relations

	between different groups. There is no potential, for or evidence that, this document will affect different protected groups/characteristics differently (including possibly discriminating against certain groups/protected characteristics).
Legal implications / regulatory requirements	To provide assurance in relation to The Health and Social Care Act 2008: Code of Practice on the Prevention and Control of Infections and Related Guidance (Department of Health, 2015).
Actions required by the Committee The committee is asked to: Note the content of this annual report and to support the Infection Prevention & Control work plan moving forward.	

Contents

1 Introduction

This is a two-part document; a report on the developments and performance related to Infection Prevention and Control (IPC) during 2019/20 and the broad plan of work for 2020/21 to support reducing the risk of healthcare associated infections (HCAIs). The report outlines the challenges faced in the year 2019/20 and the Trust's approach to reducing the risk of HCAI.

A zero-tolerance approach continues to be taken by the Trust towards all avoidable HCAIs. Good IPC practice is essential to ensure that people who use the Trust services receive safe and effective care. Effective IPC practices must be part of everyday practice and be applied consistently by everyone. The publication of the IPC Annual Report is a requirement to demonstrate good governance and public accountability.

The report acknowledges the hard work and diligence of all grades of staff, clinical and non-clinical who play a vital role in improving both the quality of patient care and stakeholders experience as well as helping to reduce the risk of infection. Additionally, the Trust continues to work collaboratively with a number of outside agencies as part of its IPC and governance arrangements in particular NHS Nene & NHS Corby Clinical Commissioning Groups and Public Health England (PHE).

2 Executive Summary

The annual report for Infection Prevention and Control outlines the Trust's performance for the prevention and control of infections in 2019/20. In addition, it highlights the role, function and reporting arrangements of the Director of Infection Prevention and Control (DIPC) and the Infection Prevention and Control Team (IPCT).

The structure and headings of the report follow the ten criteria outlined in the Health and Social Care Act 2008: Code of Practice on the Prevention and Control of Infections and Related Guidance.

2.1 Reportable Infections

The six infections that are now mandatory for reporting purposes are listed below:

- Meticillin Resistant *Staphylococcus aureus* (MRSA) bloodstream infections
- *Clostridioides difficile* infections
- Meticillin Sensitive *Staphylococcus aureus* (MSSA), *Staphylococcus schweitzieri* and *Staphylococcus argenteus* bloodstream infections
- *Escherichia coli* (*E. coli*) bloodstream infections
- *Klebsiella* species bloodstream infections
- *Pseudomonas aeruginosa* bloodstream infections

MRSA bloodstream infections and *Clostridioides difficile* infections are national contractual reduction objectives and there has been a continued focus on reducing both of these infection rates, but also on the reduction of MSSA and *E.coli* bloodstream infections.

2.2 MRSA

The HCAI objective for MRSA bloodstream infections for 2019/20 was 0 avoidable MRSA bacteraemia cases.

Cases are defined as community onset if blood cultures are collected on the day of admission or the day after; all other cases are apportioned to the Trust and named as hospital onset. It is the hospital onset cases that are included as part of the national HCAI reduction targets.

During 2019/20 there was 1 hospital-onset MRSA bloodstream infection, which is an increase from 0 MRSA bloodstream infections in 2018/19. From the post infection review this was found to be a contaminated sample.

2.3 *Clostridioides difficile* Infections

In 2019/2020 the definitions for C.diff acquisition were changed to:

- Healthcare Onset Healthcare Associated (HOHA) – sample taken on or after day 3 of admission, where date of admission is day 1
- Community Onset Healthcare Associated (COHA) – patient has been an inpatient in the Trust in past 4 weeks
- Community Onset Indeterminate Association (COIA) – patient has been an inpatient in the Trust within the last 4 and 12 weeks
- Community Onset Community Associated (COCA) – patient has not been admitted to the Trust in the past 12 weeks

It is the Trust-apportioned cases (HOHA and COHA) that are included as part of the national HCAI reduction targets and the Trust's quality goal. Therefore the numbers of CDI were expected to be higher in 2019/20 to take into account the broader definition which included COHA. The HCAI national objective set for NGH Trust apportioned patient cases was set at 40. During 2019/20 there were 44 Trust apportioned CDI patient cases.

The HCAI national objective set for NGH Trust apportioned (hospital onset) cases of *Clostridioides difficile* infections (CDI) for 2018/19 was no more than 20 hospital onset healthcare patient cases (taken on or after day 3 of admission), there were 14 Trust apportioned CDI patient cases.

Compared with shadow data collected for 2018/19 this equates to an increase from 32 to 44 patient cases (a 27% rise).

2.4 Meticillin Sensitive *Staphylococcus aureus* Bloodstream Infections

For reporting purposes, cases are apportioned to the Trust as per MRSA bloodstream infections but there are currently no national targets. NGH Trust had set themselves an internal ceiling of 13 hospital onset cases. During 2019/20 there were 24 hospital onset MSSA bloodstream infections, which is an increase on 2018/19 when there were 14 hospital onset MSSA bacteraemias.

2.5 *Escherichia coli* (*E. coli*) Bloodstream Infections

For reporting purposes, cases are apportioned to the Trust as per MRSA bloodstream infections. For 2017/18 NHS England set a 10% reduction target across each whole health economy. The local whole health economy includes Northampton General Hospital NHS Trust, Kettering General Hospital NHS Trust, Northamptonshire Healthcare Foundation Trust and the Clinical Commissioning Group (CCG). The reduction target is held by the CCG.

In 2018-19 33 patients acquired an *E.coli* bacteraemia, in 2019-20 the number was 38. The trust participated in a hydration week in conjunction with the nutrition team in May 2019 with the aim to reduce the number of gram negative bacteraemia associated with urinary tract infections.

The causes of the bacteraemia include 5 intra-abdominal, 6 hepatobiliary, 4 line associated, 13 urinary, 4 hospital acquired pneumonia, 2 genital and 4 unknown source.

2.6 *Klebsiella species* and *Pseudomonas aeruginosa* bloodstream infections

These Gram-negative bloodstream infections have been required to be reported to PHE from April 2017. For reporting purposes, cases are apportioned to the Trust as per MRSA bloodstream infections but there are currently no national ceilings. During 2018/19 there were 17 Trust apportioned *Klebsiella* species bloodstream infections and 7 Trust apportioned *Pseudomonas aeruginosa* bloodstream infections. During 2019/20 there were 17 Trust apportioned *Klebsiella* species bloodstream infections and 4 *Pseudomonas aeruginosa* bloodstream infections.

2.7 Director of Infection Prevention Control Reports to the Board of Directors

The Director of Infection Prevention & Control (DIPC) delivers an Annual Report to the Board of Directors.

The Executive Team receive updates on patients with *Clostridioides difficile* infections and MRSA bacteraemia, exception only.

The Board of Directors receive:

- Director of Nursing Board Reports on IPC exceptions (monthly)
- IPC Clinical Quality and Effectiveness Group (CQEG) Report (quarterly)
- Quality Governance Committee (quarterly)

Compliance Criterion	What the registered provider will need to demonstrate
1	Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider how susceptible service users are and any risks that their environment and other users may pose to them.

3 Governance and Monitoring

3.1 IPC Governance

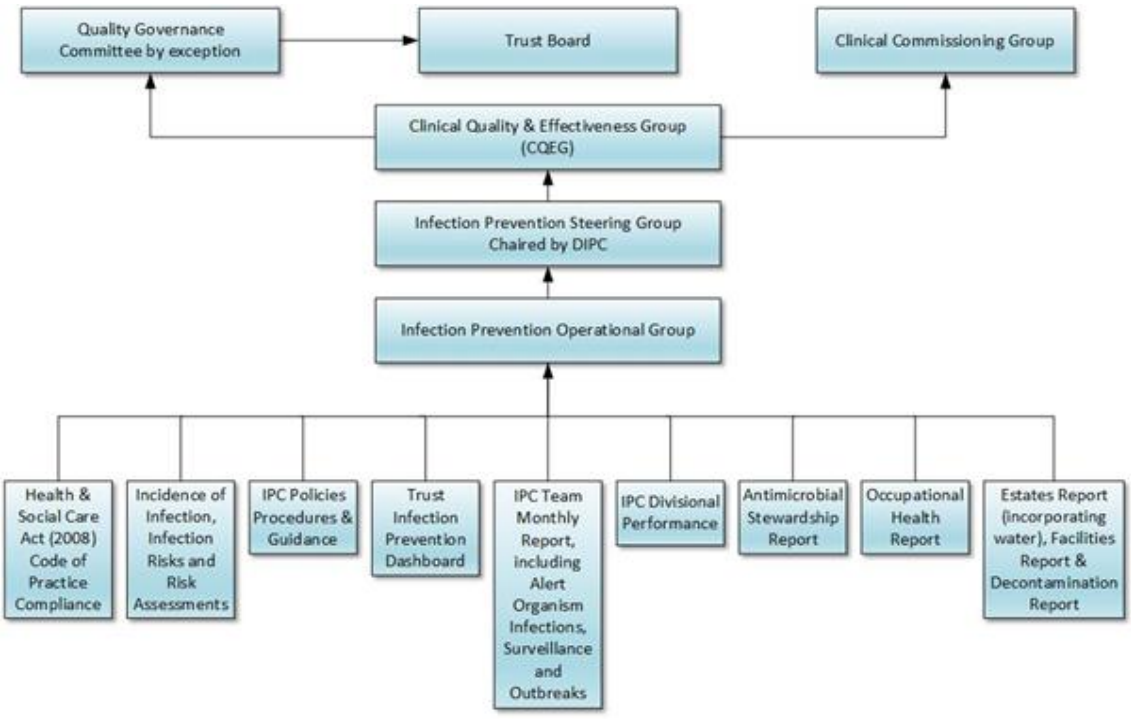
The Board of Directors has collective responsibility for keeping to a minimum the risk of infection and recognises its responsibility for overseeing IPC arrangements in the Trust.

The Trust Director of Infection Prevention and Control (DIPC) role is incorporated into the role of the Director of Nursing, Midwifery & Patient Services.

The DIPC is supported by the Medical Director, Consultant Microbiologist, Director of Estates and Facilities, the Matron for Infection Prevention & Control and the Trust Antimicrobial Pharmacist.

The Infection Prevention and Control Team (IPCT) include microbiology, virology, wound surveillance, and epidemiology. The IPCT works with pharmacy, facilities, associate directors of nursing, divisional directors, divisional managers, divisional matrons, ward managers, infection prevention and control link staff and sterile services.

Infection Prevention Steering Group Structure



In 2019/20 the Infection Prevention Steering Group (IPSG) and the Infection Prevention Operational Group (IPOG) continued to be held on a monthly basis.

The IPSG provides assurance that a zero-tolerance approach to avoidable HCAIs is delivered. The purpose of the IPSG is to provide strategic direction for the prevention and control of HCAIs within the Trust that minimises the risk to patients, staff and visitors. The DIPC provides a quarterly IPC report to CQEG from IPSG and IPC. The DIPC also provides a quarterly report to the Quality Governance Committee (QGC).

The purpose of the IPOG is to ensure that there is a managed environment within Northampton General Hospital (NGH) NHS Trust that minimises the risk of infection to patients, staff and visitors. The group is responsible for providing IPC advice at an operational level and makes recommendations to the IPSG and divisions. The Decontamination Lead and the Estates and Facilities Teams report to the IPOG.

3.2 Quality Governance Committee

The Quality Governance Committee is a sub-committee of the Trust Board and reviews areas of concern and improvement arising from the IPSG.

3.3 Links to Clinical Governance and Patient Safety

The DIPC reports the Trust IPC position to CQEG on a quarterly basis. Learning from Post Infection Reviews (PIR) for MRSA bacteraemia and *Clostridioides difficile* infections are discussed at IPOG and emergent themes and learning are shared at IPSG and at CQEG.

3.4 Clinical Commissioning Group monitoring

NHS Nene & Corby Clinical Commissioning Group (CCG) is NGH's commissioning organisation. IPC is a key element of quality commissioning and forms part of a joint commissioning quality schedule. The IPCT prepare an assurance report every month for the CCG to monitor the Trust's rate of infection.

The CCGs participate in the post infection reviews for all patients who develop MRSA bacteraemia in line with the NHS England guidelines for the management of cases. They also oversee the cases of CDI, reviewing all cases and attributing any lapses in care.

3.5 Northamptonshire Health Economy HCAI Group

The IPCT are active members of the local whole health economy HCAI group. This group is in existence to drive forward the Northamptonshire approach to infection prevention and control working together to ensure the quality of patient experience throughout the county is of equally good quality.

3.6 Infection Prevention & Control Standards and Assurance

In 2019/20 the Trust declared full compliance with the Care Quality Commission, Section 20 regulation of the Health and Social Care Act (2008) Outcome 8 Cleanliness and Infection Control. This declaration was made with due regard to regulation 12 of the Code of Practice for the NHS on the prevention and control of healthcare associated infections and related guidance.

The Trust undertakes interventions in relation to infection prevention and control as detailed within the HCAI plan of work 2019/20 (Appendix 4). This work is led by the Director of Infection Prevention and Control and supported by the Consultant Microbiologist & Infection Control Doctor, Medical Director and Matron for Infection Prevention and Control.

The IPCT continues to report numbers of MRSA/CDI to the Executive Team and to the Trust Board on a monthly basis and this is directly referenced in the Corporate Risk Register and Board Assurance Framework.

4 Healthcare Associated Infection Statistics and Targets

4.1 Surveillance

The Infection Prevention & Control Team (IPCT) undertakes continuous surveillance of alert organisms and alert conditions. Patients with pathogenic organisms or specific infections, which could spread, are identified from microbiology reports or from notifications by ward staff. The IPCT advises on the appropriate use of infection control precautions for each case and monitors overall trends.

4.2 Alert Organisms[1]

- MRSA
- *Clostridioides difficile*
- Group A *Streptococcus*
- *Salmonella* spp
- *Campylobacter* spp
- *Mycobacterium tuberculosis*
- Glycopeptide resistant *Enterococci*
- Multi - resistant Gram-negative bacilli e.g. extended spectrum beta-lactamase (ESBL) producers
- Carbapenemase-producing Enterobacteriaceae (CPE)
- Influenza
- SARS-CoV-2
- Neisseria meningitidis
- Aspergillus
- Hepatitis A
- Hepatitis B
- Hepatitis C
- HIV

4.3 Alert Conditions

- Scabies
- Chickenpox and shingles
- Two or more possibly related cases of acute infection e.g. gastroenteritis
- Surgical site infections

4.4 Current Actions to Improve Surveillance

On a weekly basis, a ward round of all patients with CDI within the Trust is undertaken by a senior member of the IPCT and the antimicrobial pharmacist. Any concerns are raised with the Consultant microbiologist and the Consultant gastroenterologist. In 2019/20 there were weekly antimicrobial reviews of wards with the Consultant microbiologist and the antimicrobial pharmacist.

4.5 Identified Priorities for 2019/20

In 2019/20, the Trust's HCAI Reduction Delivery Plan set out to:

- Reduce the number of patients with CDI and achieve the national targets and the Trusts' Quality Account
- Maintain the number of MRSA bacteraemia to achieve the national targets
- Reduce the number of patients with MSSA bacteraemia
- Support the Whole Health Economy to reduce the number of patients with *E.coli* bacteraemia

[1] Alert organisms are organisms identified as important due to the potential seriousness of the infection they cause, antibiotic resistance or other public health concerns. This is a nationally recognised term; these organisms may be part of mandatory or voluntary surveillance systems and are used as indicators of general infection prevention and control performance.

4.6 *Staphylococcus aureus* Bloodstream Infections

All *Staphylococcus aureus* bloodstream infections – sensitive to Methicillin (MSSA) or resistant to Methicillin (MRSA) – are reported on a mandatory basis through the Public Health England (PHE) HCAI Data Capture System. The Trust's incidence of MSSA and MRSA cases are reported on the PHE website. The incidence of these cases is reported publicly as acute Trust apportioned or otherwise. Over the past few years, the NHS has made significant progress in reducing MRSA bloodstream and *C. difficile* infections. The availability of a robust and accurate picture of the scale of MSSA infections, nationally and locally, will also support patients in making meaningful choices about their healthcare.

The reduction of all avoidable bloodstream infections including MSSA and MRSA continues to be an aim of the Trust.

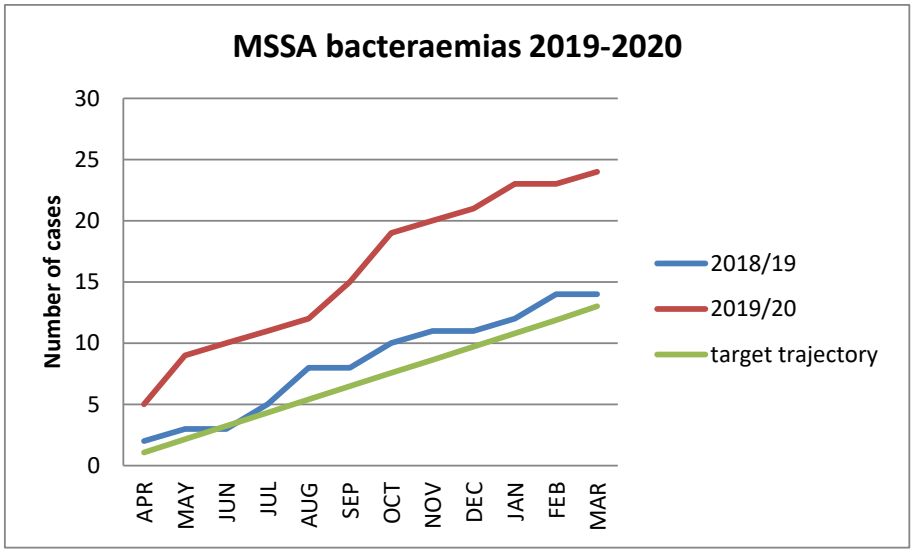
4.7 MSSA Bacteraemia

The IPCT set a revised ambition of no more than 13 cases of MSSA bacteraemia. In 2019/20 the ambition was not met with an outturn of 24 patients with hospital onset MSSA bacteraemia. These have been classified into endogenous patient cases where the bacteraemia was unavoidable and exogenous patient cases where the bacteraemia could have been avoided. In 2019/20 there were 12 patient cases which were unavoidable, 7 which were avoidable and 5 which were unable to classify. The IPCT will work within HCAI plan of work, to reduce this in 2020/21 and this will be monitored through IPSG.

A vascular access group has been set up to review practice with invasive vascular devices, this met first in February 2020. The key aims are to review current policies, practice and documentation.

Dryden ward had a period of increased incidence (PII) with 2 cases of MSSA bacteraemia within a 28 day period. One patient case was attributed to a cannula and was therefore avoidable, the other patient had endocarditis prior to the bacteraemia; this was unavoidable. The use of Octenisan has been increased to include Dryden ward as these patients can be vulnerable to infection and often have surgical procedures in the heart centre.

