University Hospitals of Leicester NHS
NHS Trust

Cover report to the Trust Board meeting to be held on 6 August 2020

	Trust Board paper F1
Report Title:	**Quality and Outcomes Committee assurance conference call – Committee Chair's Report** *This was not a formally-constituted virtual Board Committee meeting, and was confined to any time-critical items/governance must-dos only. Its purpose was to provide information on, and assurance of, progress.*
Author:	Hina Majeed – Corporate and Committee Services Officer

Reporting Committee:	**Quality and Outcomes Committee (QOC)**
Chaired by:	Ms Vicky Bailey – Non-Executive Director
Lead Executive Director(s):	Andrew Furlong – Medical Director Carolyn Fox – Chief Nurse
Date of meeting:	30 July 2020

Summary of key public matters considered by the Committee:

This report provides a summary of the key issues considered at the Quality and Outcomes Committee assurance conference call on 30 July 2020:- *(involving Ms V Bailey, QOC Non-Executive Director Chair, Professor P Baker QOC Non-Executive Director Deputy Chair, Mr A Furlong, Medical Director, Ms C Fox, Chief Nurse, Ms B O'Brien, Deputy Director of Quality Assurance, Miss M Durbridge, Director of Safety and Risk and Ms C Trevithick, CCG Representative. Mr D Kerr, Director of Estates and Facilities, Ms F Lennon, Deputy Chief Operating Officer, Ms S Leak, Director of Operational Improvement, Dr R Marsh, Clinical Director, ESM and Mr K Mayes, Head of Patient and Community Engagement attended to present their respective items):*

- **Summary of QOC Conference Call held on 28 May 2020** – paper A noted, having been submitted to the Trust Board on 2 July 2020.

- **Matter Arising Log** – paper B noted. The matters arising log would be populated with any updates provided at this meeting.

- **Premises Assurance Model Annual Report 2019-20**
  The Director of Estates and Facilities attended the meeting to present paper C which provided an annual review of the Trust's position following completion of the Department of Health 'Premises Assurance Model' (PAM). The PAM data provided UHL with a range of nationally-recognised performance metrics across Estates and Facilities functions, and covered the period 1 April 2019 – 31 March 2020 (year 2 of a 2-year assessment period). The Director of Estates and Facilities highlighted that the report demonstrated more about the systems and processes in respect of the five domains (safety, patient experience, efficiency, effectiveness and organisational governance) in place rather than the condition of the estate. Although the 2019-20 self-assessment had delivered outcomes broadly in-line with the previous assessment, further progress had not been possible due to financial, resource and workforce pressures including challenges caused by the Covid-19 pandemic. In addition to seeking independent external assurance, a number of tools had been used within the Trust to analyse performance including PLACE, ERIC, CAAS and various audits. The Director of Estates and Facilities summarised that, whilst the report concluded that 'minimal improvements were required in many fields to achieve a 'good' rating, he reiterated that there was a need for triangulation of data, additional investment and efficiency gains to drive improvement. The Medical Director and the QOC Non-Executive Director Deputy Chair voiced concern that the report did not provide assurance that robust systems were in place to demonstrate that the Trust's premises and associated services were safe. In discussion, the Director of Estates and Facilities was requested to discuss with Executive Director colleagues in respect of how the outcomes of the first four domains were embedded in internal governance and assurance processes to ensure actions were taken, where required. The Director of Estates and Facilities acknowledged this, however, noted the need for a mechanism to triangulate the various assurance metrics across the estates and facilities functions as part of the 'State of the Nation' report and thereby understand the key areas of risk. *The contents of this report were received and noted and* ***the comments made above be highlighted onto the Trust Board for its information (paper C attached to this summary).***

- **Cancer Performance Recovery 2019-20**
  Paper D, as presented by the Director of Operational Improvement, noted that cancer delivery and performance remained a priority for the Trust. Due to the current COVID-19 pandemic, there had been changes to cancer pathways, a decrease in activity and an increase in tracking of patients. The changes made followed the national and tumour site specific recommendations and ensured that patients were safe and received the time critical cancer treatments they required. This report outlined the impact on performance currently being observed and the actions being taken to ensure safe recovery and the impact on patient harm. Particular note was made regarding the changes which had been put in place to ensure pathways were safe, the use of the independent sector for cancer patients and no physical harm as a result of patient delays. In May 2020, the Trust had achieved 4 standards against the national targets. The report presented detailed a breakdown of performance against all targets and performance by tumour site for the 62-day target. In respect of the 62-day backlog, 11.7% of patients were reluctant to attend hospital and were delaying their treatment until after Covid-19. A letter from NHSE/I received in July 2020 had outlined the requirements for reducing the 62-day and 104-day cancer backlogs at pace. Due to the size and complexity of this requirement from NHSE/I, the Director of Operational Improvement advised that a phased approach to aid system recovery would be taken. The 2019 National Cancer Patient Experience Survey results for UHL had been published, the overall rating remained static at 8.7 against the national rating of 8.8. In response to a query from the QOC Non-Executive Director Deputy Chair regarding the long-standing deterioration in urology cancer performance, the Medical Director advised that this was a regional and national issue and work was underway to develop a regional solution to address issues and improve performance. In response to a query from the QOC Non-Executive Director Chair, the Director of Operational Improvement advised that harm reviews were being undertaken for all patients who had waited over 104 days to receive their first definitive treatment following a two week wait referral. The contents of the report were received and noted.

- **ED CQC Action Plan Update**
  The Clinical Director, ESM attended the meeting to provide an update on the action plan following the January 2020 CQC inspection of the Emergency Department (paper E refers). The Covid-19 pandemic had brought about a number of significant changes to the Emergency Department, many of which had supported the team to tackle and resolve the concerns raised by the CQC. The Clinical Director, ESM detailed the actions that had been put to address the following in particular:- timely and effective ambulance handovers, assessment of risks and particularly the risk of patients developing pressure ulcers, protecting dignity of patients, and medical staff recruitment. Due to overseas travel restrictions because of Covid-19, new junior doctors from abroad would not be able to join the Trust in August 2020. Therefore, changes to the ED junior doctor rotas would need to be made in order to staff the ED which had now been split into respiratory and non-respiratory departments. In response to a suggestion from the CCG Representative regarding the need for an audit to ensure that any changes introduced had been embedded within the department, the Chief Nurse requested the Deputy Director of Quality Assurance to include wording to this effect in the action plan before it was sent to CQC colleagues. The QOC Non-Executive Director Chair commended the Clinical Director, ESM and her team for their work to address the issues raised by the CQC and noted the need for measures to be put in place to ensure that the changes put in place were sustainable from a quality perspective. The Chief Nurse also echoed these comments and suggested that a proactive meeting be arranged with local CQC inspectors to keep them updated on progress.

- **Infection Prevention and Control NHS England Board Assurance Framework (BAF)**
  The Deputy Director of Quality Assurance attended to present paper F and highlighted that the NHSE/I had developed this framework to assist providers to assess themselves against the guidance as a source of internal assurance that quality standards were being maintained. NHSE/I had structured the framework around the existing 10 criteria set out in the Code of Practice on the prevention and control of infection which linked directly to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. It was therefore important for all organisations to ensure that risks were identified, managed and mitigated effectively. Members were provided with a brief update on the assessment process undertaken to complete the framework which was part of a three phase programme of work to ensure effective quality assurance around the Trust's infection prevention function. The Trust had also produced a BAF document to ensure that the risks relating to Covid-19 were being assessed and mitigated, as appropriate. Currently, the framework had been completed for internal assurance purposes only, however, it might be developed to provide external assurance in the future. The following highlights of the framework were drawn out in particular: - the Trust had (a) a good level of adherence to national policies and guidance, (b) good pathways and triage, (c) managed the PPE constraints well despite the challenges, and (d) prioritised staff welfare and supported staff to manage risk. The following challenges for the Trust were highlighted:- (i) physical environment – lack of space in clinics and waiting areas, lack of side rooms, ventilation and reduction of bed base; (ii) a gap in the data indicated that some of the usual governance processes had been discontinued during the surge in activity for COVID-19, (iii) although it was desirable to minimise staff moves to avoid cross infection, this was a significant challenge with the level of vacancies and sickness, and (iv) decontamination of PPE. The QOC Non-Executive Director Chair suggested that a further report on the changes that had been made as a result of the three phase programme of work mentioned above be presented to QOC,

when appropriate.