Figure 1



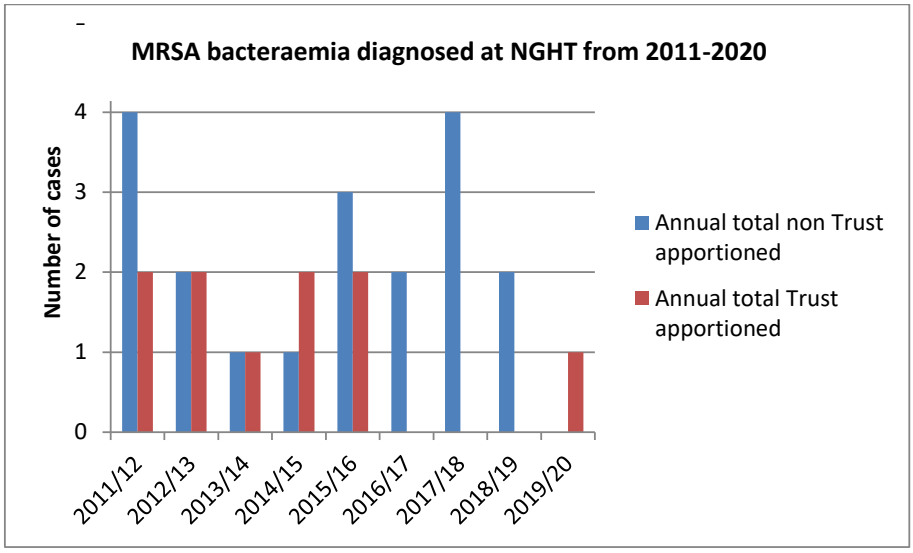
4.8 MRSA Bacteraemia

The Trust investigates every MRSA bacteraemia as an incident and undertakes a post infection review (PIR). These investigations are fed back to a multi-disciplinary group including the DIPC and members of

the Clinical Commissioning Group (CCG) and are accompanied by an action plan. These actions are monitored through the IPCT.

In 2019/20 there was one hospital onset MRSA bacteraemia. This was reviewed with PHE and was identified as a contaminated sample. Figure 2 presents the MRSA bacteraemia cases from 2011-2019 that were classified as either Community onset or hospital onset.

Figure 2

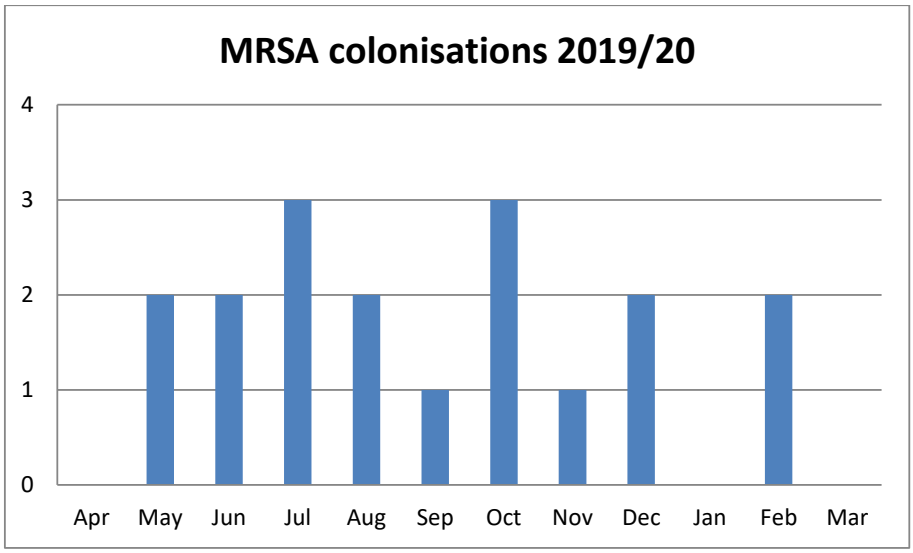


4.9 MRSA Colonisations

In 2019/20 there were 18 HCAI cases of MRSA colonisation, this was a decrease from 21 in 2018/19.

Figure 3 reflects the monthly cases of MRSA colonisations attributed to the Trust during 2019/20

Figure 3



4.10 Period of Increased Incidence of MRSA Colonisation

A Period of Increased Incidence (PII) of MRSA colonisation is defined by Public Health England as 2 or more new cases of post admission MRSA colonisation on a ward in a 28-day period. Post admission is defined as any MRSA swab dated over 48 hours after admission.

The IPCT identified a range of actions which were implemented on any ward that had 2 or more new cases in a 28-day period. For 2019/20 there was 1 PII of MRSA on Hawthorn ward.

4.11 MRSA Screening by Patient Group

In line with the Department of Health 'MRSA Screening - Operational Guidance 2' the following patient groups are screened as indicated below in Table 1.

Table 1: MRSA Screening Criteria

Patient group / Admitted to	Screening
Elective admissions as described in DH letter and operational guidance (excludes same day case patients)	Time of listing Eradication of MRSA attempted before admission
Critical Care patients	On admission to Critical Care and then weekly
Renal dialysis patients	On admission and on a weekly basis
Cardiology patients	On admission and on a weekly basis
Surgical patients	On admission and on a weekly basis
All other patients including emergency admissions	On admission

The Trust achieved compliance with the requirements for all elective patients to be screened for MRSA colonisation, under the reporting methodology advocated by the Department of Health. The overall MRSA screening compliance for the year for elective patients was 99.51% (99.6% previous year) and 96.74% (97.3% previous year) for non-elective patients. Efforts continue to achieve greater compliance.

4.12 *Clostridioides difficile* infection (CDI)

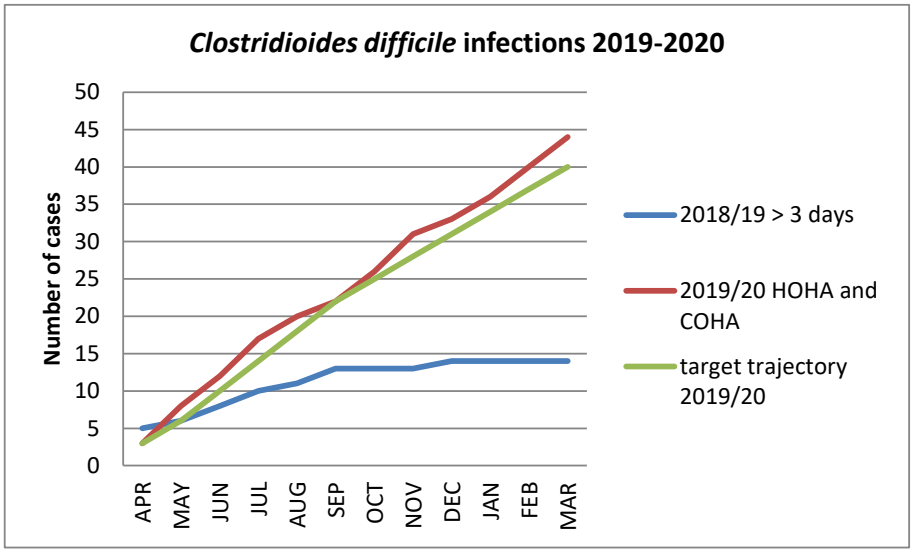
Since January 2004 it has been a mandatory surveillance requirement for the Trust to report cases of *Clostridioides difficile* toxin positive stool (previously known as *Clostridium difficile)*.

NHS England and NHS Improvement set new changes to *Clostridioides difficile* reporting and acute provider objectives for 2019/20 were set using two categories.

- Hospital onset healthcare associated: cases that are detected in the hospital two or more days after admission.
- Community onset healthcare associated: cases that occur in the community (or within two day of admission) when the patient has been an inpatient in the trust reporting the case in the previous four weeks.

The CDI target for the Trust for 2019/20 was 40 and at the out-turn was 44 patients, this now includes patients in the community who have been in hospital in the 4 weeks prior to the sample being taken, which partly explains the rise in cases from 14 in-patient cases in 2018/19.
Compared with shadow data collected for 2018/19 this equates to an increase from 32 to 44 patient cases (a 27% rise).

Figure 4



All CDI cases have been investigated by the clinical teams, the IPCT, the Consultant Microbiologist and the Antimicrobial Pharmacist utilising a Post Infection Review (PIR) process. Wards that have had Trust attributable CDI are asked to feedback their findings from the PIR process at the monthly IPOG meeting, where their learning can be shared with members of the group. Findings from the PIR are also presented through IPSG and CQEG.

Of the patient cases, 23 were HOHA and 21 were COHA. The Clinical Commissioning Group (CCG) reviews all Trust attributable CDI PIRs. In 2019/20 the CCG has reviewed the first 35 cases and found no lapses in care. In March 2020 the CCG temporarily suspended the need for the Trust to send these PIRs to the CCG due to an increase in work as a result of the SAR-CoV-2 pandemic. The Infection Prevention and Control team are reviewing the cases individually and will continue to report to IPOG, IPSG, CQEG and Governance groups.

4.13 Actions completed in 2019/20 to reduce the risk of CDI

- Implementation of the 2019/20 HCAI reduction delivery plan which included a work stream on CDI reduction and was monitored by the IPSG quarterly. This included a sustained focus on prudent antibiotic prescribing and reviewing antibiotics and proton pump inhibitors in a timely manner to protect patients from CDI.
- Completion of the separate CDI forward plan that included additional specific operational initiatives to protect patients from CDI and was also been monitored quarterly through the IPSG.
- Antibiotic Guidelines were reviewed by the Consultant microbiologist and the Antimicrobial pharmacist. This guidance has been uploaded on to the Trust intranet for ease of accessibility for all members of staff.
- Octenilin gel is being used trust wide to manage chronic wounds that are colonised or infected with pathogens, to reduce the use of antibiotics for this wounds.
- On a weekly basis, a ward round of all patients with CDI within the Trust is undertaken a senior member of the IPCT and the antimicrobial pharmacist. Any concerns are raised with the Consultant Microbiologist and the Consultant Gastroenterologist and actioned appropriately.

- Enhance cleaning sign offs have commenced; following a patient developing CDI the enhanced touchpoint cleaning procedure continues to be implemented and is now signed off by the ward Sister and Domestic manager upon completion.

- Estates, Domestic and Infection Prevention (EDI) reviews continue when a ward has a patient who has developed CDI to produce a thorough and a collaborative inspection of the ward from an IPC, cleanliness and environmental perspective.

4.14 Trust Apportioned CDI 2019/20

Table 2 presents the Trust apportioned cases of CDI for other Trusts within the locality of NGH to provide a benchmark for comparison against the Trust.

Table 2: Trust Apportioned CDI for 5 Trusts

2019/20	Ceiling	Actual	Deviation
Northampton General Hospital	**40**	**44**	**+10%**
Kettering General Hospital	39	55	+41%
United Lincolnshire Hospitals	110	80	-27%
University Hospital Coventry and Warwick	60	73	+22%
Worcester Acute Hospital	53	67	+26%

4.15 Antimicrobial Resistance: ESBL Producers (Extended Spectrum Beta-Lactamase Producers)

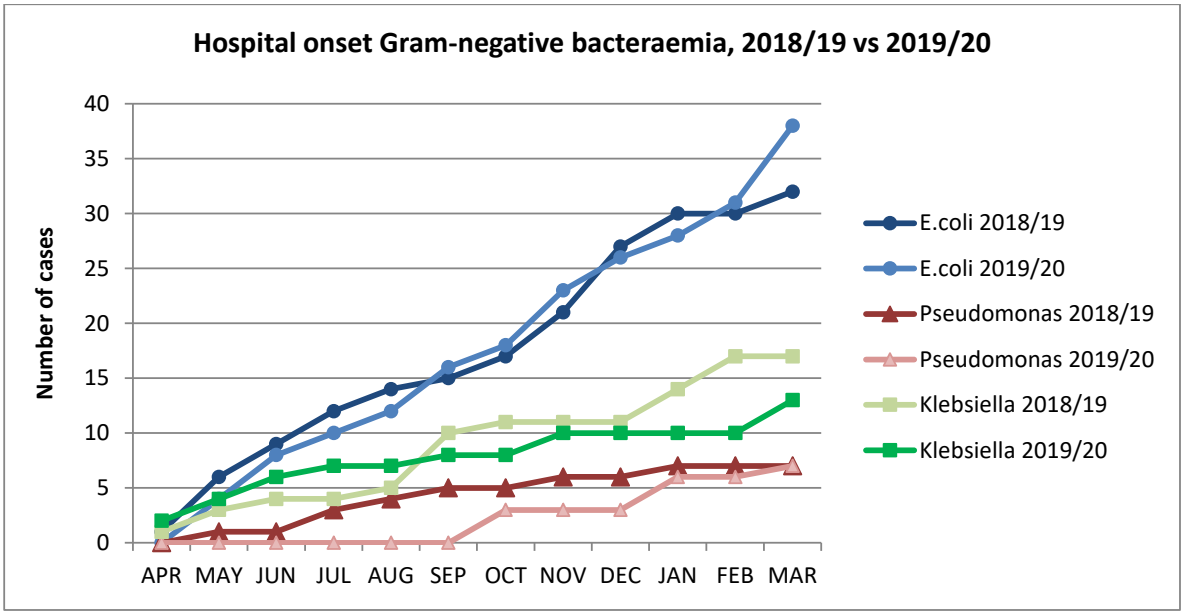
ESBLs are a group of enzymes produced by bacteria. The enzymes break down antibiotics such as cephalosporins and penicillins, but the bacteria are usually susceptible to, and hence treatable with, the carbapenem antibiotics.

The epidemiology of these bacteria is not fully understood. The emergent nature of this field of microbiology is underlined by the absence of any national case definitions for community or hospital-acquired infections with ESBL producers, or recommendations on what constitutes an episode of infection with ESBL producing bacteria. In house surveillance within the microbiology department is no longer performed. It is reported in real time through an electronic system to Public Health England (PHE).

4.16 Gram-Negative Bloodstream Infections

Hospital onset Gram negative blood stream infections: Escherichia coli (*E.coli) Klebsiella and Pseudomonas aeruginosa*

Figure 5



4.17 Escherichia coli

In accordance with DH Guidance the IPCT commenced mandatory reporting of *Escherichia coli* (*E. coli)* bacteraemia in 2011**.** All *E.coli* bloodstream infections are reported on a mandatory basis through the PHE Data Capture System.

In 2019-20, 38 patients acquired an *E.coli* bacteraemia. This compares with 33 in 2018-19 and 38 in 2017-18. The causes of the bacteraemia in 2019-20 include 5 intra-abdominal, 6 hepatobiliary, 4 line associated, 13 urinary, 4 hospital acquired pneumonia, 2 genital and 4 unknown source.

The trust participated in a hydration week in conjunction with the nutrition team in May 2019 with the aim to reduce the number of gram negative bacteraemia associated with urinary tract infections.

4.18 Klebsiella Species and Pseudomonas aeruginosa blood stream infections

From April 2017 Gram-negative bloodstream infections surveillance has been commenced by the IPCT (*Klebsiella* species and *Pseudomonas aeruginosa),* which is also reported onto the PHE Data Capture System. This will enable PHE to identify trends at the end of the year which will then support Trusts to better understand these infections and also inform IPC practice to reduce the incidence of these bloodstream infections further. There are currently no national targets for these organisms.

Klebsiella species bloodstream infections that were Trust apportioned for 2019/20, there were 16 in total. There is no national target set for 2019/20 but mandatory reporting will continue.

The *Pseudomonas aeruginosa* bloodstream infections for 2018/19 and 2019/20 are displayed in Figure 5. There were 4 Trust apportioned in total. There is no national target set for 2019/20 but mandatory reporting will continue.

For 2019/20 the IPCT has developed a Gram-negative bacteraemia forward plan which includes work streams to reduce the risk of *E.coli* and the other Gram-negative bacteraemia. This has been reviewed and updated for 2019/20. This will be monitored quarterly through IPSG. The IPCT will also continue to work the Whole Health Economy (WHE) and combine efforts to protect patients from Gram-negative bacteraemia.

4.19 Actions completed in 2019/20 to reduce the risk of *E.coli, Klebsiella, Pseudomonas aeruginosa* and other gram negative bacteraemia

Implementation of the 2019/20 gram negative forward plan which included

- a catheter care campaign, review of catheter associated urinary tract infections, introduction of new continence products and joint working with the continence group to reduce urinary tract infections as a pre-cursor infection
- Annual assessment of competence for clinical staff in aseptic non-touch technique (ANTT), specific link person focus morning on ANTT and new guidance on how and why to take a wound swab to prevent / manage wound infections to reduce the risk of skin / wound infections
- Promotion of hydration and mouth care to reduce the risk of hospital acquired pneumonia and urinary tract infections

4.20 Antimicrobial Resistance: Carbapenemase Producing Enterobacteriaceae (CPE)

CPE have similarities to ESBLs but with a wider range of effects on antibiotics – breaking down the carbapenem group of antibiotics.

In 2014/15 the DH issued guidance in the form of a toolkit and this predominantly concentrated on prevention: isolation of high-risk individuals and screening being of particular importance. Focus has been given to patients who have been an in-patient abroad in the past 12 months**.** In response to this, the IPCT collaborated with other local Trusts' and utilising the CPE toolkit has developed the following:

- A Trust wide CPE Procedural Document
- A Patient Information Leaflet
- A Staff Information leaflet
- A Training package on CPE
- A CPE surveillance sheet
- A flowchart and "how to" screen patients who are suspected to have CPE

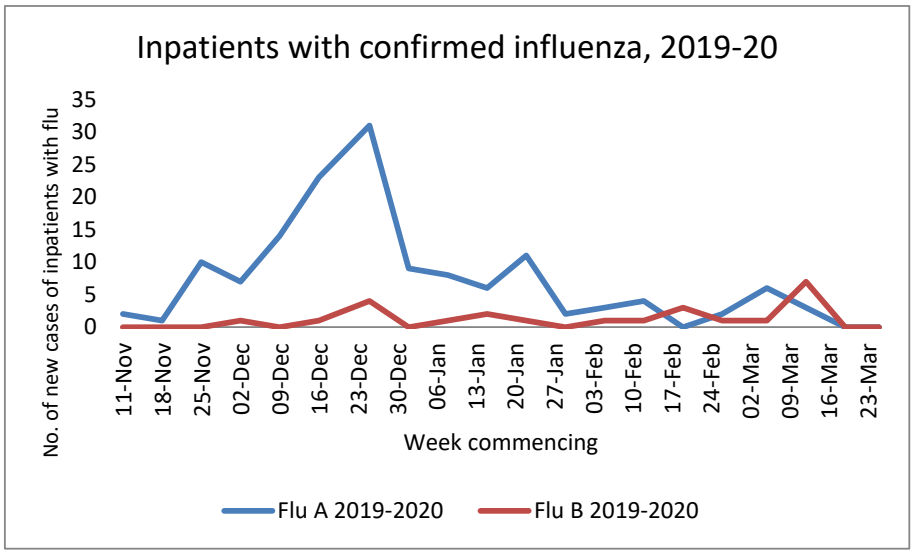
Training on CPE is given at Trust Induction and in IPC mandatory training sessions and workbooks for clinical staff.