- **Review of QOC**
  The Committee Chair introduced discussion on this item and highlighted the need for reframing the QOC in order that it took a focussed approach on controls and assurance both internal and external. She reiterated the need to collectively ensure how services were delivered in the future in order that there was a rigorous approach to quality assurance. Members were requested to consider this matter given the wider context of the Trust's external financial review. Although quality assurance was already in place in some areas, she highlighted that there was need to be more systematic, particularly due to the significant transformation in the delivery of care that the Trust had achieved due to the Covid-19 pandemic. The CCG Representative noted the need for understanding quality assurance not only from an organisation perspective but also from a population perspective and that both were dove-tailed. She undertook to circulate a paper to QOC members regarding this. The Director of Safety and Risk highlighted the need for overview and scrutiny reviews to be weaved into the current deep dive, peer, internal audit and CCG reviews in place. The Chief Nurse and Deputy Director of Quality Assurance acknowledged that the current review of QOC was well-timed given that it was the right time to embed CQC's 'good' rating and start the journey towards an 'outstanding' rating. The QOC Non-Executive Director Chair noted the comments and undertook to contact members outside of the meeting (via email) to agree an approach on how to take forward this work.

- **PPI Strategy Update**
  The Head of Patient and Community Engagement attended to present a progress update on the implementation of the Trust's Patient and Public Involvement (PPI) strategy (paper G refers). He highlighted that the Covid-19 pandemic had challenged the advancement of the ambitions of the PPI strategy but had also presented new opportunities to approach PPI from a different direction. In light of the changes to the Trust's Quality Strategy, it would be important to revise the PPI strategy to reflect the new direction of travel and therefore it would be necessary to explore ideas on how PPI could best enhance its delivery going forward. The Chief Nurse highlighted that some Patient Partners had now started attending virtual meetings via the MS Teams platform. The QOC Non-Executive Director Chair noted the improvements made and undertook to contact the Director of Corporate and Legal Affairs and the Head of Patient and Community Engagement outside of the meeting to check whether the QOC conference call would be an appropriate forum to re-introduce the involvement of Patient Partners.

- **Covid-19 Position**
  The Chief Nurse provided a verbal update in respect of the latest position with regard to Covid-19 highlighting that nosocomial Covid-19 positive infections were being appropriately monitored. The staff sickness rates from a Covid-19 perspective were reducing. Staff who were 'shielding' were now being brought back into the workplace, further to completion of appropriate risk assessments. In respect of the Covid-19 risk assessments in place for staff, 92% of BAME risk assessments had been completed. The roll-out of asymptomatic testing programme had commenced with a 2000 per week capacity across the entire workforce. Approximately 400 staff to date had joined the SIREN study (staff antibody testing). In respect of 6-week diagnostic waits, patients were being managed in-line with national guidance and Trust's policy. The Independent sector was being used, where possible, to improve the diagnostic position. Modelling had commenced to understand the capacity gaps, by service, due to new infection prevention guidelines. In response to a query from the QOC Non-Executive Director Deputy Chair, the Medical Director advised that the demand and capacity model for cancer services was being undertaken to develop a clear trajectory for key performance metrics. The Medical Director advised that options for Endoscopy including upgrading the ventilation systems in clinical areas were being evaluated, which would improve the number of cases per list. Members noted the continued challenges to restoration and recovery and highlighted the importance of improving quality assurance. Assurance was provided that, despite the increase in community patients' presentation to hospital services, infection prevention was being well-managed whereby there was no corresponding increase in Covid-19 related hospital admissions. In respect of the local Leicester lockdown, a decision on whether this would be lifted was expected on 30 July 2020.

- **2020-21 Quality and Performance Report Month 3**
  The contents of paper H were received and noted.

- **Monthly Safety Report – June 2020**
  Paper I, as presented by the Director of Safety and Risk, provided the detailed key safety events (Serious Incidents, Never Events, RIDDORs, deaths, etc.) for the month of June 2020. She particularly noted an increase in the number of formal complaints and patient safety incidents but these were not back to the levels seen before the surge in COVID-19 activity. The World Health Patient Safety Day would be held on 17 September 2020 with a focus on health workers' safety. The event would be arranged in collaboration with health system partners. The 2019/20 Annual Radiation Safety report highlighted that the distribution across incident causes showed some variation in the incidents that had been occurring. The general causes across operator incidents were similar to previous years. Referrers had a similar number of incidents compared to 2017, notably reduced compared with

2018; however, there was a very significant increase in near misses. In respect of the referrer errors, the Medical Director advised that a Nerve Centre product was being considered (as having one system would reduce the error rate), however, he highlighted that there needed to be an element of continued vigilance. In response to a query, approval was given to forward the 2019/20 Annual Radiation Safety Report to the CQC IRMER Inspector.

- **Items for noting:**– the following reports were received and noted for information:-
    - **Blood Track Traceability Report (paper J), and**
    - **EQB actions 9.6.20 and 14.7.20 (papers K1 and K2).**

Public matters requiring Trust Board consideration and/or approval:

Recommendations for approval

- None

Items highlighted to the Trust Board for information:

- **Premises Assurance Model Annual Report 2019-20 (paper C attached to this summary) –**The paper as presented, albeit a national template, only provided a limited picture of premises assurance as it was a self-assessment mainly about systems and processes and therefore limited in its scope. The Committee was therefore not assured and further discussion was requested;
- **Infection Prevention and Control NHS England Board Assurance Framework (BAF) –** QOC had reviewed this document and obtained assurance from it (shown at Appendix 2);
- The verbal update on Covid-19 and the assurance provided that, despite the increase in community patients being presented to hospital services, infection prevention was being well-managed whereby there was no corresponding increase in Covid-19 related hospital admissions, and
- The discussion regarding the **2019/20 Annual Radiation Safety Report** (as part of the Monthly Safety Report – June 2020).

Matters deferred or referred to other Committees:

None

Date of next QOC assurance conference call:	27 August 2020

Ms V Bailey – Non-Executive Director and QOC Chair

Closed 10:04am

Premises Assurance Model Annual Report

Author: Bharat Lad , Information Manager Sponsor: Darryn Kerr, Director of Estates & Facilities

Purpose of report:

This paper is for:	Description	Select (X)
Decision	To formally receive a report and approve its recommendations OR a particular course of action	X
Discussion	To discuss, in depth, a report noting its implications without formally approving a recommendation or action	
Assurance	To assure the Board that systems and processes are in place, or to advise a gap along with treatment plan	X
Noting	For noting without the need for discussion	

Previous consideration:

Meeting	Date	Please clarify the purpose of the paper to that meeting using the categories above
CMG Board (specify which CMG)		
Executive Board	07.07.2020	Decision and Assurance
Trust Board Committee		
Trust Board		

Executive Summary

Context

This paper is submitted to provide an annual review of the Trust's current position obtained from the completion of the Department of Health Premises Assurance Model (PAM). The data outputs from PAM provide the Trust with a range of nationally recognised performance metrics across Estates & Facilities functions. The report covers the period 1st April 2019 to 31st March 2020

Questions

1. What is benefit does the Trust get from PAM?
2. Will the data be benchmarked nationally?
3. What is the process for updating PAM to ensure it remains relevant between annual reviews?

Conclusion

1. PAM provides assurance to the Trust Leadership across the range of Estates & Facilities services and identifies areas requiring improvements.
2. Going forward, plans are in development to benchmark PAM against similar Acute NHS Trusts. Once the online version (currently at development stage) is in place Trust's will able benchmark nationally.
3. The E&F Compliance team co-ordinate the Trust's PAM return including collating and validating information from the Trust stakeholders. A six monthly review of PAM is scheduled in the Compliance Team annual work plan.