In 2019/120, the IPCT continued to monitor the number of CPE screens obtained and report positive cases to IPSG. The IPCT perform daily surveillance on these patients during their hospital admission, and continue to collaborate with the Site Management Team to identify patients that require CPE screening on admission or repatriation from high risk countries and hospitals. The IPCT also work in collaboration with the domestic and catering team to ensure that both teams are fully aware of the side room location of these patients, to ensure that the appropriate cleaning and catering facilities are available. The IPCT continue to work with the Pre-Operative Assessment Clinic to identify possible cases prior to admission as detailed in the HCAI forward plan.

4.21 Influenza

From 11th November 2019 to 31st March 2020 a total of 160 patients were diagnosed with Influenza (Flu). Figure 6 shows the epidemiological pattern of Flu with the number of confirmed positive patients each week and that Flu A was the dominant strain. The main peak lasted from the beginning to the end of December 2019 and there were no outbreaks or ward closures due to Flu.

Figure 6



The Flu activity within Northampton General Hospital reflected the epidemiological picture both within the East Midlands and nationally, which was reported on by PHE.

4.22 Mandatory Surveillance of Surgical Site Infections

In collaboration with the Trauma and Orthopaedic Directorate and the Surgical Division, the IPCT undertake four or five different categories of Surgical Site Infection (SSI) surveillance each quarter. Total hip replacement, total knee replacement and repair of fractured neck of femur surgeries are surveyed every quarter. The IPCT conduct further surveillance on one or two additional categories of operation every quarter that survey patients undergoing general, vascular, obstetrics and gynaecology surgeries. All data for a surveillance period must be submitted within 90 days of the end of the quarter to PHE who collate and report on the data from all hospitals that have participated. The IPCT report SSI rates to IPSG quarterly for monitoring and assurance purposes.

4.23 SSI Surveillance Conducted by the IPCT

During 2019/20 the IPCT conducted quarterly SSI surveillance on a variety of operations as presented in Table 3:

Table 3: SSI Surveillance by Quarter 2019/20

Quarter	Category	Number of operations undertaken at NGH	NGH SSI rate	National average SSI rate
1	Breast surgery	61	1.6%	0.7%
2	Breast surgery	73	0%	0.7%
3	Breast Surgery	75	0%	0.6%
	Caesarean sections	357	1.4%	3.2%
4	Breast Surgery	68	2.9%	0.6%

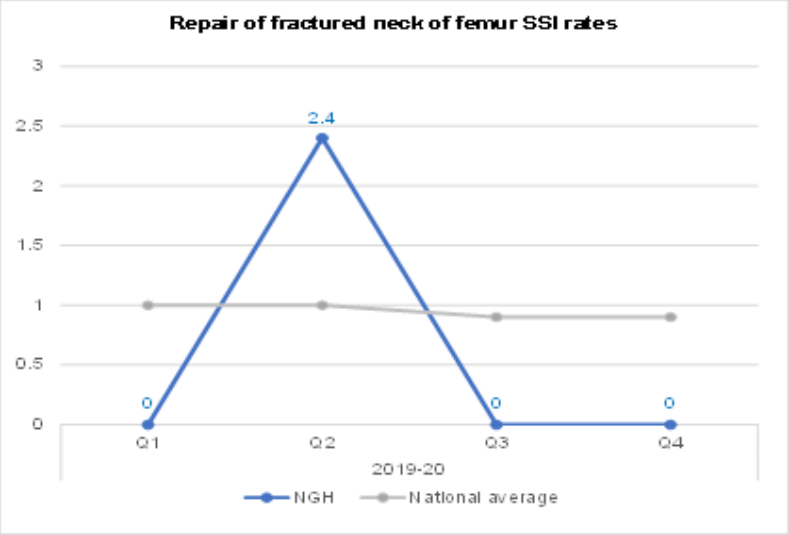
A Post Infection Review is conducted for all patients that develop a SSI and the infection is discussed with the patient's Consultant to determine whether the infection was avoidable or not. SSI rates and learning from cases are reported back to the Surgical Division through the divisional governance structure for discussion and follow up as required.

The breast surgery SSI rate was above the national average in quarter 1, this was due to two patients developing an SSI. Two patients developed superficial infections one with *pseudomonas* species isolated & mixed anaerobes and second patient isolates *Streptococcus oralis / Staph. Epidermis* pus cells SSI, for which a full post infection review was undertaken. The rate of SSI for patients undergoing breast surgery was higher than the national average for quarter 4 with two patients who developed SSIs *staph aureus* isolated infections. Following this, the IPCT are implementing prophylactic decolonisation treatment prior to surgery to reduce the risk of infection and reviewing the wound care plan.

4.24 SSI Surveillance Conducted by the Trauma and Orthopaedic Directorate

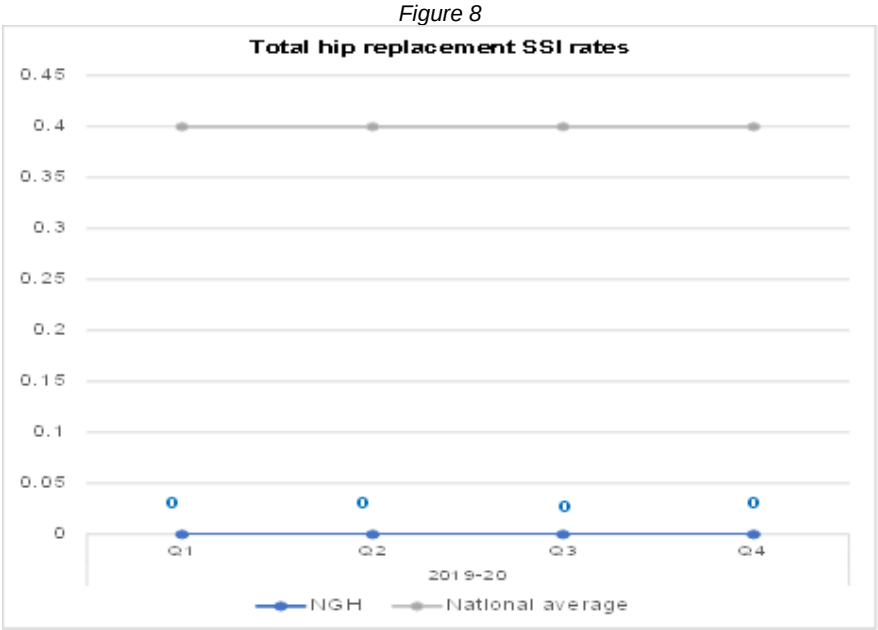
Figure 7 presents the quarterly SSI rate for the 335 patients that underwent repair of fractured neck of femur surgery in 2019/20.

Figure 7



Following rates of SSI that were higher than the national average at the start of the year, the IPCT have collaborated with the Matron for Trauma & Orthopaedics and the Practice Development Team and commenced a SSI Improvement Group to ensure that best practice is conducted with regards to surgical wound care. Figure 8 presents the quarterly SSI rate for 196 patients who underwent total hip replacement surgery in 2019/20.

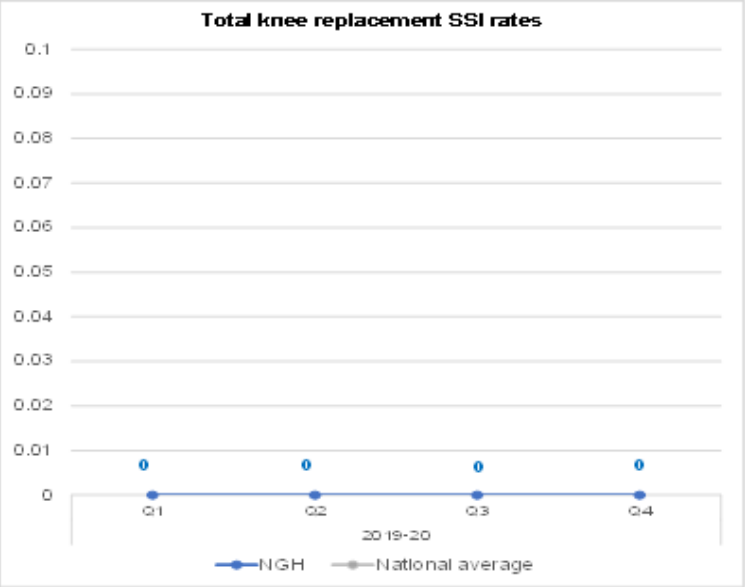
Figure 8



For total hip replacement surgeries, we had no patients develop a surgical site infection 2019/20.

Figure 9 displays the quarterly SSI rates for the 245 patients who underwent total knee replacement surgery in 2019/20.

Figure 9



For total knee replacement surgeries, surgeries, we had no patients develop a surgical site infection 2019/20.

SSI surveillance continues in 2019/20 as detailed in the SSI forward plan.

4.25 Untoward Incidents and Outbreaks

Becket ward had an outbreak of Norovirus in April 2019 with 14 patients affected.

The Becket ward team identified the signs and symptoms of Norovirus promptly and liaised well with the IPC Team to contain the virus and prevent transmission to other floors of the building. Daily outbreak meetings were held and a timeline of the outbreak maintained. An outbreak de-brief meeting was held on 1st May to determine any additional learning.

4.26 COVID-19 pandemic

On 11th March 2020 the World Health Organization declared a pandemic of COVID-19, a disease primarily affecting the respiratory system and caused by a new coronavirus known as SARS-CoV-2. To manage the pandemic the trust instigated a major incident response to proactively manage the operational functions of the organisation. The management of Infection Prevention was central to this work and the IPC team reported on a daily basis to the trust through the designated communication channels to the Executive team.

The first patient with COVID-19 in the Trust was detected on March 13th 2020. At the end of the financial year there had been 108 positive results from the Emergency Department and inpatients. 79 staff also tested positive in March 2019.

The Infection Prevention and Control team (IPCT) met daily with the Consultant Microbiologists and Director of Infection Prevention in Bronze meetings, which fed into daily Silver meetings with the aim to promote patient safety and prevent outbreaks.

Initial efforts focused on the early diagnosis of COVID-19 in the Emergency Department and ensuring staff there were aware of Personal Protective Equipment (PPE) guidance and had access to the equipment they needed. Critical Care was also a priority with Main Theatres being turned into an extension of Critical Care. Manfield theatres were then used for all surgery including potential COVID-19 cases.

Staff in some departments, who were performing aerosol-generating procedures on patients, required provision of masks rated as “FFP3” in order to be adequately protected from possible infection via airborne particles. Staff have to be fitted for FFP3 masks individually and this occupied a significant proportion of the IPC team’s time.

Several ward usage changes occurred to enable cohorting of suspected or confirmed cases. Bay doors were applied towards wherever possible, to reduce the potential for spread of the infection within wards.

4.27 Infection Prevention & Control Audit Plan 2019/20

The IPCT performed various audits throughout 2019/20 as illustrated in Table 4. All audits for 2019/20 are reported at the Infection Prevention and Control Operational Group (IPOG) for discussion and actioning; and at the Infection Prevention Steering Group (IPSG) for assurance purposes

Table 4: IPC 2019/20 Audit Plan

	Annual	6 Monthly	Quarterly	Monthly Audits
Apr 2019	Standard precautions		HHOT audit FFP3 maintenance records audit	*C.difficile* SIGHT compliance audit. Safety thermometer audit validation for CRUTIs. Patient journey through theatre audit. Waste.
May 2019		Commode cleanliness audit	Water outlet flushing audit. PICC line related BSI audit.	*C.difficile* SIGHT compliance audit. Safety thermometer audit validation for CRUTIs. Patient journey through theatre audit. Waste.
Jun 2019	Cannula-related BSI and, central-line related BSI prevalence audits. Waste.		MSSA & MRSA suppression compliance audit Mouth care audit	*C.difficile* SIGHT compliance audit. Safety thermometer audit validation for CRUTIs. Waste.
Jul 2019	Blood culture audit Waste audits weekly	Hand wash basin cleanliness audit	Water outlet flushing audit FFP3 maintenance records audit	*C.difficile* SIGHT compliance audit. Safety thermometer audit validation for CRUTIs. Waste.
Aug 2019	Aseptic non-touch technique audit		HHOT audit PICC line related BSI audit	*C.difficile* SIGHT compliance audit. Safety thermometer audit validation for CRUTIs. Waste.
Sept	Catheter-		MSSA & MRSA	*C.difficile* SIGHT compliance audit.

2019	related UTIs prevalence audit		suppression compliance audit Water outlet flushing audit	Safety thermometer audit validation for CRUTIs. Waste.
Oct 2019	Handling & disposal of sharps audit	Commode cleanliness audit	FFP3 maintenance records audit Mouth care audit	*C.difficile* SIGHT compliance audit. Safety thermometer audit validation for CRUTIs. Waste.
Nov 2019	Risk assessment /transfer checklist audit		PICC line related BSI audit HHOT audit	*C.difficile* SIGHT compliance audit. Safety thermometer audit validation for CRUTIs. SSI care bundle audit. Waste.
Dec 2019	Wound care plan compliance audit		MSSA & MRSA suppression compliance audit Water outlet flushing audit	*C.difficile* SIGHT compliance audit. Safety thermometer audit validation for CRUTIs. SSI care bundle audit. Waste.
Jan 2020		Hand wash basin cleanliness audit	FFP3 maintenance records audit Mouth care audit	*C.difficile* SIGHT compliance audit. Safety thermometer audit validation for CRUTIs. SSI care bundle audit. Waste.
Feb 2020			HHOT audit	*C.difficile* SIGHT compliance audit. Safety thermometer audit validation for CRUTIs. Waste.
Mar 2020			MSSA & MRSA suppression compliance audit Water outlet flushing audit PICC line related BSI audit	*C.difficile* SIGHT compliance audit. Safety thermometer audit validation for CRUTIs. Waste.

Compliance Criterion	What the registered provider will need to demonstrate
2	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.

5 Environmental Cleanliness 2019/20

In 2019/20 the Trust continued to complete monthly environmental cleanliness audits using an electronic audit tool that reflects the National Specifications for Cleanliness in the NHS (NPSA, 2007) and additionally the PAS 5748 Specifications for Cleanliness (BSI, 2014). The electronic audit tool enables the Domestic Supervisor to generate an action plan which is shard with the relevant Ward Manager and Matron. All cleanliness audits scores are reported monthly to IPOG and any concerns or good practice are escalated to IPSG.

The IPCT continue to work collaboratively with the Domestics, Catering and the Estates Teams to maintain a clean and safe environment for patients.

The National Standards of Cleanliness new guidelines are due out during quarter one 2020. This will require Hotel Services and the Infection prevention team reviewing current criteria's of risk and perception.

Patient-Led Assessments of the Care Environment (PLACE) occurred during 2019/20 with favourable results across the inspection requirements meeting standards and often above the national targets. A full briefing of the results was presented by the Hotel Services Manager to the Trusts Infection Prevention steering group chaired by the Director of Nursing. A full report is available.

A full pest control contract is in place with fortnightly inspections site wide and proactive "call-out" procedures to deal with seasonal pests.

5.1 Sterile Services Department

The Sterile Services Department (SSD) processed 136388 trays, procedure packs and supplementary medical devices between April 2019 and March 2020.

The department continues to provide a fully compliant service to NHFT Podiatry and a full theatre tray service to BMI Three Shires, as well as Northampton General Hospital.

We had our Notified Body Audit carried out by our External Auditors SGS Ltd, this took place over a Two day period in April 2019 with the result of 7 Corrective Action Requests being raised and received. The CAR's raised have all been addressed and closed off.

The SSD continues to be audited by our externally based Quality Advisor & Internal Auditor and these again are being carried out remotely to ensure we maintain compliance to our own procedures and all other relevant ISO standards.

Currently two members of staff are in the process of studying for the level 5 Diploma in Leadership and Management.

The SSD Governance structure implemented in 2018 continues to help us to ensure that all aspects of the work we do in SSD have patient safety as the priority as patient safety is paramount.

The Environmental checks introduced last year continue to be carried out on a monthly basis and are a worthwhile indicator to ensure we continue to reach or exceed the infection and prevention control standards.

Compliance Criterion	What the registered provider will need to demonstrate
3	Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.

6 Antimicrobial Stewardship

6.1 Compliance with Trust Antibiotic Policy

The clinical pharmacists performed a Trust wide antimicrobial point prevalence audit in September 2019. Areas that do not have a regular pharmacy visit were excluded (Maternity, Emergency Department, Singlehurst). The aim was to audit antimicrobial prescribing and compliance to the Trust Antibiotic Policy. Data was collected over a 3 day period in September 2019.

This is in response to the Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance, criteria 3 of which states that procedures should be in place to ensure prudent prescribing and antimicrobial stewardship to optimise patient outcomes and there should be an ongoing programme of audit, revision and update.

Table 5 presents the results of the Trust wide antimicrobial point prevalence audit (September 2019) The previous audit was conducted in April 2019 and the corresponding results are in brackets ().

Descriptor	Number	Proportion	Comments
Total number of patients seen	485 (551)		Data was received from adult inpatient wards that get a regular pharmacy service
Number of patients on antibiotics	176 (214)	36% (39%)	This proportion has reduced from April 2019 (38.8%)
Total number of antibiotics prescribed	199 (279)	1.13 (1.30) per patient	
Number adhered to the policy (excluding micro advice patients)	139 (183)	79% (73%)	New metric discussed in ASG which excludes patients given micro advice different to policy, to give a clearer picture of adherence.
Excluding micro &sensitivity	139 (183)	80% (77%)	Valid reasons for non-compliance include; • Micro approved = 22 (previously 29) • No guidelines for infection = 5 (previously 12) • Cultures and sensitivities=4 (previously 13)
Appropriate abx ie Adhered + all appropriate non adhered	177	89%	Adherence to policy has increased from

			73.2% to 78.1 %. Decreased microbiology involvement from last audit (29 in April). Possibly due to improvements in guidelines and increased microbiology involvement on the wards (weekly stewardship round)
Number of intravenous (IV) prescriptions	113 (163)	56.8% (58%)	This is similar to April 2019 (30% of IV prescriptions were on Walter Tull, Creaton and Becket ward)
Number of oral prescriptions	86(116)	43% (43%)	
Average duration of IV antibiotics	4.06 (Previously 3.08 days)		This is higher than in April. Several patients were on long courses for infective endocarditis, which could be the reason for the increase.
Average duration of oral antibiotics	1.94 (Previously 2.64 days)		This has reduced from previous years. Duration is now mandatory on the all ePMA drug charts and Trust guidelines have been updated to reflect appropriate use of oral antibiotics.
Duration of antibiotic administration stated for oral antibiotic	86	100% on adult wards	All oral antibiotics now have mandatory durations when prescribed on EPMA.
Duration of antibiotic administration stated for IV antibiotic	48 (40)	42.% (25%)	Compulsory durations are not required for IV antibiotics due to the risks of prescriptions expiring and missed doses of critical antibiotics occurring. It is expected that all antibiotics discussed with micro should have a review date/ duration. The increased number of durations stated could be a reflection of some auditors mixing oral and IV data together. The data collection forms were found not to be clear enough and will be amended before next audit to ensure

			more accurate results.
Number of antimicrobial prescriptions with one or more omitted dose	18 (25)	9% (9%)	This is the same as the previous audit. Most common reasons for this were: • Patient refused • Drug unavailable • Stat dose given recently therefore dose not due

An overall compliance of **79 %** to the antibiotic guidelines was achieved when excluding deviations due to microbiology advice. This rises to **80%** when culture sensitivity is taken into account, while appropriate antibiotic rises to **89%** when non adherent antibiotics reviewed. The overall compliance has increased from **73%** to **79%** in the previous audit and could potentially be due to the updated and new guidelines being uploaded to the intranet, and therefore more empirical treatments are now available for more conditions. This could be reflected by less micro involvement (22 vs 29) and less indications marked as guideline not available (5 vs 12) than previous in the previous audit. The antimicrobial pharmacists are currently updating the microguide app to reflect the changes in trust antimicrobial guidance and regular teaching sessions and role specific mandatory training is in development to support changes in practice to comply with the updated guideline.

The most common causes of non-compliance to the policy included:
- 62% of the non-adherence (excluding micro advice) was due to Co-amoxiclav use for various indications, most commonly urinary tract infection (UTI), lower respiratory tract infection (LRTI), combination of both LRTI and UTI, and also for asthma exac, skin/wound/abcess infection.
- Use of meropenem in patients with penicillin allergy and for LRTI not in policy.
- Use of Tazocin for LRTI not in policy and pro-longed courses as well as a case of a 24hr infusion for patient transferred from Kettering.
- 50% (11/22) antibiotics which were not appropriate were for respiratory conditions and these were all on medical wards.

Due to COVID19 and staffing levels, the next audit has been planned for September 2020.

6.2 Anti-Microbial Resistance: Commissioning for Quality and Innovation (CQUIN)

Antimicrobial resistance (AMR) has risen over the last 40 years and is linked to the inappropriate and overuse of antimicrobials.

There were 3 CQUINS with antimicrobial aspects for 2019/20.

1a- Improving the management of lower urinary tract infections in older people
100 patients need to be audited quarterly.
4 criteria must all be met in at least 60% of patients to get any financial reward.
- Was the diagnosis of lower UTI based on documented clinical signs or symptoms in accordance with PHE UTI Diagnosis Guidelines?
- Has a urine sample been sent to microbiology in line with PHE/NICE guidance?
- Was a urine dip stick test used to diagnose the lower UTI?
- Antibiotic choice: as per NICE NG109 or Local guidelines

1b- Improving surgical prophylaxis in elective colorectal surgery
100 patients need to be audited quarterly.
Only 1 dose of antimicrobial prophylaxis given for at least 60% of elective colorectal surgeries according to local guidance to get any financial reward.
- Antimicrobials can be continued if documented reason for this

Medicines optimisation CQUIN triggers 5

Quarter 1- – Start review of Anti-Fungal guidelines.
Quarter 2 - - Identification of an Anti-Fungal Stewardship team that meets the standards as set out in the NHS England Antifungal Stewardship Implementation Pack.
Quarter 3 - Diagnostic Gap Analysis Survey completed.
Quarter 4 - Audits undertaken as per local agreement and as set out in the NHS England Antifungal Stewardship Implementation Pack, with the first audit being the baseline audit and Blueteq forms completed as per contract.

Complete the Report of review of Antifungal Stewardship guidelines and submit them to NHS England.

This CQUIN is part of the overall medicines optimisation CQUIN and each quarters objective needed to be completed.

CQUIN 2019/2020 summary Table

	Target	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Result
1a- Improving the management of lower urinary tract infections in older people	Min 60 to Max ≥ 90%	35%	25%	Cancelled	Cancelled	Not achieved, but trust reached agreement with CCG
1b- Improving surgical prophylaxis in elective colorectal surgery	Min 60 to Max ≥ 90%	38.46%	86.79%	92%	Cancelled	Achieved average 72.4%
Medicines optimisation CQUIN trigger 5	See details above	Achieved	Achieved	Achieved	Cancelled	Q1-Q3 Achieved

The trust decided to stop Q3 and Q4 submission for the UTI CQUIN and later the Q4 for colorectal and antifungal CQUIN were also cancelled due to the COVID-19 pandemic.
Locally a financial agreement was reached with the CCG for all the CQUINS.

CQUIN's-2020/2021
There were 3 CQUIN's planned with antimicrobial aspects for 2020/21, these were all later cancelled. CCG1 and CCG13 were going to be led by other teams but with pharmacy supporting promoting these, with pharmacy leading the antifungal stewardship CQUIN.

CCG1: Appropriate antibiotic prescribing for UTI in adults aged 16+
5 criteria must all be met in at least 40% to ≥ 60% of patients to get a financial reward.
1. Documented diagnosis of specific UTI based on clinical signs and symptoms;
2. Diagnosis excludes use of urine dipstick in people aged 65+ years and in all Catheter Associated UTI (CAUTI);
3. Empirical antibiotic regimen prescribed following NICE / local guidelines;

4. Urine sample sent to microbiology as per NICE requirement; and,
5. For diagnosis of CAUTI, documented review of urinary catheter use is made in clinical record:

Exclusions
Patients prescribed antibiotic prophylaxis for the treatment of recurrent UTI; pregnant women; chronic tubulo-interstitial nephritis.

CCG13: Treatment of community acquired pneumonia in line with BTS care bundle
4 criteria must all be met in at least 45% to ≥ 70% of patients to get a financial reward.

1. Perform a chest x-ray within 4 hours of hospital arrival time.
2. Pneumonia severity score (CURB65) calculated and documented in the medical notes during the ED and/or acute medical clerking.
3. Receive antibiotics within 4 hours of hospital arrival time.
4. Antibiotic prescription is concordant with severity score and in line with CG191 or local guidelines.

Exclusions
• Discharged from hospital within previous 10 days of the current admission for pneumonia.
• Admissions within previous 8 weeks of the current admission for pneumonia under the treatment function code for medical oncology (370), clinical oncology (800), or clinical haematology (303).

PSS6: Antifungal Stewardship
At least 75% to ≥ 90 of patients treated by approved antifungals as per local guidelines and reviewed appropriately by the AFS team within 7 days for a financial payment

Exclusions
Fluconazole/nystatin, any topical use of antifungals, prophylaxis, patients who received antifungals for thrush / superficial fungal infections.

The 2020/21 CQUINS have been on hold and have not started due to the COVID-19 pandemic. We are awaiting an update regarding these.

6.3 Training initiatives

Training sessions have been provided to medical core trainees, junior doctors and clinical pharmacists in the previous 12 months. Key teaching themes emphasised effective stewardship, risks from resistance, developing understanding of antibiotics and *C.difficile*. These will continue to be implemented. A role specific mandatory training package on antimicrobial stewardship has been developed by the antimicrobial pharmacists with input from infection prevention nurses and microbiologist. The e-learning package is mandatory for all doctors, pharmacists and nurses and aims to cover key aspects of antimicrobial stewardship, awareness of current guidelines and important information on resistant pathogens such as CPE. This has training has been available from November 2019 and can be accessed on the intranet, from the mandatory training page, under role specific training.

6.4 Antibiotic campaigns

Antibiotic Awareness Week & European Antibiotic Awareness Day

This annual awareness day was marked at NGH by encouraging staff to make a pledge to not dipstick over 65s and promote appropriate antibiotic use. This was carried out in the visiting wards and targeted staff to raise awareness of antimicrobial stewardship. Sessions in the Cripps postgraduate centre was also performed to target clinicians. A mobile trolley was used to raise awareness with spin the wheel and stewardship and infection prevention related questions.

Key themes that were advertised included

- Promotion of UTI CQUIN
- Promotion of Microguide- antibiotic guide
- Promotion of correct documentation of patients allergies
- Awareness of new guidelines and how to access them

6.5 Antimicrobial Stewardship Group (ASG)

The remit of this group is to develop and implement the organisation's antimicrobials programme for all adults and children admitted to hospital. Meetings took place in May, September and December 2019 and developments have included.

- Active participation in Anti-Microbial Resistance CQUIN and submission of data
    - AMR CQUIN Part CCG1a: Improving the management of lower urinary tract infections in older people
    - AMR CQUIN Part CCG1b: Improving surgical prophylaxis in elective colorectal surgery
    - MO CQUIN PSS1 Medicines Optimisation and Stewardship PSS CQUIN Indicator

- Maintaining and updating an action plan for antimicrobial stewardship in line with NICE gap analysis
- All antimicrobial guidelines and therapeutic drug monitoring reviewed and updated to promote antimicrobial stewardship
- Mandatory role specific training in Antimicrobials and Antimicrobial Stewardship reviewed and completed
- Review and monitoring of antibiotic consumption and expenditure and as well any governance issues.

6.6 Other Antimicrobial Developments

Weekly antimicrobial consultant ward rounds are conducted on ITU to improve stewardship. Microbiologists are in regular contact with clinicians. Weekly stewardship ward rounds are conducted on a chosen ward for a month with the microbiologist, antimicrobial pharmacist and a ward doctor. An antimicrobial pharmacist attends the weekly C. Difficile ward round with an infection prevention nurse.

Sepsis boxes have been distributed around the hospital with 2 vials of meropenem to be used in cases of red flag sepsis. This has been done in conjunction with the clinical sepsis lead and sepsis nurse. Responsibility for replenishing the stocks of meropenem lies with the ward as when a vial is used a form should be sent to pharmacy to request a top up of stock. Sepsis box audits are completed by the antimicrobial team on a quarterly basis.

The antimicrobial pharmacists virtually review ICT scripts for narrow therapeutic antibiotics in terms of monitoring requirements or dose adjustments based on ICE results or concerns from the ICT team.

Antifungal stewardship group developed, compromising of an antimicrobial pharmacist and consultant microbiologist.

6.7 Planned Developments for 2020/21

Development	Timeline	Information
OPAT service review	August 2020	To perform a fresh review of staffing and infrastructure
Development of malaria guidelines	August 2020	No current guidelines for this.
Develop IV to oral antibiotic policy	August 2020	To prompt review of IV antibiotics
CQUIN Support CAP and UTI CQUIN and Lead Antifungal CQUIN	June 2020	Teaching around UTI diagnosis (re: PHE and NICE literature) and treatment Teaching around CAP management Promotion of antibiotic guidelines Conduct antifungal stewardship team reviews
Antibiotic awareness week	November 18-24th 2020	Plan to promote awareness of stewardship
Continue education on stewardship to support reduction in consumption as part of NHS contract	Ongoing	Promote guidelines in the trust and conduct mini point prevalence audit to assess adherence to trust guidelines.
Quarterly: random audit	Ongoing	Assurance on compliance of appropriate review of antibiotics in patients
Update and develop Microguide	January 2021	Used increasingly by junior doctors to refer to guidelines Completed by antimicrobial pharmacist team
Stewardship rounds	ongoing	Continuation of weekly antimicrobial stewardship rounds on one ward/month Attend weekly C. Difficile ward round Restart attending weekly diabetic foot ward round Continuation of antifungal stewardship group
Update and develop E-learning	June 2021	Promotion of e-learning and collaboration with IPC for Nurse/midwife section
Development of patient information leaflet (PIL) for oral antibiotics	August 2020	PIL for patients attending A&E
Explore how EPMA upgrades can increase antimicrobial stewardship	September 2020	Possibility of having set antibiotics depending on severity of community acquired pneumonia to be explored with EPMA team
Explore how IBOX can be utilised for stewardship	June 2020	To liaise with IBOX team regarding identification of IV antibiotics
Recruitment to vacancy in antimicrobial pharmacy team	June 2020	To help achieve our planned work

Compliance Criterion	What the registered provider will need to demonstrate
4	Provide suitable accurate information on infections to service users, their visitor and any person concerned with providing further support or nursing/medical care in a timely fashion.

7 Provision of IPC Information

Information pertinent to IPC is provided to patients, visitors and staff in a variety of appropriate mediums and reflects seasonal trends in local and national infections.

7.1 Information for patients and visitors

The Trust provides patients, carers and visitors with information as required through patient information leaflets, the Trust internet site and signage across the organisation. The IPCT are always widely available to discuss specific infections with patients and their carers and answer any questions that they may have.

7.2 Information for staff

Information for staff is available in the IPC policies, procedures and clinical guidelines on the Trust intranet. Care pathways and care plans also provide condition specific information for staff. The IPC intranet page also hosts information sheets on a variety of infectious diseases, videos for aseptic non-touch technique, blood culture collection and the CDI change package, and information on how to access IPC mandatory training and contact the IPCT.

HCAI information for staff is documented on patient admission proforma, interdepartmental transfer forms, relevant care plans and also on discharge letters. The community healthcare providers are informed by the Trust IPCT when patients are discharged with HCAIs where care is required to be continued.

In 2020/21 the IPCT will continue with the IPC monthly campaigns that focus on a specific element of IPC practice each month. During the monthly focus, good news stories are published in the Trust insight magazine and e-bulletin, relevant screen savers are circulated, and the infection prevention information boards monthly reports to divisional governance meetings also encapsulate the focus of the month.

Compliance Criterion	What the registered provider will need to demonstrate
5	Ensure that people who have or develop an infection are identified promptly and receive the appropriate treatment and care to reduce the risk of passing on the infection to other people.

8 Identification of Patients with Infection

The IPCT ensure that patients with, or at risk of, infection are identified at the earliest opportunity and receive the appropriate treatment by:

- Visiting the Emergency Department and Admission Units daily to identify patients with suspected or confirmed infections on admission to the Trust
- Attending the daily clinical safety huddles to provide specialist IPC advice to the staff
- Co-ordinating the daily update of the Side Room Monitor Tool on Ibox throughout 2019/20 to identify side rooms for patients with, or at risk of, infection.
- Checking of alert flags on Camis for patients with *C.difficile* or resistant organisms
- Co-ordinating the weekly CDI ward round
- Conducting surveillance and follow up of patients with MSSA and MRSA colonisations, *C.difficile,* a antigen carriers, patients at risk or confirmed with CPE or *Candida auris* and patients with catheter-related urinary tract infection and surgical site infection, to work with the nursing, medical and pharmacy teams to ensure that they receive appropriate treatment and care to minimise the risk of cross-infection.

Compliance Criterion	What the registered provider will need to demonstrate
6	Ensure that all staff and those employed to provide care in all settings are fully involved in the process of preventing and controlling infection.

9 Staff IPC Training and Development

All staff roles include the relevant principles of infection prevention and control practice in the job description. How this is applied is outlined at the individual's local induction.

9.1 IPC Mandatory Training

Training was integral to developing staff knowledge of IPC practices and updates to policies in 2019/20.The IPCT delivered training across the entire spectrum of staff and for a wide range of purposes from generic Trustwide sessions at induction to bespoke training on very specific issues.

The IPCT fully support the Trust mandatory training programme, delivering sessions for all staff at mandatory training sessions. Attendance to these sessions is recorded on the Trust central training record database and compliance to IPC mandatory training is tracked within the IPC Reports. Table 6 presents the Trustwide 2019/20 IPC mandatory training compliance.

Table 6: IPC Mandatory Training Compliance

	2019									2020		
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Trained in month	323	300	342	382	328	291	340	293	254	380	410	237
Compliance	85.25%	85.07%	85.02%	86.17%	85.15%	84.64%	84.27%	83.89%	83.77%	92.73%	85.00%	83.90%

Training compliance dipped in Q3 2019. This was monitored through IPSG and reached 92.73% in January 2020, however this dipped again as the priority switched to preparations for COVID-19. Much face-to-face training was cancelled and the requirement for staff to complete all mandatory training was temporarily suspended. It should be anticipated that the training compliance figures for Q1 2020 will be below the 85% target.

9.2 Developments

In October 2019 the IPCT held their annual conference. This was well attended, with approximately 50 healthcare workers, many of whom were Infection Prevention Super links. Feedback from the conference was well evaluated.

Compliance Criterion	What the registered provider will need to demonstrate
7	Provide or secure adequate isolation facilities.

10 Isolation

The majority of wards now have ibox. The few wards that remain without ibox will be having it installed in due course. Ibox is an electronic white board which has superseded the Electronic Side Room Monitoring Tool. Staff are able to identify patients that are managed in side rooms and the reason for their isolation. Each ward has the facility to identify and update ibox, so that patients can be transferred out of single rooms, in the event that another patient requires isolation. This is checked daily by a member of the IPCT and the information is available to the Site Management Team.

Compliance Criterion	What the registered provider will need to demonstrate
8	Secure adequate access to laboratory support as appropriate.

11 Laboratory Services

Diagnostic microbiology is provided on site as part of NGH Pathology services.

Compliance Criterion	What the registered provider will need to demonstrate
9	Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections.

12 Policies

The Trust has IPC policies, guidelines and standard operating procedures in line with the Health and Social Care Act 2008; Code of Practice on the Prevention and Control of Infections and Related Guidance.

These documents are monitored utilising a variety of audit tools to measure staff compliance with guidance as detailed in section 5 of this report. Additionally, through induction and ad-hoc bespoke sessions, training for all staff types is undertaken to ensure they are kept informed of current policies and procedures as outlined in section 9 of this report.

13 Saving Lives

Saving Lives is a National compilation of High Impact Interventions (HII) utilising a "Care Bundle" approach based on evidence based practice. It was first published in 2005 and updated in 2010. It was delivered at NGH in 2007. It directly measures clinical processes and therefore in addition to the IPC Audit Plan, each clinical area completes monthly a self-assessment audit against the relevant High Impact Interventions for that clinical area. These results populate the Trust's Infection Prevention dashboard along with results from the monthly hand hygiene observational audits, cleaning audits, MRSA bacteraemia and *Clostridioides difficile* infection figures. The IPCT updated these audit tools in April 2017 to reflect evidence-based best practice.

The Infection Prevention dashboard supports continuous quality improvement, development and there has been a strong focus on trend analysis and providing safer care for patients in 2019/20. The dashboard is presented and monitored monthly through the IPOG.

14 Hygiene Code Compliance

The Trust is registered with the Care Quality Commission (CQC) under the Health and Social Care Act 2008, and as a legal requirement must protect patients, staff and others from acquiring healthcare associated infections by compliance with the Hygiene Code.

The IPCT continue to align and update supporting evidence to provide assurance of compliance with the Hygiene Code and report areas of non-compliance to IPSG for monitoring and assurance.

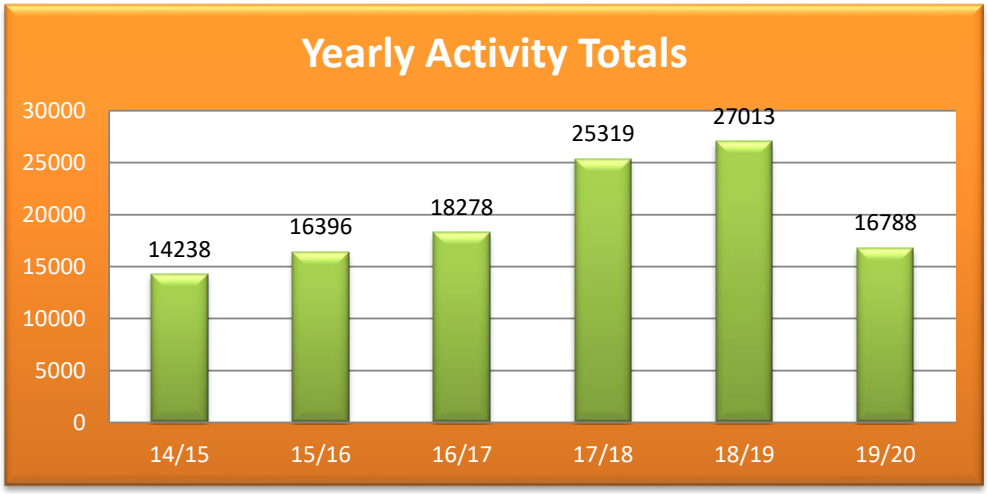
Compliance Criterion	What the registered provider will need to demonstrate
10	Ensure so far as is reasonably practicable, that care workers are free of and are protected from exposure to infections that can be caught at work and that all staff are suitably educated in the prevention and control of infection associated with the provision of health and social care.