Input Sought

QOC are asked to note that the 2019/20 PAM has delivered outcomes broadly in-line with the previous 2018/2019 PAM assessment. Further progress was hampered by financial, resource and workforce pressures. Whilst the overall summary table indicates 'minimal improvement required in many fields to achieve a 'good' rating, this should be considered in the context of UHL as a large and complex organisation that will require additional investment, along with efficiency gains to achieve the next step up. With this in mind a transformed structure will maximise opportunities to achieve these efficiency gains within the current financial environment, which will still require additional investment in resources, infrastructure and assets to drive improvement.
The Trust board are asked to support implementation of another two-year PAM assessment cycle to provide premises assurance across the PAM fields.

For Reference

This report relates to the following UHL quality and supporting priorities:

1. Quality priorities

Safe, surgery and procedures	Not applicable
Safely and timely discharge	Not applicable
Improved Cancer pathways	Not applicable
Streamlined emergency care	Not applicable
Better care pathways	Yes
Ward accreditation	Not applicable

2. Supporting priorities:

People strategy implementation	Yes
Estate investment and reconfiguration	Yes
e-Hospital	Not applicable
More embedded research	Not applicable
Better corporate services	Yes
Quality strategy development	Yes

3. Equality Impact Assessment and Patient and Public Involvement considerations:

- What was the outcome of your Equality Impact Assessment (EIA)? N/A

- Briefly describe the Patient and Public Involvement (PPI) activities undertaken in relation to this report, or confirm that none were required – none were required.

- How did the outcome of the EIA influence your Patient and Public Involvement n/a

- If an EIA was not carried out, what was the rationale for this decision? This paper has no impact on Equality.

4. Risk and Assurance

Risk Reference:

Does this paper reference a risk event?	**Select (X)**	**Risk Description:**
Strategic: Does this link to a ***Principal Risk*** on the BAF?	X	Estates Infrastructure risk
Organisational: Does this link to an ***Operational/Corporate Risk*** on Datix Register	X	Estates Infrastructure risk
New Risk identified in paper: What ***type*** and ***description***?		
None		

5. Scheduled date for the **next paper** on this topic: TBC
6. Executive Summaries should not exceed **5 sides** [My paper does not comply]

DATE: June 2020

REPORT BY: Bharat Lad, Information Manager

SUBJECT: Premises Assurance Model (PAM)

Introduction

The NHS Premises Assurance Model (PAM) enables NHS Trusts to utilise an evaluation model that produces a range of nationally recognised performance metrics across Estates & Facilities services. Department of Health guidelines give NHS Trusts the option of carrying out one or two year PAM assessments. As from April 2020 PAM will be included in the NHS Standard Contract.

The current UHL PAM assessment was configured to be populated across a two year period, thus making the current 2019/20 data set year two of two.

PAM Self-Assessment Questions (SAQs) are grouped into five Domains; these are broken down into individual and further sub-questions known as prompt questions. The model is completed by scoring the Prompt Questions under each SAQ. The five domains are:

- Safety (Hard and Soft Facilities Management)
- Patient Experience
- Efficiency
- Effectiveness
- Organisational Governance

The NHS PAM is a tool that allows the Trust to better understand the efficiency, effectiveness and level of safety applicable to our estate and how that links to patient experience.

The first four domains cover the main areas where Estates and Facilities impact on safety and efficiency. The Organisational governance domain acts as an overview of how the other four domains are managed as part of the internal arrangements of the organisation. Its objective is to ensure that the outcomes of the Domains are reported up to NHS Trust Boards and embedded in internal governance processes to ensure actions are taken where required.

The NHS PAM provides a tool to enable the Trust to assure to our patients, commissioners and regulators that robust systems are in place to demonstrate that our premises and associated services are safe.

Methodology of Assessment

Evidence was gathered by the Estates & Facilities Statutory Compliance Team to enable the assessment to be undertaken.

Peer groups were set up across clinical and non-clinical management teams within the Trust, including; Infection Prevention, Health & Safety, Risk Management, Medical Engineering, Emergency Planning, Estates & Facilities Management Performance & Quality Teams and other Specialists.

Additionally, the use of Compliance Assessment & Analysis Systems (CAAS) toolkit was used to support and verify the PAM evidence provided by the Peer groups. The CAAS system provides a scoring which allows the Trust to drill down and look at performance & processes in relation to the following compliance areas; Asbestos, Asset Management & Maintenance, Contingency Planning, Contract Management, CQC Standards, Decontamination, Electrical Systems, Facilities Infection Prevention, Fire Safety, Health Safety, COSHH, Lifts, Mechanical Systems, Safe & Accessible Buildings, Security Management, Sustainability, Ventilation, Waste Management & Water
Action Plans developed in CAAS support and validate actions for PAM.

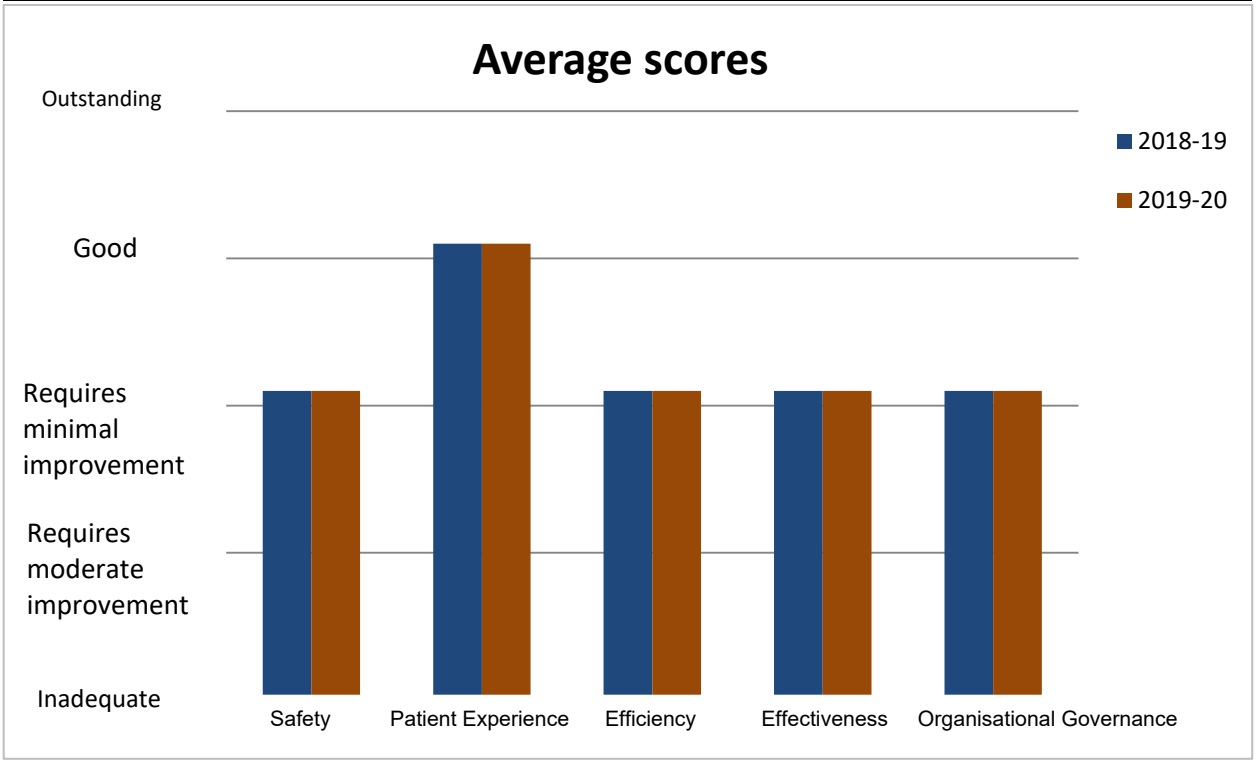
Rating Scale

Not Applicable	Does not apply to either the organisation or there is no need to prepare an action plan.
Outstanding	Compliant plus evidence of high quality of service and innovation
Good	Compliant, no action requires (where there was no policy, other documents, procedures & processes were in place to mitigate.
Minimal Improvement	The impact on patients/staff/organisation has the potential to be low.
Moderate Improvement	The impact on patients/staff/organisation has the potential to be medium
Inadequate	Action is required quickly – high impact for patients/staff.