15 Occupational Health

Activity

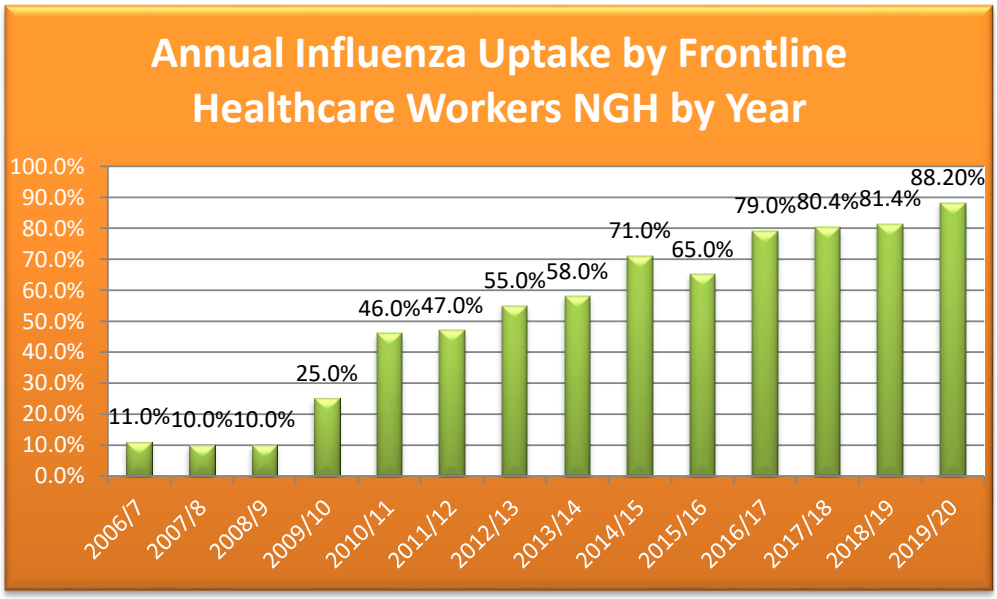
The aim of the clinical activity of the occupational health department is to look at the effects of health on work, and work on health. In screening our staff on employment, a programme of vaccinations and tests can be planned to protect the employee and the patients they care for, as well as making sure that any health matters are supported.
The decrease in activity for 19/20 (Graph 1) was due to changes in the establishment and a shortfall of clinic nurse time. Clinic time increased through the year and recovered by March 2020.

Graph 1



Flu Vaccination Campaign

The flu campaign in 2019/20 achieved the highest uptake on record with 88.2% (graph 2).
4400 vaccinations were administered during the flu campaign. The work was undertaken by three OH nurses and two nurse colleagues in the maternity area.
Graph 2:



CQUIN

The CQUIN standard for Flu was achieved for 19/20 with a target of 80% within the 5 months of the campaign (October to February). The value of the 19/20 CQUIN to the Trust was £586,750

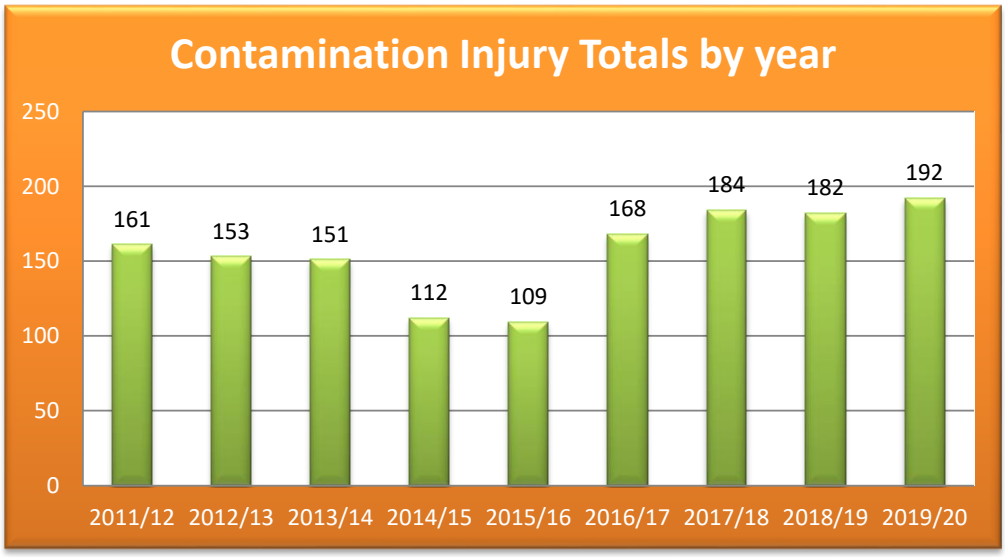
Contamination Injuries

In looking at the total number of contamination injuries by year we can see that there has been a small increase in injuries reported to OH in 19/20 from 184 to 192. Graph 3 below shows data for NGH employees only.

In the total activity data there were an additional 67 injuries sustained by external clients mostly working in the dental profession.

The OH team notify the Health & Safety team when they have seen an employee for an injury, and also notify the employee's manager if they do not attend for an injury related appointment; this is noted on 'Datix' for future reference. Detailed information on contamination injuries is provided to the Infection Control Committee on a quarterly basis.

Graph 3

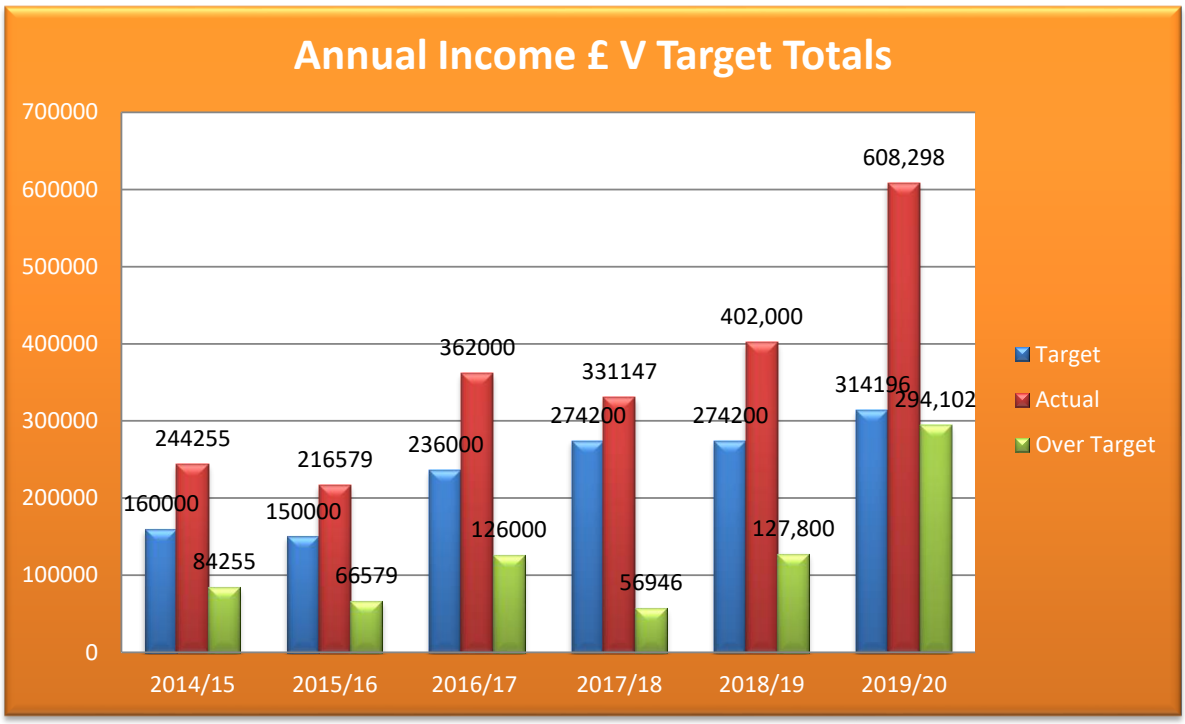


External Services

The external work of the service continues to grow with new customers using the service on an ad hoc basis, and the maintenance of contracts with NHS England and the University of Northampton. Although activity figures were reduced in this financial year the costs of service to external customers had been increased.

The target for 2019/20 was £314196 and was exceeded by £294,102 (graph 4); the total figure for external income being £608,298. Comparing income to the Occupational Health budget, the income has made the OH service cost neutral to the organisation.

Graph 4



Authors	Graham Pike – Interim Infection Prevention Matron Ros Pounds – Infection Prevention & Control Clinical Nurse Specialist Mark Duggan – Decontamination Lead Claire Brown – Occupational Health Manager/Specialist Shamsul Hoque – Antimicrobial Pharmacist
Owner	Sheran Oke
Date	September 2020

16 Appendix 1 - IPCT Structure 2019/20

Post	Post holder	WTE
Board Executive Lead (DIPC)	Ms Sheran Oke	Not defined
DIPC	Ms Sheran Oke	Not applicable
Chair of the Trust Infection Prevention and Control Steering Group	Ms Sheran Oke	Not applicable
Consultant Medical Microbiologist	Dr Minas Minassian Dr Basel Alouanti Dr Prasanna Kumari	Not defined Not defined
Band 8a IPC Matron	Mrs Wendy Foster	1 x 1.0
Band 7 IPC Clinical Nurse Specialists	Mrs Holly Slyne Mrs Ros Pounds	1 x 1.0 1 x 1.0
Band 6 IP Support Nurses	Mrs Jean Hart Mrs Katie. Draper Miss Natalie Clews Mrs Jane Sanjeevi	1x 0.4 1x 1.0 1x 1.0 1x 1.0
Band 5 Support Nurse	Mrs Gill Jones	1 x 0.8
Band 4 Secretarial Administration and Surveillance	Mrs Karen Tiwary	1 x 1.0

Infection Prevention Steering Group (IPSG)

Terms of Reference

Membership	• Director of Nursing, Midwifery & Patient Services/DIPC or nominated Deputy (chair) • Matron for Infection Prevention & Control or nominated deputy • Consultant Microbiologist • Consultant Anaesthetist & Sepsis Lead • Deputy Director of Quality & Governance • Associate Director of Nursing for Medicine • Associate Director of Nursing for Surgery • Deputy Director of Midwifery • Associate Director of Nursing for Oncology • Head of Estates / Deputy Director of Facilities • Head of Hotel Services • Antimicrobial Pharmacist
Quorum	8 members
In Attendance	• Deputy Director of Nursing, Midwifery & Patient Services • Occupational Health Lead • Public Health England (PHE) representative • Patient representative • Sepsis Lead • Minute taker
Frequency of Meetings	• Monthly
Accountability and Reporting	• Accountable to the CQEG
Date of Approval by CQEG	• TBC
Review Date	• March 2021

Infection Prevention Steering Group

Terms of Reference

1. Constitution

The Trust hereby resolves to establish a steering Group of the Clinical Quality and Effectiveness Group (CQEG) to be known as the Infection Prevention Steering Group.

2. Purpose

The purpose of the Steering Group is to provide strategic direction for the prevention and control of Healthcare acquired infections in Northampton General Hospital NHS Trust that minimises the risk of infection to patients, staff and visitors.
The Steering Group will:

- Strengthen the performance management of Health Care Associated Infections (HCAI's) and cleanliness across the Trust
- Provide assurance to the Board that policy, process and operational delivery of infection prevention and control results in improved patient outcomes
- Make recommendations as appropriate on Infection Prevention Control matters to the Board via CQEG
- Performance Manage the Trust against the Infection Prevention and control strategy
- Will ensure that there is a strategic response to relevant new legislation and national guidelines

3. Membership

- Director of Nursing, Midwifery & Patient Services/DIPC or nominated Deputy
- Matron for Infection Prevention & Control or nominated Deputy
- Consultant Microbiologist
- Consultant Anaesthetist / Sepsis Lead*
- Deputy Director of Quality & Governance
- Associate Director of Nursing for Medicine*
- Associate Director of Nursing for Surgery*
- Associate Director of Midwifery*
- Associate Director of Nursing for Oncology*
- Head of Estates and Deputy Director of Facilities
- Head of Hotel Services
- Antimicrobial Pharmacist

4. Quorum, Frequency of meetings and required frequency of attendance

- No business shall be transacted unless eight members of the Steering Group are present, one of whom must be the Chair or their nominated Deputy and 2 clinical representatives from the Divisions (as indicated by * above).
- The Steering Group will meet monthly.
- Members of the Steering Group are required to attend a minimum of 9 meetings held each financial year.

5. In attendance

In addition to the core membership, other staff will be invited to attend by the Chair of the Steering Group.

6. Authority

The Steering Group is authorised by CQEG to investigate any activity within its terms of reference and to seek any information it requires to provide assurance to the Board. The Steering Group will seek external expert advice and invite attendance if considered appropriate.

7. Duties

- To ensure the Trust adheres to the Code of Practice for the NHS on the prevention and control of healthcare associated infections and related guidance, Health and Social Care Act (2008)/ The Hygiene Code updated 2015.

- To fulfil the Trust's statutory and other responsibilities as provider of health services, achieving and maintaining the standards required by the Care Quality Commission and other National/Regulatory/Professional bodies.

- To review trust policies, procedures and guidance for the prevention and control of infection and to monitor their implementation; ensuring that such policies are evidence based, reflect relevant legislation and published professional guidance. Recommend submission and approval to Procedural Document Group.

- To develop the annual infection prevention and control programme of activity and ensure that it is submitted to Quality Governance Committee (QGC) and approved by the Trust Board

- Monitor achievement of the objectives contained within the annual programme.

- To receive, review and endorse the annual Infection Prevention and Control Report.

- Management and investigation of outbreaks of infection.

- To receive a written Infection Prevention & Control report which includes**:**

    i. Outbreaks of infection
    ii. MRSA & Clostridioides difficile data
    iii. Isolation deficits
    iv. Trust compliance with externally set targets
    v. Progress against the rolling infection prevention & control programme
    vi. Audit outcomes
    vii. Training and development plans/ compliance
    viii. Updates of relevant legislation / guidance/ best practice
    ix. Campaigns planned or delivered

- Receive a written highlight report with minutes as an appendix from the Infection Prevention Operational Group and review the TOR annually.

- To receive written reports from the Trust operational IPC group to ensure that assurance is gained as to the implementation of Infection Prevention & Control practices & policies within the Trust. Providing assurance that all appropriate measures are being taken to assist the achievement of the national and local infection present ambition.

- Receive written reports from Deputy Director of Estates and Facilities in relation to water safety, decontamination compliance, structural/ building works that are planned within the Trust. To

ensure that prevention and control of infection is considered as part of all service or building development activity, changes to HTM's or ACOP that may have infection control implications

- Receive written reports from the Head of Hotel services in relation to food hygiene, Environmental Health visits/ reports, PLACE outcome reports, cleaning compliance with standards and audits, domestic service training plans & compliance, and introduction of new cleaning products or systems of work.

- Receive written reports from the Occupational Health Manager which include needlestick injuries, flu vaccination programme compliance, outbreak issues affecting staff, any incidents of staff TB or BBV that have been or are currently under investigation or look back exercises for any infectious disease where an increased incidence has been reported nationally, to ensure that the staff and therefore the patients, are adequately protected where possible to do so.

- Receive written reports from the antimicrobial pharmacist which include an update from the Antimicrobial Stewardship Group.

- Receive written reports from the Associated Director of Nursing/Midwifery as requested by the Chair in relation to specific Infection Prevention and Control matters.

- To make recommendation to other committees and departments within the Trust on all infection control matters and techniques, and advise when necessary on the selection of equipment appropriate to the prevention of infections.

- To promote and facilitate education of all grades and disciplines of staff in procedures for the prevention and control of infection report compliance.

- Public Health England (PHE) update.

- To disseminate information and advice on prevention and control of infection to all appropriate Trust Division and their Directorates.

- To monitor the performance of the infection prevention and controls programme and make suggestions for improvement.

8. Accountability and Reporting arrangements

The minutes of the Steering Group meetings shall be formally recorded by the Secretary/Surveillance Assistant**.** Copies of the minutes of the Steering Group meetings will be provided to all members of the Group and will be available to all Trust Board members.

The Steering Group Chair shall prepare a written summary report to CQEG after each meeting. The Chair of the Steering Group shall draw to the attention of CQEG any issues that require escalation to the Trust Board, require executive action or support.

Sub-committee and reporting arrangements

The Steering Group shall have the power to establish sub-groups for the purpose of addressing specific tasks. In accordance with the Trust's Standing Orders, the Steering Group may not delegate powers to a sub-group unless expressly authorised by the Trust Board.

The terms of reference, including the reporting procedures of any sub-group must be approved by the Steering Group and reviewed as stated below.

9. Administration

The Infection Prevention Steering Group shall be supported administratively by the Infection Prevention and Control Secretary /Surveillance Assistant

- Agreement of the agenda for Steering Group meetings with the Chair

  Requesting of reports from authors in a timely manner in accordance with the reporting schedule

- Collation of reports and papers for Steering Group meetings

- Circulate agenda and papers for the meetings 7 days in advance of the Meeting

- Ensuring that suitable minutes are taken, a record of matters arising and actions are accurately documented

- All reports will be submitted in writing with a front sheet

10. Requirement for review

These terms of reference will be formally reviewed by the Steering Group at least annually.

FOI Reminder
The minutes (or sub-sections) of the Board, unless deemed exempt under the Freedom of Information Act 2000, shall be made available to the public, through the meeting papers.

18 Appendix 3 - Terms of Reference for the Infection Prevention Operational Group

NHS
Northampton General Hospital
NHS Trust

Infection Prevention Operational Group (IPOG)

TERMS OF REFERENCE

Membership	• Deputy Director of Nursing (Chair) • Matron for Infection Prevention • Matron for Surgery Division • Matron for Medical Division • Matron for Maternity • Matron for Paediatrics • Matron for Theatres • Estates Manager • Domestic Manager/Team Leader/Supervisor • Catering Manager or Team Leader • Therapies Manager • Head of Capacity or Deputy • Decontamination Lead
Quorum	Seven members that must include: • Deputy Director of Nursing (Chair or nominated deputy) • Matron for Infection Prevention or nominated deputy from Infection Prevention Team • Matrons from across the specialities (5)
In Attendance	• Minute taker The Group would have the authority to co-opt any person necessary to assist in its work plan or deliberations
Frequency of Meetings	Monthly
Accountability and Reporting	This group is accountable & reports into the Trusts Infection Prevention & Control Steering Group
Date of Approval by IPSG on behalf of Quality Governance Committee	March 2019
Review Date	March 2020

Northampton General Hospital NHS Trust

Infection Prevention Operational Group (IPOG)

TERMS OF REFERENCE

1. Constitution

The Infection Prevention Steering Group hereby establishes a sub-group known as the Infection Prevention Operational Group.

Its principle aim is to bring together, under the chairmanship of the Deputy Director of Nursing together with the Matrons, the Infection Prevention Team and the nominated Estates and Facilities Leads, to ensure that all operational practices and issues relating to infection prevention are evaluated and discussed.

2. Purpose

The purpose of the IPOG is to ensure that there is a managed environment within the Trust that minimises the risk of infection to patients, staff and visitors. The group is responsible for providing professional advice at an operational level to the Trust, sharing good practice and making recommendations to the IP Steering Group and Divisions.

3. Membership

- Deputy Director of Nursing (Chair)
- Matron for Infection Prevention
- Matrons (or nominated deputies)
- Estates Manager
- Domestic Manager/Team Leader/Supervisor
- Catering Manager or Team Leader
- Therapies Manager
- Clinical Site Manager for Capacity and Flow
- Decontamination Lead

The group have the authority to co-opt any person necessary to assist in its deliberations.

4. Quorum, Frequency of meetings and required frequency of attendance

No business shall be transacted unless seven members of the group are present. This must include:

Seven members that must include:

- Deputy Director of Nursing (Chair or nominated deputy)
- Matron for Infection Prevention or nominated deputy from Infection Prevention Team
- Matrons from across the specialities (5)

The group will meet monthly. Members of the group are required to attend a minimum of 80% of the meetings held each financial year.

5. In attendance

- Administrative support
- Others may attend by invitation of the Chair.

6. Authority

The group is authorised by the Trust to investigate any activity within its terms of reference and to seek any information and to make any recommendations through the Infection Prevention Steering Group (IPSG), through its Chair that is deemed appropriate, or any area within the terms of reference where action or improvement is required.

7. Duties

- The Trust adheres to the Code of Practice for the NHS on the prevention and control of healthcare associated infections and related guidance, Health and Social Care Act (2015), (the "Hygiene Code").
- To receive reports on specific operational problems with respect to the incidence of infection or of infection risks for evaluation and discussion, and to make appropriate recommendations to the IP Steering Group.
- To review, update and develop Trust policies, procedures and guidance for the prevention and control of infection and to monitor their implementation; ensuring that such policies reflect relevant legislation and published professional guidance, prior to approval by IP Steering Group.
- To monitor Divisional performance regarding adherence to infection control practice through the monitoring of the Trust Infection Prevention Dashboard, Infection Prevention and Control audits and ensure appropriate actions are put in place where required.
- To discuss relevant issues presented by the Infection Prevention & Control Team (IPCT) and any other member of the group
- To provide monthly reports and make recommendation to the IP Steering Group and departments within the Trust on all infection control matters and techniques, and advise when necessary on the selection of equipment appropriate to the prevention of infections.
- To promote and facilitate education of all grades and disciplines of staff, in procedures for the prevention and control of infection report compliance.
- To ensure that prevention and control of infection is considered as part of all service development activity.
- To disseminate information and advice on prevention and control of infection to all appropriate Trust Directorates.
- To monitor the performance of the infection prevention and controls programme and make suggestions for improvement, including review of improvement plans from Divisions.

8. Accountability and Reporting arrangements

The minutes of the group meetings shall be formally recorded by the minute taker. Copies of the minutes of group meetings shall be available to all members. The group will provide a monthly highlight report on its work to the IPSG with the minutes of this meeting included as an appendix.

19 Appendix 4 - Healthcare Associated Infection Plan of Work, 2020-21

Priorities and key goals for 2020-21

- A reduction in the number of patients with *Clostridioides difficile* infection CDI (<40 cases until set new CDI objectives)
- Zero patients with MRSA bacteraemia
- A reduction in the number of patients with MSSA bacteraemias (<13 unavoidable cases)
- Sustain measurement of *E.coli* bacteraemia within the Whole Health Economy
- Sustain measurement of CRUTI prevalence and incidence
- Sustain measurement of surgical site infection infections through PHE SSI surveillance system
- Sustain CPE screening processes
- To implement the 2020-21 IPC communications plan

The plan is built upon the criteria of the Health and Social Care Act (2008) Code of Practice for Adult Social Care on the Prevention and Control of Infections and Related Guidance (2015). This set out ten criteria against which the Trust is assessed on how it complies with registration requirements of infection prevention.

BRAG Key	
	Complete
	On-track
	Delivery issues
	Unable to deliver

Hygiene Code Compliance Criterion 1 – Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider how susceptible service users are and any risks that their environment and other users may pose to them								
Objective	**Programme of work (action)**	**Timeframe and milestones**	**Lead**	**BRAG**				**Progress and comments**
				Q 1	Q 2	Q 3	Q 4	
1 a There are appropriate management and monitoring arrangements for a zero tolerance approach to HCAIs	To agree the corporate priorities for HCAI reduction for 2019-20 as detailed above	Q1	IPC Matron					
	Clinical teams to undertake case review using principles of RCA and PIR on all cases of NGH attributable: • MRSA bacteraemia • CDI • *Staph. aureus* bacteraemia • *E.coli* bacteraemia Within the recommended time frame for each microorganism	Q1, 2, 3 and 4	IPC Matron					
	To prepare a monthly IPC report, which is presented monthly at IPSG and IPOG and quarterly at CQEG, on all cases of NGH attributable: • MRSA bacteraemia • CDI • *Staph. aureus* bacteraemia • *E.coli* bacteraemia • Klebsiella species bacteraemia • *Pseudomonas aeruginosa* bacteraemia	Monthly	IPC Matron					
	All deaths due to CDI (recorded on part 1a of the death certificate) and the CDI 30 day mortality data to be reported quarterly to IPSG and CQEG.	Quarterly	Consultant Microbiologist					
1 b Promote a culture of continuous quality improvement in IPC	To review and update IPSG terms of reference and IPOG terms of reference annually	February 2021	IPC Matron					
	To provide monthly Infection Prevention and Control report to IPSG giving assurance to the group and escalating any concerns	Monthly	IPC Matron					
	To provide quarterly Infection Prevention and Control report to CQEG giving assurance to the group and raising any concerns	Quarterly	IPC Matron					
	To present surveillance data regarding HCAIs	Monthly	IPC Matron &					

	to IPSG		cons. micro					
	To present the CDI PIRs monthly at IPOG, and share the learning to prevent further CDI acquisition	Monthly	Matrons and ward Managers					
	To implement the IPC audit plan for 2020-21 and report monthly at IPOG and IPSG. *(For further information please refer to the IPC annual audit plan).*	Monthly	IPC Matron					
	To implement the IPC surgical site surveillance plan for 2020-21 and report quarterly at IPSG and CQEG. *(For further information please refer to the IPC surgical site surveillance plan).*	Quarterly	IPC Matron					
	IPCT to deliver the 2020-2021 communication plan	Ongoing	IPCT & comms team					
	To meet monthly with Ward Sister / Matrons to conduct a 'IPC Ward Review'	Monthly	IPCT / Ward Sisters / Matrons					
	To provide updates to the IPC Board Assurance Framework document, supplying evidence to support the assurance in the document and devising and implementing action plans whenever gaps in assurance are identified.	Monthly	IPC Matron					
	To report on wards engagement / progress with IPC issues at IPOG	Monthly	Matrons					

Hygiene Code Compliance Criterion 2 – Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention of infections

Objective	Programme of work (action)	Timeframe and milestones	Lead	BRAG				Progress and comments
				Q 1	Q 2	Q 3	Q 4	
2 a Maintenance of a clean, safe and appropriate environment which facilitates the	The Trust Hotel Services Manager and Domestic Manager will report key issues monthly to IPOG as a standing agenda item	Monthly	Hotel Services Manager & Domestic Manager					
	Review and monitor monthly cleaning audit scores through the dashboard trend analysis at IPOG, as a standing agenda item. For areas	Monthly	IPC Matron & Matrons					

prevention and control of HCAI	of poor compliance, Matrons are challenged by the chair of the group							
	IPCT and Domestic Team to sustain the enhanced cleaning standard operating procedure to deliver enhanced touch point cleaning when required	Monthly	IPCN & Domestic Manager					
	IPC Team to join Domestic Team on a minimum of four Cleaning Audits a month, to peer review and reported in the IPC monthly report	Monthly	IPCT & Domestic Team					
	IPC Matron and Estates Manager to complete a bi-monthly review of the Trust Estate and action any IPC issues	Bi-monthly	Matron for IPC & Estates Manager					
	IPCT, Estates and Domestic Team to complete a review of the ward (EDI inspection) following every case of CDI, periods of increased incidence or outbreaks of infection and report outstanding issues to IPOG as a standing agenda	Monthly	Matron for IPC, Domestic Manager & Estates Manager					
	IPCT, Estates and Domestic Team to complete EDI inspections for all Out-Patient Departments (OPD) annually as detailed in the EDI OPD forward schedule	Monthly	Matron for IPC, Domestic Manager & Estates Manager					
	IPCT & Estates perform Airborne Fungal Spores and Contamination of Water Services risk assessments prior to Estates work commencing	Ongoing	IPC Matron & Estates Projects Lead					
	The Trust Estates Maintenance Manager will report key issues monthly to IPOG as an agenda item	Monthly	Estates Maintenance Manager					
	The Deputy Director of Facilities will provide a comprehensive report quarterly to IPSG as detailed on the Infection Prevention and Control plan of work	Quarterly	Deputy Director of Facilities					
2 b Decontamination standards are monitored and adhered to	The Lead for Sterile Services reports up through the organisation through Governance meetings, Medical Devices Committee and IPOG.	Monthly	Decontamination Lead					

2 c Water safety requirements are monitored and adhered to	The Trust Water Safety Lead / Responsible Person will ensure that the Water Safety Group operates according to its terms of reference and reports quarterly to the IPSG as detailed on the Infection Prevention and Control forward plan	Quarterly	Deputy Director of Facilities					
	The Trust Deputy Responsible Person will report and update any water safety issues to IPOG	Monthly	Estates Maintenance Manager					

Hygiene Code Compliance Criterion 3 – Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance

Objective	Programme of work (action)	Timeframe and milestones	Lead	BRAG				Progress and comments
				Q 1	Q 2	Q 3	Q 4	
3 a To improve antimicrobial prescribing and stewardship	The Trust Antimicrobial Lead will ensure that the Antimicrobial Stewardship Group will operate according to its terms of reference	Bimonthly	Antimicrobial Lead					
	The Antimicrobial Pharmacists will provide an Antimicrobial report quarterly to the IPSG as per the Infection Prevention and Control forward plan	Quarterly	Antimicrobial pharmacists					
	Antimicrobial audits will be presented to IPSG as part of the antimicrobial report as per the Infection Prevention and Control forward plan	Quarterly	Antimicrobial pharmacists					
	The Trust Antimicrobial Pharmacists will deliver the actions from the NICE antimicrobial guidance gap analysis as part of the antimicrobial report as per the Infection Prevention and Control forward plan	Quarterly	Antimicrobial pharmacists					
	The Antimicrobial Pharmacists will continue to prompt Proton Pump Inhibitor (PPI) review for patients commencing antibiotics as detailed in the *C.diff* Forward Plan	Monthly	Antimicrobial pharmacists					

Hygiene Code Compliance Criterion 4 – Provide suitable accurate information on infections to any person concerned with providing further support or nursing/medical care in a timely fashion

Objective	Programme of work (action)	Timeframe and milestones	Lead	BRAG				Progress and comments
				Q 1	Q 2	Q 3	Q 4	
4 a Provide useful information for staff on the prevention and control of infections	Produce Trust wide screensavers, huddle sheets or posters as required to clarify IP procedures and processes	Monthly	IPCT					
	Send out information via email system to communicate updates on IPC practices or polices as required e.g. during outbreaks	Monthly	IPC Matron					
	To implement the IPC communication strategy and monthly focus on specific aspect of IPC	Monthly	IPCT					
4 b Provide useful information for patients and visitors on the prevention and control of infections	Provide patient information leaflets on C.difficile, MRSA, ESBLs, CPE, norovirus, influenza, surgical site infection prevention, central venous access devices, peripheral venous cannulas, urinary catheters, enteral feeding and using decolonisation treatment	Monthly	IPCT					
	Provide outbreak information to patients and visitors regarding ward closures and preventing the spread of infection with the support of the Trust communications team	Q1,2,3,and 4	IPCT					

Hygiene Code Compliance Criterion 5 – Ensure that people who have or develop an infection are identified promptly and receive the appropriate treatment and care to reduce the risk of passing the infection on to other people

Objective	Programme of work (action)	Timeframe and milestones	Lead	BRAG				Progress and comments
				Q 1	Q 2	Q 3	Q 4	
5 a To minimise the risk of CPE through screening and care of suspected, presumptive or confirmed positive	To maintain CPE screening processes according to Trust CPE Policy	Monthly	IPC Matron					

cases								
5 b To remain within the C.diff trajectory of 40 cases for 2020-121	To monitor C.diff trajectory and if ceiling is exceeded to put on to the risk register	Monthly	IPC Matron					
	To continue to identify wards that require support for 1 case of C.diff or period of increased incidence (2 or more cases within 28 days), conduct PIR for all post admission C.diff cases and maintain the C.diff antigen positive surveillance	Q1, Q2, Q3 and Q4	IPCT					
	To implement the 2020-21 C.diff plan of work	Q1, Q2, Q3 and Q4	IPCT					
5 c To minimise the risk of infection to patients by conducting MRSA screening and managing patients who are colonised or infected with MRSA effectively	To maintain MRSA screening processes according to Trust MRSA policy, monitor elective and emergency screening compliance and conduct surveillance of previous MRSA positive inpatients.	Q1, Q2, Q3 and Q4	IPCT					
	To maintain prophylactic decolonisation processes according to the MRSA Policy, audit compliance quarterly and report to IPSG	Q1, Q2, Q3 and Q4						
5 d To minimise the risk of infection to patients by preventing *Staph. aureus* bacteraemias	To maintain surveillance of *Staph. aureus* bacteraemias and management of local MSSA infections according to the MSSA SOP	Q1, Q2, Q3 and Q4	IPCT					
5 e To minimise the risk of infection to patients by prevention Gram-negative bacteraemias	To implement the 2020-21 Gram-negative bacteraemia plan of work	Q1, Q2, Q3 and Q4	IPCT					
5 g	IPCT to review all patients who acquire an alert	Q1, Q2, Q3	IPCT					

To minimise the risk of cross-infection for alert organisms	organism infection and provide ongoing advice and support to medical and nursing staff	and Q4						
	IPCT to conduct surveillance and management of outbreaks of infection	Q1, Q2, Q3 and Q4	IPCT					
	IPCT to commence flagging patients with previous MRSA, C.diff, MSSA and CPE on CAMIS inpatient management system	Q2	Matron for IPCT					
	IPCT to work with Site Management Team to utilise the Side Room facility on iBox and identify patients that need isolating	Q1, Q2	IPCT, Site Management Team					
5 h To minimise the risk of infection to patients from catheter-related urinary tract infections	IPCT to report CAUTI case reviews quarterly to IPOG and IPSG to identify key themes	Q1, Q2, Q3 and Q4	IPCT					
	IPCT to deliver the CAUTI element of the Gram-negative bacteraemia forward plan to address the themes identified from the retrospective case reviews	Q1, Q2, Q3 and Q4	IPCT					
5 i To minimise the risk of infection to patients from line-related infection	To conduct CVC-related bloodstream infection surveillance	Q1, Q2, Q3 and Q4	IPCT					
	To conduct PICC-line and midline related bloodstream surveillance and report to IPOG and IPSG quarterly	Q1, Q2, Q3 and Q4	IPCT					
5 j To minimise the risk of infection to patients from influenza	IPCT to develop and implement a 2020-21 Flu Ready action plan in collaboration with Occupational Health Team to present at IPSG in Aug 2020	Q2	IPCT					
	IPCT to work with the Microbiology Laboratory Manager to support point of care testing for Influenza	Q1, Q2, Q3 and Q4	IPCT Microbiology Laboratory Manager					
5 k To minimise the risk of infection to patients from Middle Eastern Respiratory Syndrome (MERS)	To implement the MERS section of the Viral Respiratory Infections procedural document in the Emergency Department	Q1, Q2, Q3 and Q4	IPCT & ED Matron					
	To reflect and learn from each patient with suspected MERS in the ED to improve practice and share at IPOG	Q1, Q2, Q3 and Q4	IPCT & ED Matron					
5 l To minimise the risk of infection to patients	IPCT to hold Bronze level meetings daily to review national guidance, discuss areas of concern and ensure guidance is shared and	Q1, Q2, Q3 and Q4	IPCT, Microbiologists & DIPC					

from SARS-CoV- 2 (the virus which causes Covid-19)	followed across the Trust. To report to Silver level group daily.							
	IPCT to communicate with departments, to ensure understanding of guidance, provide teaching materials and ensuring adequate stocks of PPE are available	Q1, Q2, Q3 and Q4	IPCT					
5 m To minimise the risk of infection to patients from hospital acquired infection (HAP)	To audit mouthcare practice quarterly to ensure practice implemented in Q4 of 2018/19 is embedded and sustained	Q1, Q2, Q3 and Q4	IPCT					
5 n To minimise the risk of infection to patients from surgical site infection (SSI)	To continue to have quarterly SSI group meetings to discuss patients that develop SSI within T&O and to address recurring themes and implement actions	Q1, Q2, Q3 and Q4	IPCT PDNs Matron for T&O T&O Consultants Theatre Educator					

Hygiene Code Compliance Criterion 6 – Ensure that all staff and those employed to provide care in all settings are fully involved in the process of preventing and controlling infection								
Objective	**Programme of work (action)**	**Timeframe and milestones**	**Lead**	**BRAG**				**Progress and comments**
				Q 1	Q 2	Q 3	Q 4	
6 a Staff receive appropriate IPC training	IPC is part of induction and mandatory training. IPC mandatory training is to be monitored and reported to CQEG by the Infection Prevention Matron	Quarterly	IPC Matron					
	IPC Team to make mandatory IPC training more accessible to ward teams by delivering IPC training in the clinical environment	Q1, Q2, Q3 and Q4	IPC Team					
	To deliver ANTT cascade training, with a focus on medical wards, and to have annual assessments of competence every 2 years	Q1, Q2, Q3 and Q4	IPCT					
6 b IPC workforce and capability	To ensure that all IPCT members are skilled, knowledgeable and have an appraisal process in place to ensure clear objectives and	Q1, Q2, Q3 and Q4	IPC Matron					

	development needs							
	To develop competencies for the IPC Superlinks and scope out Cleanliness Champions role	Q1	IPCT					
6 c Hand hygiene	Continue to reinforce the Hand Hygiene Code of Practice in practice	Q1, Q2, Q3 and Q4	IPC Matron					
	Celebrate Hand Hygiene Week	Q1	DIPC, ADNs IPCT Matrons					