Overall Summary

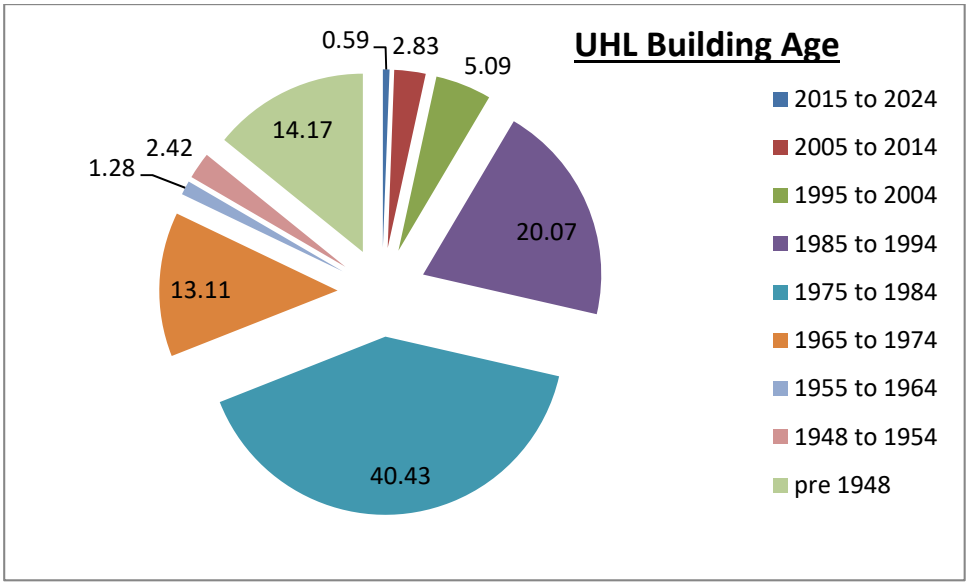
Table 1

Domain	Domain statement
Safety	The organisation provides assurance for Estates, Facilities and its support services that the design, layout, build, engineering, operation and maintenance of the estate meet appropriate levels of safety to provide premises that supports the delivery of improved clinical and social outcomes.
Patient experience	The organisation ensures that patient experience is an integral part of service provision and is reflected in the way in which services are delivered. The organisation will involve patients and members of the public in the development of services and the monitoring of performance.
Efficiency	The organisation provides assurance that space, activity, income and operational costs of the estates and facilities provide value for money, are economically sustainable and meet clinical and organisational requirements.
Effectiveness	The organisation provides assurance that it's premises and facilities are functionally suitable, sustainable and effective in supporting the delivery of improved health outcomes.
Organisation governance	How the organisations board of directors deliver strategic leadership and effective scrutiny of the organisations estates and facilities operations. How the other four Domains are managed as part of the internal governance of the NHS organisation. Its objective is to ensure that the outcomes of the Domains are reported to the NHS Boards and embedded in internal governance and assurance processes to ensure actions are taken where required.



The Trust reported mixture of “Requires minimal Improvement” and, “Good” ratings.

The 2019-20 PAM results are broadly comparable with those reported 12 months ago. Financial and resource pressures have been a barrier to further progress. There is a risk across four of the five domains in table 1 that any of them could drop from ‘minimum improvement required’ to ‘moderate improvement required’ if workforce gaps and building, infrastructure and equipment attrition is not funded to drive improvement. Some buildings and infrastructure equipment has been well maintained beyond the design lifecycle and in some cases out of scope with revised standards and guidance currently in place. This is best illustrated when we look the age profile of the UHL building stock, which clearly confirms that over 50% of our estate, was built between 1965 & 1984 and over 73% was built between 1965 – 1994 - see table below:



With this in mind the Trust has been Successful in the bid for the emergency backlog monies £10.3m, priorities includes legionella, pseudomonas, critical ventilation, fire safety, EHO improvements, theatre upgrade, med gas, asbestos, accessibility (DDA) and electrical infrastructure.

The Trust was also successful in their bid for £450m of capital investment over the next 5 years, from the Government to complete our investment and reconfiguration plans.

The £450m programme includes:

- A new Maternity Hospital and dedicated Children's Hospital at the Royal Infirmary
- Two 'super' intensive care units with 100 beds in total, almost double the current number
- A major planned care Treatment Centre at the Glenfield Hospital
- Modernised wards, operating theatres and imaging facilities
- A new stroke rehabilitation unit and primary care/diagnostic hub at the General Hospital
- Additional car parking

Whilst this will drive improvement in patient care and compliance to current standards, the Trust's maintenance backlog liability will remain in excess of £80 million and in need of a committed five year investment plan aligned to the Trust's 'Becoming the Best' objective

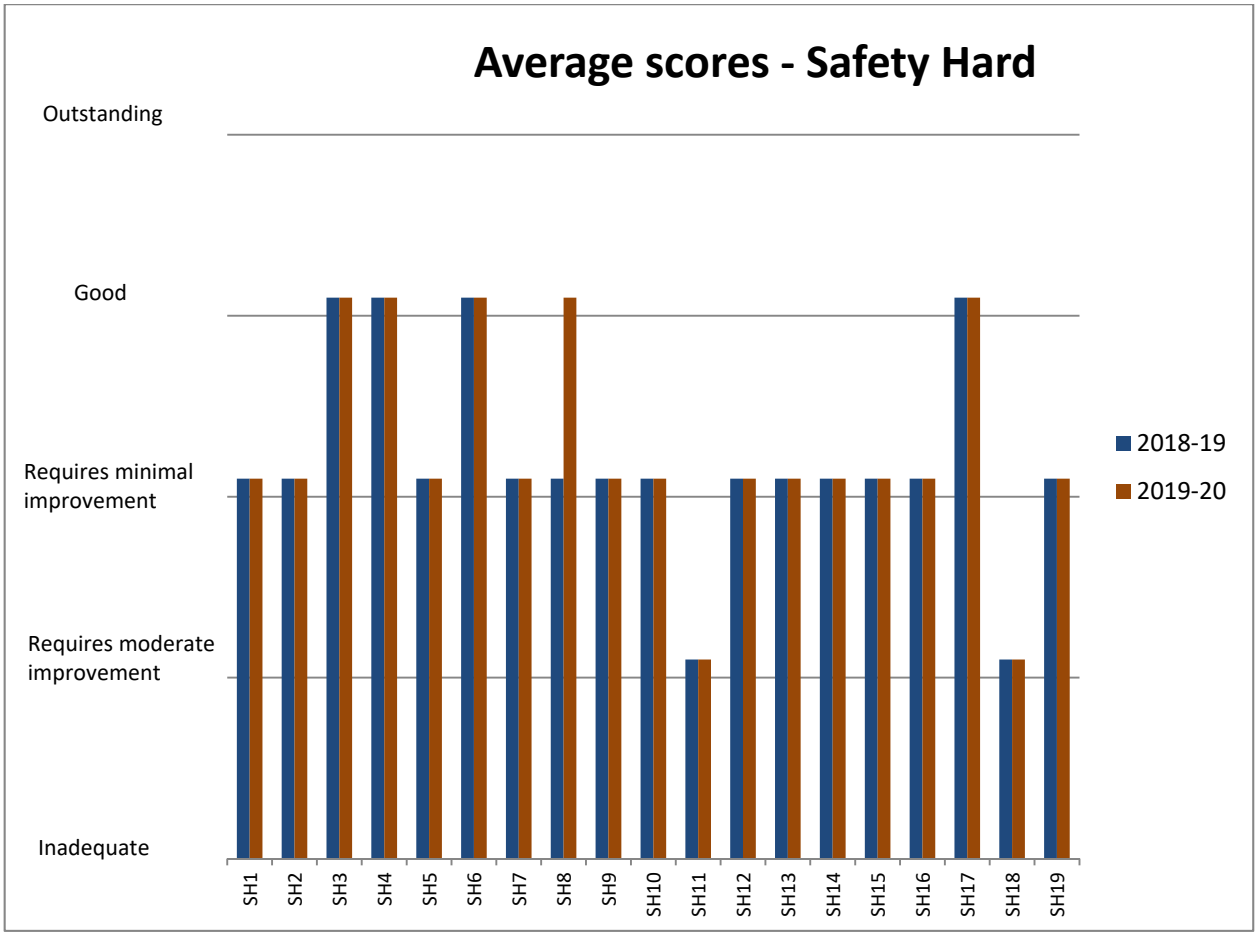
Summary by Domain

Safety (Hard FM):

The organisation provides assurance for Estates, Facilities and its support services that the design, layout, build, engineering, operation and maintenance of the estate meet appropriate levels of safety to provide premises that supports the delivery of improved clinical and social outcomes.