Hygiene Code Compliance Criterion 7 – Provide or secure adequate isolation facilities								
Objective	**Programme of work (action)**	**Timeframe and milestones**	**Lead**	**BRAG**				**Progress and comments**
				Q 1	Q 2	Q 3	Q 4	
7 a To provide advice regarding appropriate isolation use	IPCT to undertake daily review of the urgent care wards ED & Nye Bevan to identify patients admitted that require isolation	Q1, Q2, Q3 and Q4	IPSNs					
	To attend the safety huddle daily to provide isolation and IPC advice	Q1, Q2, Q3 and Q4	IPSNs / IPCN / IPC Matron					
	IPCT to undertake daily review of patients in side rooms and update iBox to facilitate the Site Management Team in effective patient placement	Q1, Q2, Q3 and Q4	IPSNs					

Hygiene Code Compliance Criterion 8 – Secure adequate access to laboratory support								
Objective	**Programme of work (action)**	**Timeframe and milestones**	**Lead**	**BRAG**				**Progress and comments**
				Q 1	Q 2	Q 3	Q 4	
8 a The microbiology laboratory is accredited	The diagnostic microbiology is provided on site as part of the NGH pathology services. The Microbiology Laboratory Manager ensure that accreditation is achieved annually	Annually	Microbiology Laboratory Andrea O'Connell					

Hygiene Code Compliance Criterion 9 – Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections								
Objective	**Programme of work (action)**	**Timeframe and milestones**	**Lead**	**BRAG**				**Progress and comments**
				Q 1	Q 2	Q 3	Q 4	

9 a To ensure that evidence based IPC policies and associated procedural documents are available	The IPC policies and associated procedural documents are reviewed three yearly and in accordance with new guidance	Q1, Q2, Q3 and Q4	IPCT					
	IPC policies and procedural documents are audited as per the IPC annual audit programme in accordance with the requirements of the Hygiene Code	Monthly	IPCT					

Hygiene Code Compliance Criterion 10 – Ensure so far as is reasonably practicable, that care workers are free of and are protected from exposure to infections that can be caught at work and that staff are suitably educated in the prevention and control of infection associated with the provision of healthcare								
Objective	**Programme of work (action)**	**Timeframe and milestones**	**Lead**	**BRAG**				**Progress and comments**
				Q 1	Q 2	Q 3	Q 4	
10 a To ensure that healthcare workers are protected from communicable diseases and from work exposures	Occupational health advice is available for staff	Q1, Q2, Q3 and Q4	Occupational Health Team					
	IPC Matron and Occupational Health Lead meet quarterly to discuss operational issues	Quarterly	IPC Matron & OH Lead					
	Occupational Health Team provide a quarterly report to IPC regarding key issues	Quarterly	Occupational Health Team					
	IPC training is mandatory for all staff and reported quarterly to CQEG via the IPCT report	Quarterly	Matron IPC					
	IPCT to facilitate fit testing for FFP3 masks for paediatric staff, anaesthetic staff, Urgent Care staff and Critical Care staff	Q1, Q2, Q3 and Q4	IPCT					

UNIVERSITY OF LEICESTER
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Report To	**PUBLIC TRUST BOARD**
Date of Meeting	**24 September 2020**

Title of the Report	**Annual Fire Safety Report 2019/20 including the Annual Statement of Fire Safety Compliance**
Agenda item	**15**
Presenter of Report	Stuart Finn, Director of Estates and Facilities
Author(s) of Report	Stuart Finn, Director of Estates and Facilities James Stewart, Estates Compliance and Fire Safety Manager

This paper is for: (delete as appropriate)

X Approve	☐ Receive	☐ Note	Assurance
To formally receive and discuss a report and approve its recommendations OR a particular course of action			To reassure the Board that controls and assurances are in place

Executive summary

This annual report has been produced to give the Trust Board an overview of fire safety for the period April 2019 to March 2020 and, to provide assurance that the Trust is meeting its statutory responsibilities**.**

It includes a forward look of the key fire safety priorities proposed for the financial year 2020/21.

The report requests Board approval for the Group Chief Executive for Northampton General Hospital NHS Trust and Kettering General Hospital NHS Foundation Trust to sign the Annual Statement of Fire Safety Compliance (included at the end of this report)

Related Strategic Pledge	Which strategic pledge does this paper relate to? 1. *We will put quality and safety at the centre of everything we do*

Risk and assurance	Does the content of the report present any risks to the Trust or consequently provide assurances on risks - Yes
Related Board Assurance Framework entries	BAF – please enter BAF number(s) 1.7
Equality Analysis	Is there potential for, or evidence that, the proposed decision / document will not promote equality of opportunity for all or promote good relations between different groups? N If yes please give details and describe the current or planned activities to address the impact. Is there potential, for or evidence that, the proposed decision / document will affect different protected groups/characteristics differently (including possibly discriminating against certain groups/protected characteristics)? N If yes please give details and describe the current or planned activities to address the impact.
Financial Implications	Failure to meet statutory obligations under Health and Safety legislation may result in fines. To maintain fire safe premises and services, continued capital investment, as agreed in the Estates Capital plan, must continue.
Legal implications / regulatory requirements	Failure to meet statutory obligations under The Regulatory Reform (Fire Safety) Order, Department of Health Firecode and Health and Safety legislation may result in fines and suspension of services

Actions required by the Board

The Board is asked to note the actions taken to deliver fire safety within the Trust during the reporting period April 2019 to March 2020 and give approval for the Group Chief Executive for Northampton General Hospital NHS Trust and Kettering General Hospital NHS Foundation Trust to sign the Annual Statement of Fire Safety Compliance (included at the end of this report)

UNIVERSITY OF LEICESTER
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Annual Fire Safety Assurance Report

Executive summary

This annual report has been produced to provide the Trust Board with an overview for the period April 2019 to March 2020 and, to provide assurance that the Trust is meeting its statutory responsibilities.

All fire safety arrangements and building alterations within the Trust are modelled on the recommendations made by the Department of Health in their Firecode fire safety guidance documents. These are referenced and supported within the Trust's Fire Safety Policy.

During 2019/20 the Trust's Estates team was enhanced with the additional employment of a Fire Safety Officer (training) (band 5) and a Fire Safety Advisor (band 7).

The Fire Safety Adviser was tasked with reviewing Fire Safety arrangements. A number of issues around the fire alarm system, fire compartmentation, fire training, the management of fire alarm activations and internal audit including Fire Risk Assessments and Fire Evacuation Planning were identified.

An action plan was produced and is in place to track progress against these issues; the plan is managed through the Trust Fire Committee.

In March 2019 an Estate Compliance paper, including fire safety, was presented to the Trust Board.

To ensure an additional level of review and monitoring of estate compliance, the Board requested a monthly Estates Compliance report is presented to the Finance and Performance Committee and that the report includes fire safety; this has been put in place.

A full conditional survey of the site has been completed by a specialist contractor to review condition of the fire compartmentation structures.

Following receipt of this report (August 2019) the Business, Fire & Compliance Manager investigated the most suitable and cost-effective way forward to manage these breaches. A tender exercise was completed, and a contractor selected to commence remedial works. The works to repair the breaches is managed on a risk basis and commenced in November 2019 and is ongoing. These works are included within the Estates Capital Plan.

The Trust has continued to upgrade and renew the site Fire Alarm System. Work throughout the reporting period has included a focus on the effectiveness of the system and a number of corrections/improvements have been made.

A new specialist contractor was employed by the Trust and has delivered an improved service in maintaining the system and addressing the issues identified.

Investigations by the contractor, has highlighted that the existing system is nearing capacity and, to continue to add devices will require, considerable further investment.

The current system is 'closed protocol' which restricts our options to work on, or extend the system. Changing to an alternative 'open protocol' system will be a complex process but will deliver improved access to the system and the potential to review other systems available on the market.

The system continues to operate safely but, a full review and feasibility study will take place during 20/21 to set the strategy for future upgrades and how additional capacity is delivered.

Staff training is a key control measure in reducing risk and it is imperative that staff fully understand their roles and responsibilities should a fire occur. Through programmed fire safety training events during the 2019/20 the new Fire Safety Training role has delivered an improved training package for staff.

Fire Response Team training has been delivered and further practical training sessions to ensure all members of the Fire Response Team have a full working knowledge of the site.

Site Management Team attend all Fire Alarm activations other than pre-alarms. They received additional practical training sessions and to enable this. These sessions were delivered on a 1:1 basis to ensure they were able to attend.

All areas of the Trust has a Fire Risk Assessment (FRA) and Local Emergency Evacuation Plans (LEEPS) in place and all have been reviewed during the reporting period.

All high risk areas (categories 1 and 2) have been reassessed by the new Fire Safety Adviser and these assessments have been used to prioritise the Estates Capital Plan (approx. £1M is being invested into fire safety each year).

A review of all FRAs is being completed by an external fire specialist. Categories 3 will be completed during September 2020 and categories 4 to 6 during October 2020.

For additional assurance the external specialist will also complete a review of the high risk category 1 and 2 assessments completed by the Trust Fire Safety Team.

In May 2019 an independent (Fire) Peer Review / Audit was completed to provide additional assurance that suitable fire safety arrangements at the Trust were in place. The report recognised improvements made and supported Estates approach to management of fire safety. The report made a number of further recommendations which have been added to the fire safety action plan. A key recommendation was to meet with the local Fire and Rescue Service (FRS) to discuss the current status and to brief them on the Trust's actions. A series of meetings have been held and the FRS have been, and continue to be, supportive of the Trust's approach.

Meetings and on-site inspections/visits with the FRS continue and supportive relationships have been developed.

Continued investment in fire safety through the annual capital plan has allowed the Trust to ensure that building/structural fire risks are eliminated or mitigated as far as practicable. However, cavity barriers and asbestos ceilings continue to be the biggest concern in the structural fire protection of the Trusts buildings especially in "Oxford method" construction. The age of these buildings presents concerns for the condition of the structural fire precautions within them, along with the age of the electrical wiring system.
In addition to the fire safety management measures detailed above, the continued extension of the water mist automatic fire suppression system into building works has provided increased fire protection, mitigating some of this risk and providing life safety and business continuity.

Work to update the site fire plans (these are building/construction plans) across the site, annotated with compartment, sub-compartment and high risk areas fire resisting construction and the estimated site of cavity barriers has been completed. This work has enabled the programming of fire door maintenance and upgrades to be undertaken and have assisted with the inspection of cavity barriers.

Following a fire safety report submitted to the Trust Board in January 2020 identifying significant issues on the top floor (Critical Care Floor) of Blocks 41 & 42, an emergency plan of remedial works, supported by Northamptonshire Fire & Rescue Service, was implemented.
A weekly fire safety task and finish group, chaired by the Trust's Director of Finance, and an additional daily meeting chaired by the Trust CEO were put in place to ensure pace was maintained. The FRS attended a number of these meetings.

During the period from February to present, significant estates work has continued at pace and remains on track to complete in November 2020.

Work has included, completion of 60 minute fire lines across the Critical Care floor, along with construction of new fire escapes, review and delivery of LEEPs and training, live fire drill exercises and improved fire communications across site.
The FRS have been involved and supportive of the programme and have visited site on several occasions to inspect.
This work has provided assurance that all staff and patients on the Critical Care floor can be evacuated to a place of safety in the event of a fire. Infrastructure works, live fire drills, new FRAs and LEEPs have provided assurance that this has been achieved and witnessed by the Trust Fire Safety Team and the FRS.
Work continuing to November 2020 will provide further levels of assurance and, the safety of the area and safe evacuation is not compromised during that period.

A Governance review of fire safety was completed by Director of Corporate Development, Governance & Assurance in February 2020.

Reports on Fire Safety Compliance and updates on the Governance review have been regularly presented and discussed at Trust Board monthly from January 2020.

TIAA are an organisation commissioned by the Trust to carry out internal audits to provide independent assurance. During this reporting period, TIAA were requested to carry out an audit of fire safety. They are currently undertaking the audit and the draft report is expected in September/October 2020.

At the time of writing this report:

Fire policy	Approved by the Fire Safety Committee. Next review in August 2022
Fire strategy	New 5 year strategy has been developed and shared with Fire committee
Fire Risk Assessments (FRAs)	337 FRA are in place FRAs are split into 6 risk categories; Wards and other Patient Sleeping Risks ITU & HDU & Theatres and, Staff Sleeping accommodation risks are the two highest categories; the FRAs for these categories have been re reviewed and all re written.
Local Emergency Evacuation Plans (LEEPS)	100% compliance. 190 plans in place
Fire drills	100% compliance
Fire wardens	100% compliance. 190 wardens in place
Fire training	83% and increasing
Fire Safety Team	Trust's Estates team has been expanded; Compliance and Fire Manager (band 8), Fire Safety Officer (training) (band 5) and a Fire Safety Advisor (band 7)

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Annual Fire Safety Assurance Report

1. Introduction

This report sets out an assurance review of fire compliance for the period April 2019 to March 2020.

Regulatory Reform (Fire Safety) Order 2006, (RRO)

The Regulatory Reform (Fire Safety) Order replaced all existing fire safety legislation applicable to hospitals; the current suite of Fire Code documents addresses the changes brought about by the Order.

The Fire Safety Order, in line with the other Regulatory Reform initiatives, has limited local government involvement and has placed the responsibility for compliance within an employer's duty to '*self-assess'* their own premises and make such modifications as necessary.

The imposed fire risk is managed by the Fire Safety Manager through Trust approved procedures and control measures. The management of fire safety is audited by the Fire and Rescue Authority whose primary role is enforcement and not the provision of prescriptive fire safety advice.

2. Policies, Procedures, Protocols etc.:

The Trust Fire Safety Policy has been approved by the Fire Safety Committee and at PDG and is next due for review in August 2022.

The Fire Safety Guidance Note that gives further guidance on all matters of fire safety is due for review in the next 12 months.

3. Roles and Responsibilities

HTM 05-01 Responsibility for Managing Fire Safety in Healthcare buildings ultimately lies with Northampton General Hospital NHS Trust as they are the employer under the RRO. The Chief Executive Officer has direct responsibility for Fire Safety and has delegated their duties to the Trust Fire Safety Manager. Under the RRO any other members of staff who have responsibility to any extent are also responsible under the RRO.

Previously the Trust employed one band 5 Fire Officer; during the reporting period this position increased to:

- Business Compliance Manager including fire (band 8)
- Fire Safety Advisor (band 7)
- Fire Safety Trainer (band 5)

This change significantly strengthens the resources of the Fire safety Team and enables the delivery of fire compliance across the Trust.
In addition, membership of the Fire Response Team has also been strengthened and now has a consistent approach.

An improved training programme for site management training, including 1:1 for key staff has been delivered by the Fire Safety Officer.
All Fire Response Team members completed part 1 (theory) of their training. A programme for all to receive part 2 (practical session) is currently being implemented.

Fire Wardens Currently there are 190 areas that should have a fire warden in place. In December 2019, with staff movements etc. there were only 180 (94.7%) in place. The Fire

Safety Trainer delivers fire warden training annually. It is a requirement the Fire Wardens undergo a refresher every 3 years.
In January 2020, the Fire Safety Team undertook a proactive training programme and by February 2020 the figure was 100% of the site covered.

A register of fire wardens is maintained by the Fire Safety Trainer which is distributed monthly to Divisional and Directorate managers, Heads of Departments and Matrons showing compliance. These are also reported to the Fire Committee and the Trust Health and Safety Committee. During the reporting period and, as an additional level of reassurance, Divisional scorecards were also amended to indicate fire compliance.

4. Incidents:

Fire Incidents (actual fire)			
Year	**No.**	**Location**	**Occurrence**
2014 – 15	5	Sturtridge bin store Cripps Recreation o/s Maxillo Facial o/s South Entrance Car Park 1	External bin store dealt with by Fire Service. Overheated fan bearing. Bin fire successfully dealt with by staff. Fire in bush dealt with by Fire Service. Car fire initially dealt with by staff then Fire Service.
2015 – 16	5	Allebone ward Cripps Recreation Child Health Offices Abington Ward HDU	Overheated fluorescent light. Magicians' volcano. E-cigarette battery in persons pocket. Patient set fire to bedding successfully dealt with by staff. Sparks from electrical socket.
2016 – 17	0		
2017 - 18	1	Balmoral ward	Oil filled radiator caught fire successfully dealt with by staff.
2018 – 19	2	Balmoral Ward Heart Clinic	Staff member placed a towel in the microwave to heat it up for a patient Small Fire Cautery Device, plasma blade set fire to operators glove.
2019 - 20	5	Paddington ward Rockingham Corridor Becket ward Nye Bevan Car Park Outside A&E	Smoke from dishwasher Cooking left unattended Smoke from Battery Recycling Bin Minor Car Fire - Engine Compartment Waste-Paper Bin

There were no serious incidents during 2019/20, however there were several fire alarm activations caused by cooking left unattended. One of these was significant and required the floor to be evacuated. Of the others they too were all in communal kitchens in residential blocks. The Fire Safety Team are trialling a cooker timing device that will switch off the supply to the cooker after a set amount of time with a view to connecting to all cookers in residential communal kitchens.

False Alarms				
Year	**Unwanted Fire Signals**	**False Alarms**	**Pre-Warnings**	**Misting System**
2014 – 15	21	57	78	0
2015 – 16	31	41	86	2
2016 – 17	15	54	147	2
2017 - 18	27	53	125	2
2018 -19	16	56	132	6
2019 - 20	20	120	97	6

False alarm are activations of the fire alarm system when there is no fire and are divided into two types:

- *False alarm where the fire alarm activates but the Fire Service does not attend*
- *Unwanted fire signal where the alarm activates and the Fire Service attends.*

False Alarms have been broken down into the following areas:

Malicious Actuation of Break Glass Point	*0*
Break Glass Point Actuated – Good Intent	*28*
AFA Good Intent e.g. Toast, Fumes, Smoking, Steam	*52*
AFA Electrical / Mechanical Fault	*4*
AFA Contractor / Test Error	*5*
AFA Contaminated Head e.g. flies, dirt	*7*
AFA Cause unknown	*9*
AFA Pre Warning	*97*
AFA Equipment Fault	*15*
Water Mist	*6*

Pre-warnings occur when a detector reaches a certain threshold, this could be smoke, fumes, aerosol, dust, but is not sufficient for the detector to go into full alarm. Fire Response Team does attend. Pre warnings are generally linked to the older devices.

Misting System is interfaced to the fire alarm system to alert the hospital if it actuates. All of the actuations so far have been accidental by a person knocking a head and setting the system off.

Unwanted Fire Signals have increased by 20% whilst there has been a 114% increase in false alarms.

The Fire Safety Team continue to monitor and record all fire alarm activations and follow up all areas of concerns and trends

Analysis has shown there has been an increase in fire alarm activations both in pre alarm and full alarm from causes: Steam; 47 actuations and Heat Build Up; 23 actuations. The key findings showed that dual type detectors (heat & smoke) have been fitted in kitchens and roof spaces. Where this has been found, detectors have been adjusted or replaced to more suitable detectors for their environment.

Fire & Rescue Service Attendance to Site		
Time	**No. of Activations (including Pre-Warnings)**	**No. of Times FRS Attended**
Between the hours of 08:00 and 20:00	160	1
Between the hours of 20:00 and 08:00	42	22

For the last five years Northamptonshire Fire and Rescue Service have not attended calls from automatic fire alarms to the hospital between the hours of 0800 – 2000hrs. Their stance is that they will not attend during these times unless we confirm that there is a fire. They do not accept the activation of the fire alarm system as confirmation. Their attendance is therefore reliant on the hospital making a direct 999 call to them confirming a fire. This could result in a delay in their attendance during the day.

It has been agreed with the FRS that should there be a fire alarm activation in Block 41 & 42 (includes Critical Care floor and Main Theatres), there will be automatic attendance 24 hour a day.

5. Risk Assessment:

It is a statutory requirement of the RRO that the Responsible Person has in place a fire risk assessment for all premises for which they have responsibility. The Trust employs a Fire Safety Adviser who, as part of their responsibility's, carries out these assessments using a pro-forma template from HTM 05-03.
All areas of the Trust has a fire risk assessment in place and have been reviewed during the reporting period.

To come into line with the Industry Standard, all of the current Fire Risk assessments are being re-assessed and re-written using this new pro forma known as PAS 79 (Public Available Specification). This work commenced within the reporting period.

As part of this process, the premises within the Trust have been assessed at high level to identify the priorities for re-inspection, taking into account the recent compartmentation survey results and type of use. The following risk categories were agreed and align with HTM guidance.

Priority	Description
1	Wards and other Patient Sleeping Risks ITU & HDU & Theatres
2	Staff Sleeping Accommodation
3	Outpatient and patient areas that do not have sleeping risks
4	Ancillary areas such as Plant rooms Laundry and other higher risk areas
5	Non patient and staff only areas
6	Other areas as identified

A full review and re-write of assessments in categories 1 and 2 commenced during the reporting period. .
The outcome of these high risk reviews found that there were urgent works required in blocks 41 and 42, Critical Care Floor (detailed below).
The remaining assessments of categories 1 and 2 have been completed by the Fire Safety Team and concluded there are no areas within the Trust that are recorded as 'intolerable' or require immediate action.

A review of all FRAs is being completed by an external fire specialist.
Categories 3 will be completed during September 2020 and categories 4 to 6 during October 2020.
For additional assurance the external specialist will also complete a review of the high risk category 1 and 2 assessments completed by the Trust Fire Safety Team.

Fire Safety on the Critical Care Floor - Block 41 & 42
The top floor of Blocks 41 & 42 (Critical Care floor) was of concern to the Fire Safety Team, consequently the Trust FSA carried out full Fire Risk Assessments of theses wards and identified significant issues with fire compartmentation and means of escape.
A report was written to the Trust Board highlighting concerns should a fire break out in this area, following which a Task and Finish group was set up and met daily to devise a plan of action and to manage actions undertaken to improve the fire safety precautions on the Critical Care Floor.

The Fire and Rescue Service were contacted and with their assistance a suitable plan of action was agreed and improvements were made with urgency and speed.

During the period from February to present, significant estates work has continued at pace and remains on track to complete in November 2020.
The FRS have been involved and supportive of the programme and have visited site on several occasions to inspect.

This work has provided assurance that all staff and patients on the Critical Care floor can be evacuated to a place of safety in the event of a fire. Infrastructure works, live fire drills, new FRAs and LEEPs have provided assurance that this has been achieved and witnessed by the Trust Fire Safety Team and the FRS.
Work continuing to November 2020 will provide further levels of assurance and, the safety of the area and safe evacuation is not compromised during that period.

Following the findings and in particular the ITU / HDU, emergency funding was sought and agreed and a new ITU / HDU is currently under construction alongside the existing Theatre block at ground floor level. The building is due for handover April 2020 which will be followed by a period of training and commissioning.

Other and Existing Mitigations

- There are 337 Fire Risk Assessments in place covering all areas of the Trust. Within each Fire Risk assessment significant findings of the inspection are recorded, and an action plan created to improve and/or upgrade the fire safety measures in the hospital. The Action Plan is formerly reviewed on a quarterly basis through the Fire Safety Committee.
- Fire wardens carry out fire safety checks which identify fire safety breaches
- There is an automatic water mist fire suppression system that will, when activated, control or extinguish a fire.
- There is in a place a comprehensive fire alarm and automatic fire detection system which will give early warning of any fire incident allowing staff to react in a quick and timely manner. The system has a service and maintenance agreement in place with an approved provider and is tested weekly.
- All members of staff receive refresher fire training annually.
- A Fire Response Team who will attend all fire and false alarm incidents or when the fire alarm has been activated 24/7.

6. Maintenance

Fire Alarm System
Increased inspections of the fire alarm system highlighted a number of legacy faults. A new maintenance specialist was commissioned and their additional resource and support has been critical in delivering a fully operational system. The system was fully tested and maintained during the reporting period.

Misting System
An automatic water mist fire suppression system has been installed to cover the Service corridor and plant rooms, the service corridor of Main Theatres; Medical Records; Portering Services; A & E; Resuscitation; FIT stop; Clinical Observation; bin store; corridor outside ITU; Nye Bevan and bin stores.

The system has been fully maintained by a specialist contractor.

Suppression Systems
There are 3 suppression systems on site covering IT Suites, HV switch room and the main cookers in the food production unit. These systems have been fully maintained by a specialist contractor.

Other Maintenance
Both Fire Extinguishers and Emergency Lighting have annual inspections as part of their routine maintenance. This is completed by specialist contractor.
All electrical systems have been tested and inspected by an external specialist contractor.
An independent Electrical Authorising Engineer is appointed by the Trust and reviews electrical compliance as part of their 6 monthly audits.

7. Training and Development

	Induction	Refresh of Knowledge	Mandatory	Ward	W/Book	ELearning	Number Trained	% Trust Compliant
2014 - 15	997	965	1048	605	0	772	4387	67.0
2015 – 16	1060	1725	192	719	111	879	4686	78.2
2016 – 17	1064	1250	196	629	943	1022	5104	80.7
2017 – 18	1055	1234	141	543	1063	1264	5300	81.9
2018 – 19	986	904	45	540	1288	1326	5358	82.7
2019 - 20	1092	1028	83	601	1637	737	5471	83.5

There are several forums where fire training is undertaken and all the sessions have been adapted to deliver a consistent fire safety core message.

The formal training sessions include:

Induction	Fire Wardens
Refreshers	Fire Response
Midwives	ROK
Volunteers	ELearning
Junior Doctors	Workbooks.

In addition to the programmed training, the Fire Safety Team have supported all departments to arrange more departmental specific on-site training where the Fire Safety team provide additional training as required and support in running table top or passive fire drills.
The Fire team have also supported staff with the production or review of their Fire Evacuation Plans.

Staff training figures have continued to increase year on year since 2013.

To facilitate specialist training in the use of Fire Extinguisher a fire simulator with laser operated extinguishers has been purchased. This has allowed for safe classroom teaching in the use of extinguishers without exposing any of our staff to any hazard or risk.

Emergency Fire Evacuation Drills
It is a statutory requirement of the RRO and a mandatory requirement of Firecode that all members of staff take part in a fire drill at regular intervals.
Whilst this can be undertaken in staff and outpatients areas it is difficult to achieve within in-patient areas, in these areas a table top exercise can be undertaken.

Out of a possible 190 areas, 100% are now in date following an extensive effort to by the Fire Safety Team to go out to individual wards that were falling behind and help with their specific training needs.

The Fire Safety Adviser monitors completion of drills and distributes monthly to Divisional and Directorate managers, Heads of Departments and Matrons showing compliance.

These are reported to the Fire Committee and the Trust Health and Safety Committee and is now also monitored as part of fire compliance section which has been added to the Divisional Scorecards.

Local Emergency Evacuation Plans
It is a statutory requirement of the RRO that every area has a Local Emergency Evacuation Plan (LEEP) for staff to follow should a fire occur. To enable the plan to be completed there is a template available to download from the Intranet which the manager of the area must complete.
Once completed the plan is sent to the Fire Safety Adviser who will approve it and arrange for it to be uploaded onto the Policy and Procedures section of the Intranet.
The plan is to be reviewed annually to ensure that it is still current.
Out of a possible 190 areas 100% have been reviewed.

The Fire Safety Adviser monitors completion of plans and distributes monthly to Divisional and Directorate managers, Heads of Departments and Matrons showing compliance.
These are reported to the Fire Committee and the Trust Health and Safety Committee and is now also monitored as part of fire compliance section which has been added to the Divisional Scorecards.

To assist each department with production of Evacuation plans the Fire Safety Team proactively visited departments to assist respective heads with their review. Where requested, the Fire Safety Team also deliver presentations on site and walk through evacuation procedures.

8. Resilience

Fire Safety Governance
The Fire Safety Committee meets at quarterly intervals and has a set Agenda covering – Action Plan, Fire Incidents and False Alarms, Staff Training.

The membership of the meeting consists of Deputy Director of Estates and Facilities & Head of Estates, Fire Safety Adviser, Health and Safety Manager, Head of Resilience, Site Management, Nursing representative, Non-Nursing representative, Fire Response Team representative.

The Committee reports to the Trust Health and Safety Committee.

In support of the Fire Safety Group and to enhance our Governance procedures, the Estates team have introduced a formal Technical Team Meeting monthly to discuss and identify technical issues that may need oversight from the Fire Safety Group.

Fire Logbooks and Safety Information Manual
Logbooks are kept at each fire alarm control panel for the recording of any activation, test or fault on that panel.

Fire Safety Information Manuals (Fire Precautions Manual) have been issued to all occupied areas of the hospital.

Included in the Manual is a copy of the Fire Safety policy and Fire Policy guidance document with sections on fire extinguishers, staff training, fire drills, fire wardens, hazards in the area and fire risk assessment.

Fire Alarm System
The fire alarm and automatic fire detection system is a fully integrated and functioning part of the fire safety measures in the hospital. Due to the complexity of the site the current fire alarm system has received substantial investment to reach its current standard however, investment needs to continue to ensure that the system continues to maintain this standard.
Over the last 10 years approximately 50% has been upgraded. However, the system is a closed protocol system and there is limitation to further improvements. The circuits with which the detectors and associated equipment fitted is nearing capacity and there is limited room for expansion.

Following a GAP analysis of the system it was found that further additional equipment is required across the site as detailed below (these works are included in the estates fire capital plan):

Equipment Required	Emergency Lighting	Call Point	Sounder	Sounder Beacon	Flashing Beacon	Detectors	Grand Total
Total	1314	128	191	120	20	1066	2839

Work continued during the period to amend/correct the cause and effect, particularly in patient areas, to ensure the correct evacuation or alert signal.

Audit, Surveys & Service Reports
Audit
Audit of the fire safety systems is undertaken locally by our Fire Safety team, reporting to the Fire Safety Committee through the production of quarterly reports.

An external Approved Engineer (AE) undertakes two inspections per year, once as a re-assurance visit and the second to undertake an independent full inspection. The AE reports findings to the Fire Safety Committee 6 monthly

Northamptonshire Fire & Rescue Service carry out full Fire Safety Audits every two years, however due to other demands for the Fire and Rescue Service to undertake inspections within the Trust following Grenfell there has not been a full inspection since 2014. Northamptonshire Fire & Rescue Service have been to site on numerous occasions to support the Fire Safety team. They have indicated that a full inspection will be carried out in the next 12 months.

A Governance review of fire safety was undertaken by Director of Corporate Development, Governance & Assurance in February 2020. The report made 16 recommendations.

Of the 16 recommendations:

- 12 have been completed;
- 2 are on track to complete (Exec training and review of ToR for Estates Tech meeting
- 2 have slipped but have a due date set (review of Estates Governance reporting structure)

Where actions have been closed, evidence of assurance has been provided to the Governance Team.

In addition to this review, TIAA are currently undertaking an additional review of Fire Safety. The draft report is expected in September/October 2020.

Service Reports
In addition to Programmed Preventative Maintenance (PPM) carried out by Estates Department, all safety systems undergo comprehensive maintenance undertaken by external specialist contractors.

All results are recorded either through system specific recording systems and action plans or through Estates Computer Aided Facilities Management System (Agility). Follow up and remedials are actioned and recorded accordingly. High risk elements are reported through the Fire Safety Committee.

Evidence of these inspections were provided to the FRS as assurance of Trust safety measures in March 2019.

9. The Forward View

The key driver is to reduce both the current risks that sit at 25 and improve fire safety and assurance. The Trust is on track to move assurance to ‘Reasonable Assurance’ by November 2020.

Following completion of significant fire safety works across site and based on the results of the TIAA audit and independent review of the FRAs, the General Fire Safety risk that covers the entire site will be reviewed with the aim to reduce the risk from 25.

To align with annual reporting, the Annual Fire Board paper will be brought forward to May 2021.

The focus for 2020/21:

- Adoption of a 5 year strategy that identifies the fire safety priorities in high risk areas and enables continued improvement year on year.
- With external specialist support, continue to review and re-inspect the entire site on a risk-based approach through thorough Fire Risk Assessment.
- Emergency plans – continue to support departments and assist in reviewing all Local Emergency Evacuation Plans
- Ensure all areas undertake an annual fire drill
- Ensure all areas have in place a fire warden who is carrying out fire safety checks
- Fire training – continue to improve quality of training and increase compliance above 85%.
- Continue on site familiarisation exercises/drills with Fire and Rescue Service
- Plan for 2021/22 a full inter-service major incident exercise with the Fire and Rescue Service to test the Trust's emergency and continuity plans
- Continue Capital investment in fire safety through:
    - Continued phased upgrade of the fire alarm and automatic fire detection system including the recommendations from the GAP analysis that brings the system up to an L1 standard.
    - Continued extension of automatic water mist fire suppression system
    - Completion of fire barrier inspection and remedial works
    - Continued upgrade and extension of emergency lighting
    - Continued upgrade/replacement of fire doors

COVID19

In March 2020 COVID19 began to take hold of the country and NGH took all necessary action to deal with this pandemic and keep staff visitors and patients safe. Some of the actions undertaken did have an impact on our Fire Safety Systems, however the Fire Safety Advisor undertook a risk assessment at that time and deemed the precautions implemented to be acceptable as a temporary measure under the circumstances.

Hoardfast PVC partitions were quickly installed on wards to help reduce the risk of spread of the virus, however the Fire Safety Advisor did inform the Trust that these would need to be removed once COVID19 was under control. Should it be necessary to keep these partitions permanently then they would need to be replaced with a more suitable alternative that meets the HTM 'fire code' Class '0' rating for circulation areas and escape routes.

Request for Board Approval

The Regulatory Reform (Fire Safety) Order replaced all existing fire safety legislation applicable to hospitals; the current suite of Fire Code documents addresses the changes brought about by the Order.

The Fire Safety Order, in line with the other Regulatory Reform initiatives, has limited local government involvement and has placed the responsibility for compliance within an employer's duty to 'self-assess' their own premises and make such modifications as necessary.

Therefore, this report provides assurance for the Board and requests their approval for the Group Chief Executive for Northampton General Hospital NHS Trust and Kettering General Hospital NHS Foundation Trust to sign the Annual Statement of Fire Safety Compliance

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ANNUAL STATEMENT OF FIRE SAFETY COMPLIANCE

NHS Organisation Code: **RNS**	NHS Organisation Name: **Northampton General Hospital NHS Trust**	
I confirm that for the period 1st April 2019 to 31 March 2020 , all premises which the Trust owns, occupies or manages, have fire risk assessments that comply with the Regulatory Reform (Fire Safety) Order 2005, and;		
1	There are no significant risk arising from the fire risk assessments	
OR **2**	The Trust has developed a programme of work to eliminate or reduce as low as reasonably practicable the significant fire risks identified by the fire risk assessment	Y
OR **3**	The organisation has identified significant fire risks, but does NOT have a programme of work to mitigate those significant fire risks*****	
* *Where a programme to mitigate significant risk HAS NOT been developed, please insert the date by which such a programme will be available, taking account of the degree of risk* Date:		
4	During the period covered by this statement, has the organisation been subject to any enforcement action by the Fire and Rescue Authority? If yes, outline the details of the enforcement action in Annex A – Part 1	N
5	Does the organisation have any unresolved enforcement action pre-dating this statement? If Yes, outline the details of unresolved enforcement action in Annex A – Part 2	N
6	The organisation achieves compliance with the Department of Health Fire Safety Policy, contained within HTM 05-01, by the application of Firecode or some other suitable method	Y
7	There is a current fire safety policy in place	Y

Fire Safety Manager:	Name: Frank Pye E-mail: frank.pye@ngh.nhs.uk
Contact Details:	Telephone: 01604 544740 Mobile:
Chief Executive:	Simon Weldon Group CEO
Signature of Chief Executive:	
Date:	

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A G E N D A

PUBLIC TRUST BOARD

Thursday 24 September 2020
09:30 via ZOOM at Northampton General Hospital

Time	Agenda Item		Action	Presented by	Enclosure
09:30	**INTRODUCTORY ITEMS**				
	1.	Introduction and Apologies	Note	Mr A Burns	**Verbal**
	2.	Declarations of Interest	Note	Mr A Burns	**Verbal**
	3.	Minutes of meeting 30 July 2020	Decision	Mr A Burns	**A.**
	4.	Matters Arising and Action Log	Note	Mr A Burns	**B.**
	5.	Patient Vlog	Receive	Ms S Oke	**Verbal.**
	6.	Chairman's Report	Receive	Mr A Burns	**Verbal**
	7.	Chief Executive's Report	Receive	Mr S Weldon	**C.**
PERFORMANCE					
	8.	Integrated Performance Report	Assurance	Mrs D Needham Non - Executive Directors	**D.**
GOVERNANCE					
	9.	NGH Improvement Plan	Assurance	Ms C Campbell	**E.**
	10.	IPC Board Assurance Framework	Assurance	Ms S Oke	**F.**
STRATEGY					
	11.	Post Covid-19 Reset	Assurance	Mr Pallot	**G.** **To Follow.**
	12.	Academic Strategy	Assurance	Mr M Metcalfe	**H.**
ANNUAL REPORTS					
	13.	Safeguarding Annual Report	Assurance	Ms S Oke	**I.**
	14.	Infection Prevention Annual Report	Assurance	Ms S Oke	**J.**

Time	Agenda Item		Action	Presented by	Enclosure
	16.	Fire Safety Annual Report & Fire Safety Board Compliance Statement	Assurance	Mr S Finn	**K.**
CLOSING ITEMS					
	16.	Questions from the Public (Received in Advance)	Information	Mr A Burns	**Verbal.**
11:50	**17.**	**ANY OTHER BUSINESS**		Mr A Burns	**Verbal**

DATE OF NEXT MEETING

The next meeting of the Public Trust Board will be held at 09:30 on 26 November 2020 in the Board Room at Northampton General Hospital.

RESOLUTION – CONFIDENTIAL ISSUES:

The Trust Board is invited to adopt the following:

"That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest" (Section 1(2) Public Bodies (Admission to Meetings) Act 1960).