Table 2

SAQ code	Self-Assessment Question - Is the Organisation/site safe and compliant with well managed systems in relation to:	SAQ code	Self-Assessment Question - Is the Organisation/site safe and compliant with well managed systems in relation to:
SH1	Estates and Facilities Operational Management	SH10	Mechanical Systems e.g. Lifting Equipment
SH2	Design, Layout and Use of Premises	SH11	Ventilation, Air Conditioning and Refrigeration Systems
SH3	Estates and Facilities Document Management	SH12	Lifts, Hoists and Conveyance Systems
SH4	Health & Safety at Work	SH13	Pressure Systems
SH5	Asbestos	SH14	Fire Safety
SH6	Medical Gas Systems	SH15	Medical Devices and Equipment
SH7	Natural Gas and specialist piped systems	SH16	Resilience, Emergency and Business Continuity Planning
SH8	Water Systems	SH17	Reporting and implementing Premises and Equipment issues
SH9	Electrical Systems	SH18	Contractor Management
		SH19	Safety and Suitability of Premises and Services



Overall this domain scored, “Requires minimal improvements”.

During this reporting period Trust’s Estates team maintained a relatively steady state position, but progress was limited due to staff recruitment and retention pressures. Currently Estates Specialist Services have a shortage of Authorised Persons (APs) and Competent Persons (CPs) to fully meet the requirement of Health Technical Memorandum (HTM) guidance for Piped Medical Gases, Electrical Low Voltage, Boilers and Pressures, Lifts & Ventilation services. The Electrical High Voltage is currently satisfactory but succession planning training needs to be considered for this and all other AP and CP roles. Funding and course selection of new appointments and refresher training will be sourced in-line with a training matrix developed for the AP’s and CP’s. New Authorising Engineers have been appointed for Electrical High and Low Voltage, Lifts and Boilers and Pressures this year. Currently alternative online / video conferencing technologies are being developed to facilitate the AP appointments and Authoring Engineer Audits as they are overdue as a result of COVID 19 restrictions.

A recent audit of critical ventilation systems has identified a number of non-conformances to current standards in clinical areas and a number of ward upgrades required to meet Covid-19 isolation requirements. It will not only require additional capital funding to address the engineering and environmental issues it will also require access and business interruption to the service provision to carry out the work.

Water systems in a number of augmented care areas continue to record elevated Pseudomonas results that are controlled by implementing Infection Prevention patient Risk Assessment measures such as the introduction of microbiological filters in areas such as AICU, Maternity, BMTU, Osborne Building and PICU. However, in order to fully address the Pseudomonas risk it will be necessary to carry out substantial improvements to the water distribution systems requiring ward/area closures for the duration of the work.

Emergency backlog monies have been made available to reduce priority work identified in the Water Risk Assessments (WRA).

All paper based Asbestos reports held by the Trust are currently been uploaded into the MiCAD property management software , which will allow the Trust to meet it statutory requirement in terms of having an up to date Asbestos Register and providing and communicating our asbestos information to the relevant parties in a timely manner.

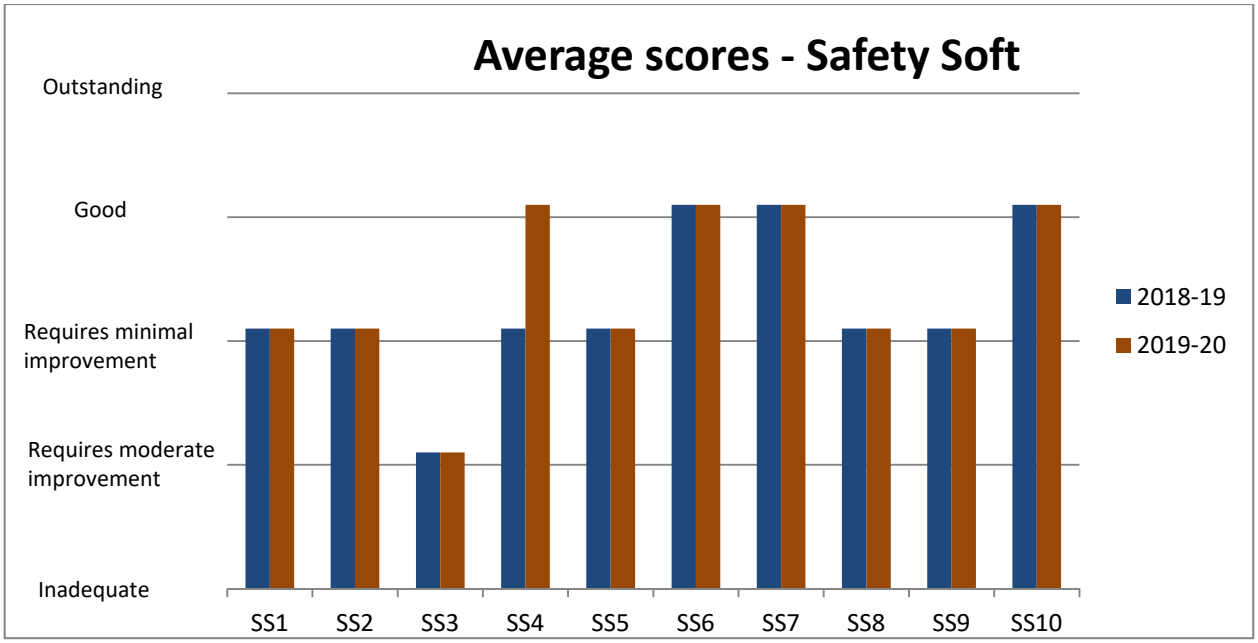
Funding has been made available from the Emergency backlog monies for fire safety in terms of upgrading fire safety systems and fire compartmentation.

Safety (Soft FM):

The organisation provides assurance for Estates, Facilities and its support services that the design, layout, build, and Soft FM Services meet appropriate levels of safety to provide premises that supports the delivery of improved clinical and social outcomes.

Table 3

SAQ code	Self-Assessment Question - Is the Organisation/site safe and compliant with well managed systems in relation to:
SS1	Catering Services
SS2	Decontamination Processes
SS3	Waste and Recycling Management
SS4	Cleanliness and Infection Control
SS5	Laundry Services and Linen
SS6	Security Management
SS7	Transport Services and access arrangements
SS8	Pest Control
SS9	Portering Services
SS10	Telephony and Switchboard



Overall this domain scored, “Requires minimal improvements”.

A general lack of progress across the soft Facilities Management fields in this domain can be attributed to workforce gaps, equipment suitability & end of equipment lifecycle, especially in Domestic services and Catering services. The Trust has been successful in the bid for the emergency backlog monies and £400k has been allocated for catering services, following an EHO inspection which highlighted major failings

Generally where the Trust relies on service contracts to provide a service, i.e. Linen, Pest Control, Window Cleaning and Waste Management, these are well managed. Quotes have now been received (with procurement) to upgrade/replace car parking equipment. Service provider, including car parking providers have been outstanding in assisting the Trust during the COVID 19 outbreak.

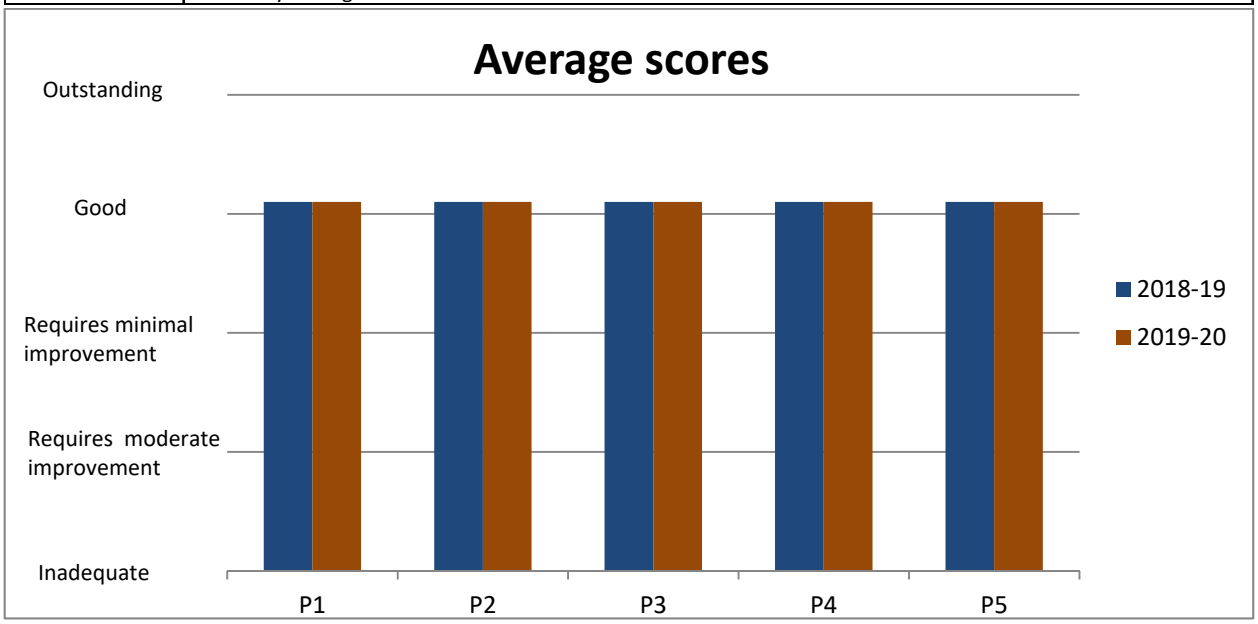
UHL PLACE continue to fall below the national standards, however it needs to be noted that the 2019 PLACE standard have been updated making it harder to compare year on year progress.

Patient Experience:

The organisation ensures that patient experience is an integral part of service provision and is reflected in the way in which services are delivered. The organisation will involve patients and members of the public in the development of services and the monitoring of performance.

Table 4

SAQ code	Self Assessment Question - Does your organisation:
P1	How are people who use estates and facilities services, the public and staff engaged and involved?
P2	Ensure that patients, staff and visitors perceive that the condition, appearance, maintenance and privacy and dignity of the estate is satisfactory?
P3	Ensure that patients, staff and visitors perceive cleanliness to be satisfactory?
P4	Ensure that NHS Catering Services provide adequate nutrition and hydration through the choice of food and drink for people to meet their diverse needs?
P5	Ensure that access and car parking arrangements meet the reasonable needs of patients, staff and visitors and are effectively managed at all times?



Overall this domain scored, “Good”

For this domain the Trust has good systems in place to ensure the Patient Experience is monitored and measured via PLACE, Staff Engagement (Listening into Action) Staff Appraisals, Visitor Engagement (Friends & Family Test) and Patient Experience via the Patient Information Liaison Services. Cleaning standards & meals are also monitored by the E&F internal audit team.

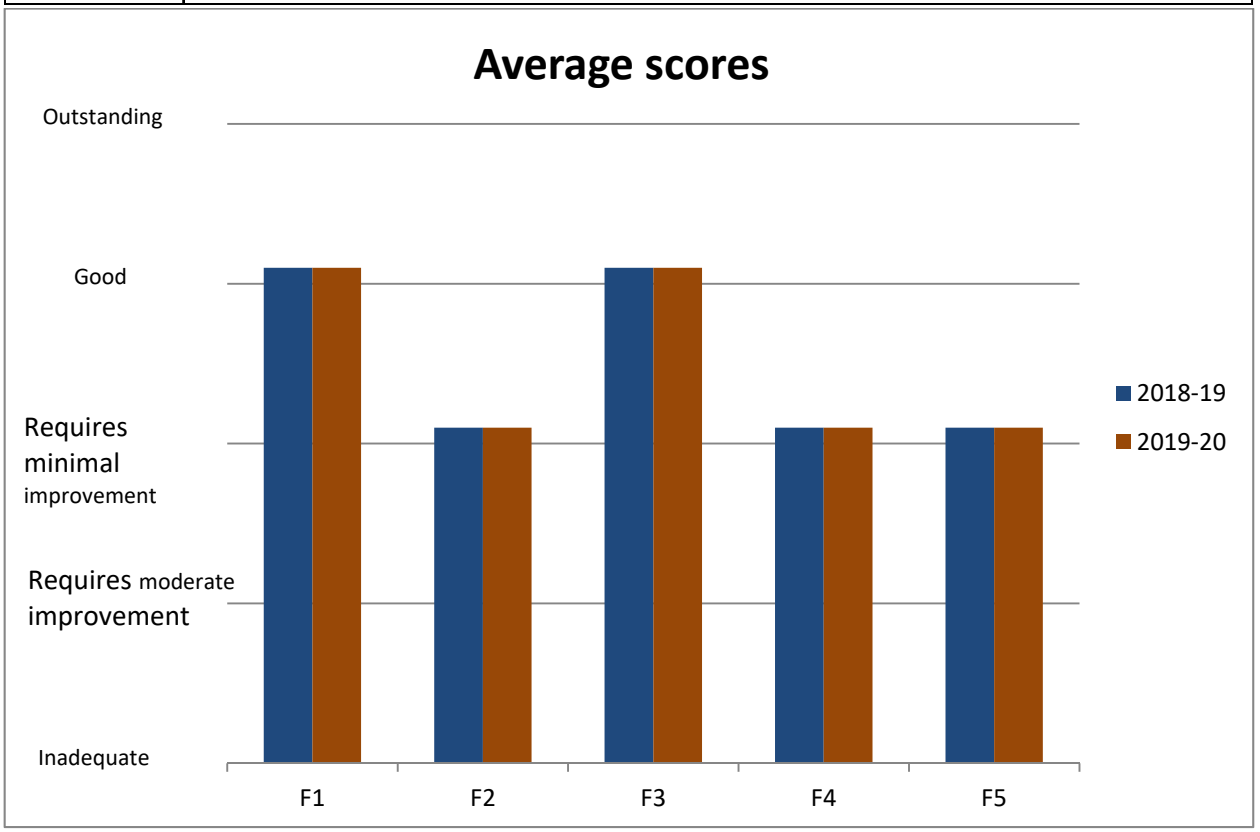
UHL PLACE continue to fall below the national standards, however it needs to be noted that the 2019 PLACE standard have been updated making it harder to compare year on year progress.

Efficiency:

The organisation provides assurance that space, activity, income and operational costs of the estates and facilities provide value for money, are economically sustainable and meet clinical and organisational requirements.

Table 5

SAQ code	Self Assessment Question - Does your Organisation/site have a well-managed approach to achieving value for money and cost improvements in relation to:
F1	A well-managed approach to performance management of the estate and facilities operations?
F2	A well-managed approach to improved efficiency in running estates and facilities services?
F3	Improved efficiencies in capital procurement, refurbishments and land management?
F4	A well-managed and robust financial controls, procedures and reporting?
F5	An Estates and Facilities services are continuously improved and sustainability ensured?



Overall this domain scored, "Good".

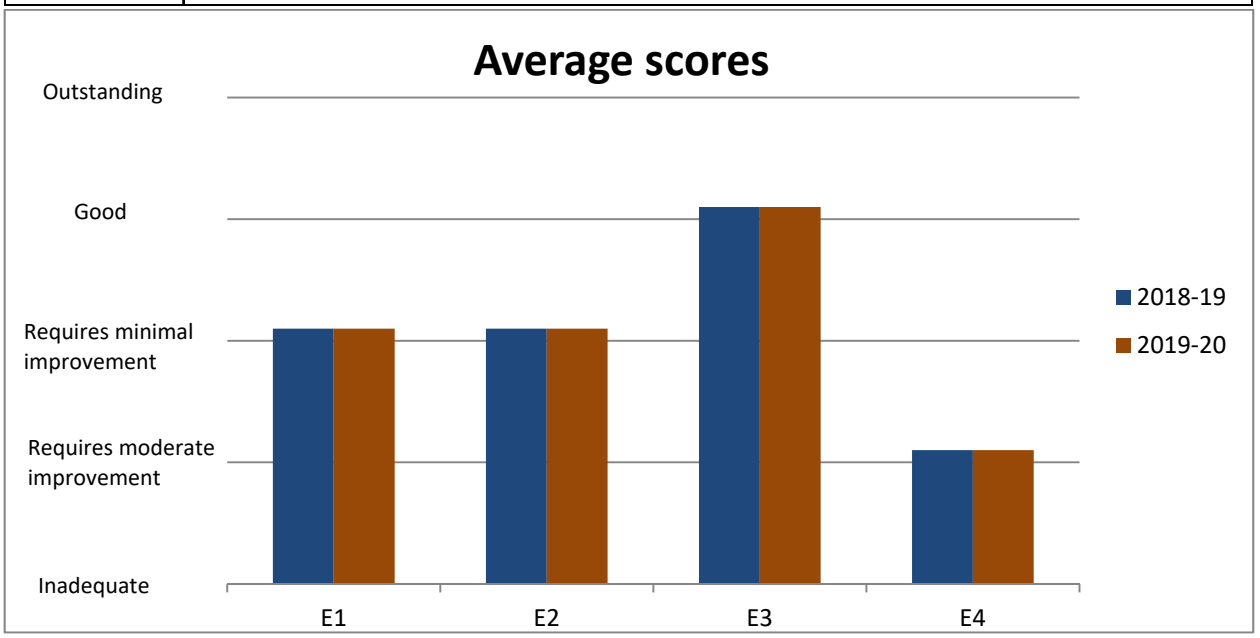
The Trust uses various tools for analysing performance including PLACE, ERIC, PAM (now mandatory), and CAAS and audits. Independent external assurance is gained from Environmental Health Officer, Waste audits, CQC/Regularly inspections and Authorising Engineer's reports.

Data derived from the ERIC return and PLACE is benchmarked through the Department of Health's Model Hospital database. The E&F Property Management Team manage space information across the Trust using the MiCAD property management system, which is configured to monitor performance in accordance with Lord Carter's recommendations for space utilisation. See attached Carter Analysis Dashboard in *Appendix* I.

Effectiveness:
The organisation provides assurance that its premises and facilities are functionally suitable, sustainable and effective in supporting the delivery of improved health outcomes.

Table 6

SAQ code	Self Assessment Question - Does your Organisation/site:
E1	A clear vision and a credible strategy to deliver good quality Estates and Facilities services
E2	A well-managed approach to town planning
E3	A well-managed robust approach to management of land and property
E4	A well-managed annually updated board approved sustainable development management plan



Overall this domain scored, "Requires minimal improvements".

Whilst the Trust has a Sustainability Development Management Plan (SDMP) approved by the Trust board. Implementation of the plan is restricted by a lack of funding and investment due to the Trust's financial position.

The Trust was successful in their bid for £450m of capital investment over the next 5 years, from the Government to complete our investment and reconfiguration plans.

The £450m programme includes:

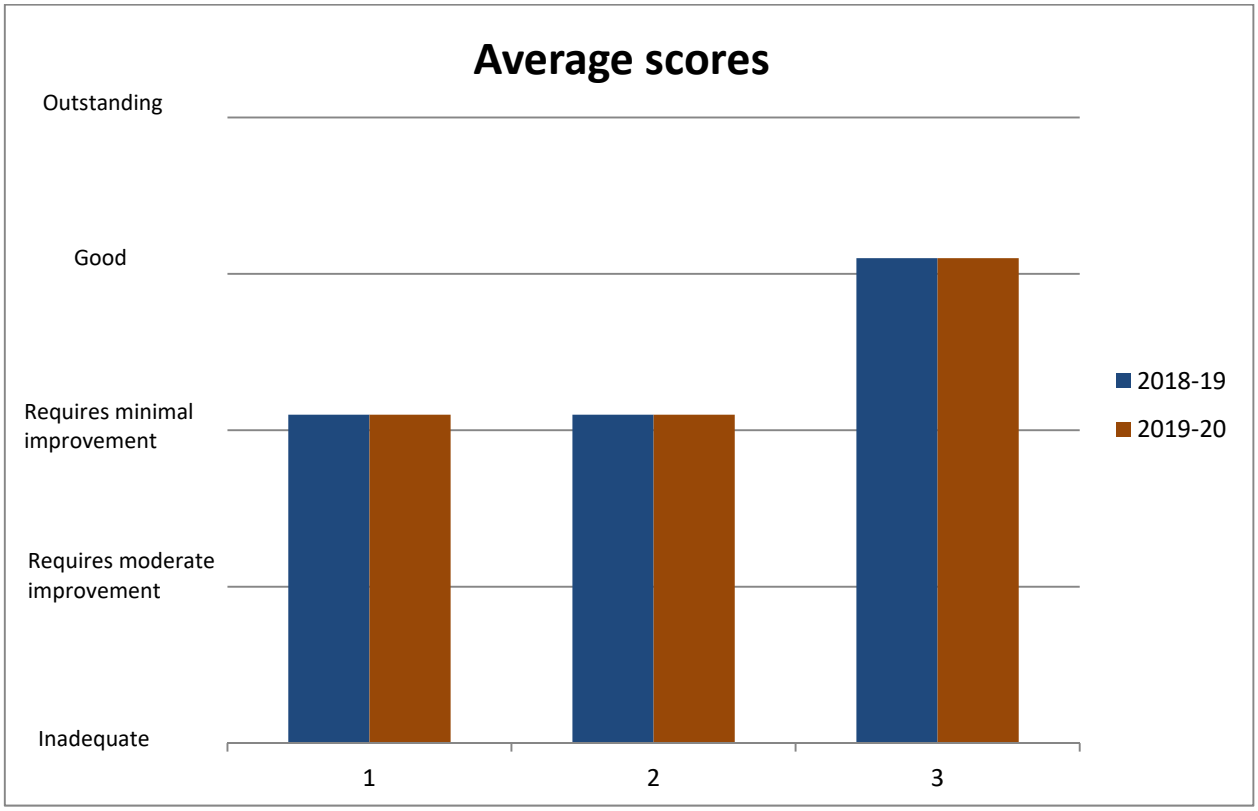
- A new Maternity Hospital and dedicated Children's Hospital at the Royal Infirmary
- Two 'super' intensive care units with 100 beds in total, almost double the current number
- A major planned care Treatment Centre at the Glenfield Hospital
- Modernised wards, operating theatres and imaging facilities
- A new stroke rehabilitation unit and primary care/diagnostic hub at the General Hospital
- Additional car parking

Governance:

How the organisations board of directors deliver strategic leadership and effective scrutiny of the organisations estates and facilities operations. How the other four Domains are managed as part of the internal governance of the NHS organisation. Its objective is to ensure that the outcomes of the Domains are reported to the NHS Boards and embedded in internal governance and assurance processes to ensure actions are taken where required.

Table 7

SAQ code	Self Assessment Question - Does your organisation:
G1	Does the Estates and Facilities governance framework have clear responsibilities and that quality, performance and risks are understood and managed?
G2	Does the Estates and Facilities leadership and culture reflect the vision and values, encouraging openness and transparency and promoting good quality estates and facilities?
G3	Does the Board have access to professional advice on all matters relating to Estates and Facilities assurance and linked to Regulators and Inspectors requirements?



Overall this domain scored, “Requires minimal improvement”

Following the repatriation of FM services in 2016, E&F have maintained existing reporting lines into UHL Groups and Committees. Significant risks are reported through the Trust’s risk management arrangements and capital funding is targeted to support the clinical strategy of the Trust and significant risks.

Recommendations

To acknowledge that a mainly 'steady state' position has again been maintained despite significant financial, operational and workforce pressures experienced over the last 12 months, including challenges caused by COVID 19, which will continue to have a direct effect on services provided by E&F for the short to medium term. E&F will and have adapted the way it operates to the, "new normal "by having an agile and flexible workforce, which will be needed to be supported by innovative ideas and strong leadership.

To acknowledge that E&F are managing buildings, equipment and infrastructure that are approaching, or beyond their design lifecycle, thus making a sudden and unexpected failure and/or a non-conformance to standards more likely to occur and therefore new investment will continue to be required to comply with statutory standards, however, exciting times lay ahead and it is hoped that the Reconfiguration of the UHL sites will gather pace over the coming years- to support the Trust's Quality Strategy "Becoming The Best".

The Trust board is asked to support the implementation of the PAM cycle starting April 1st 2020 and ending 31st March 2021. A report will be generated annually in-line with the DoH guidance and presented to EQB, QOC and the Trust Board.

Carter Analysis Dashboard

University Hospitals of Leicester NHS Trust

Clinical and Non Clinical Space

Carter Metrics 2016 (Pre Land Swap)
Clinical: 61%
Non Clinical: 36%
Commercial & Retail: 3%

Carter Metrics (First Quarter 2017))
Clinical: 59%
Non Clinical: 38%
Commercial & Retail: 3%

Carter Metrics (Second Quarter 2017)
Clinical: 72%
Non Clinical: 24%
Commercial & Retail: 3%

Carter Metrics (First Quarter 2018)
Clinical: 72%
Non Clinical: 24%
Commercial & Retail: 3%

Carter Metrics (Second Quarter 2018)
Clinical: 72%
Non Clinical: 24%
Commercial & Retail: 3%

Carter Metrics as reported in 2018-19 ERIC
Clinical: 68%
Non Clinical: 29%
Commercial & Retail: 3%

Overall Clinical Space
UHL
68%

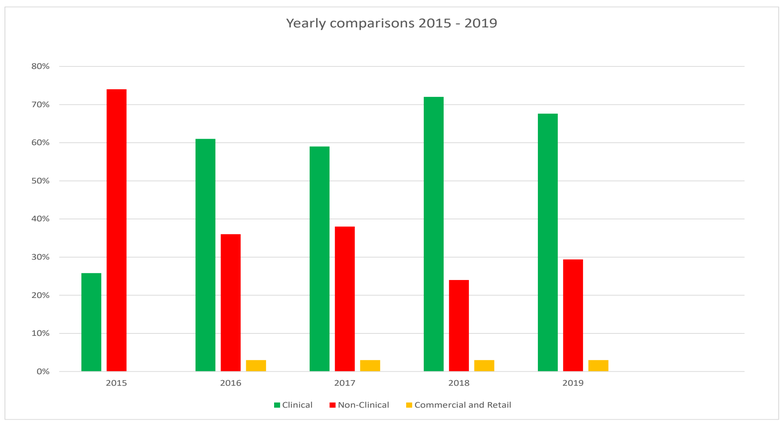
Overall Non Clinical Space
UHL
29%
Carter recommends that non-clinical space should be no more than 35%.

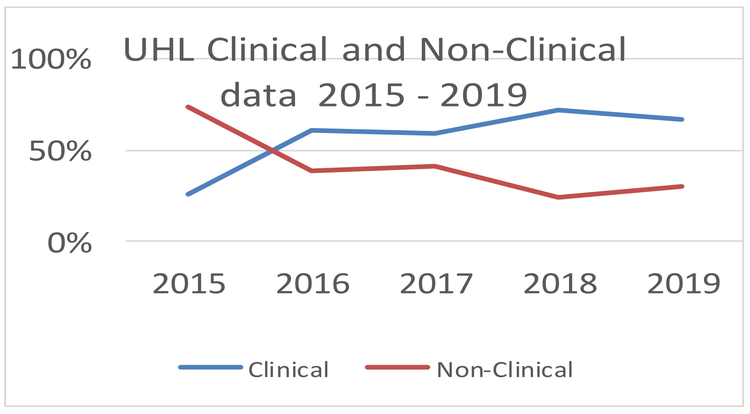
Carter Definition of Clinical and Non-Clinical

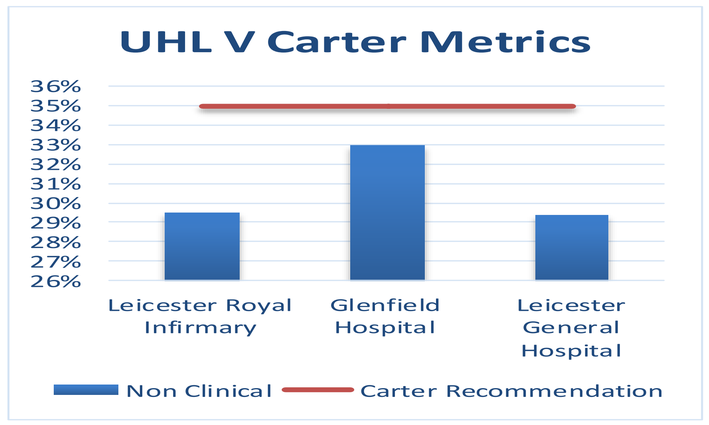
Clinical space is that used for the clinical treatment of patients, such as Wards, OPD, A&E, Theatres, ITU, SCBU, CCU, Day Surgery, Radiology, clinics etc.

Non Clinical space are those departments that are not accessible to patients, for example, administration offices, laboratories, industrial process, plant rooms, operational support areas and amenity areas (Carter, 2016).

Commercial and Retail is where the Trust earns income from external sources, both people and organisation from commercial activities both directly or indirectly. (EFM Consulting, 2016)







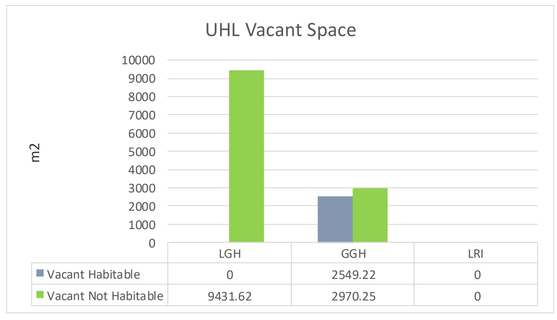
The yearly comparison charts demonstrates how the changes in definition affected the percentage of 'Clinical' and 'Non Clinical' spaces.

Changes in definition from ERIC to Carter

New definitions were brought in midway 2016 at short notice, and as such definitions were changed from 'Patient' and 'Non Patient Area' to 'Clinical' and 'Non Clinical'. An additional category was included in order to distinguish 'Commercial and Retail' space which was not part of the ERIC definitions. Following the new Carter changes the report highlights that only 35% of space should be non clinical. The graphical illustration above suggests that UHL is Carter compliant across the portfolio with the three sites averaging well below the recommended figure. During the second quarter of 2017 the figures were revised again decreasing the non clinical spaces by at least 18%.

Overall the UHL averages well below Carters recommendation, taking into account the UHL has acquired eight buildings from the recent land swap scheme. Once occupation for these buildings have been confirmed, this could reduce the non clinical percentage even more.

Vacant/Empty Spaces



Overall Vacant Space
UHL
0%
Carter recommends that the maximum amount of vacant space should only be 2.5%. Figure does not include buildings which are not fit for habitation.

Site	Building	Vacant Habitable	Vacant Not Habitable
LGH	Block 15 YDU (Wakerley Lodge)	0	999.03
LGH	Block 30 Jackson House	0	629.21
LGH	Block 97 Brandon Unit	0	7829.05
GGH	Mansion House Garages	0	107.61
GGH	Mansion House	2346.36	40.04
GGH	Mansion House Extension	0	367.36
GGH	Snoezelen Building	0	706.68
GGH	Treatment Unit	0	662.79
GGH	Recreation Hall	400.32	36.42
GGH	Walled Garden Structures	0	331.56
GGH	Artefact Store and Old Kitchen	0	579.34

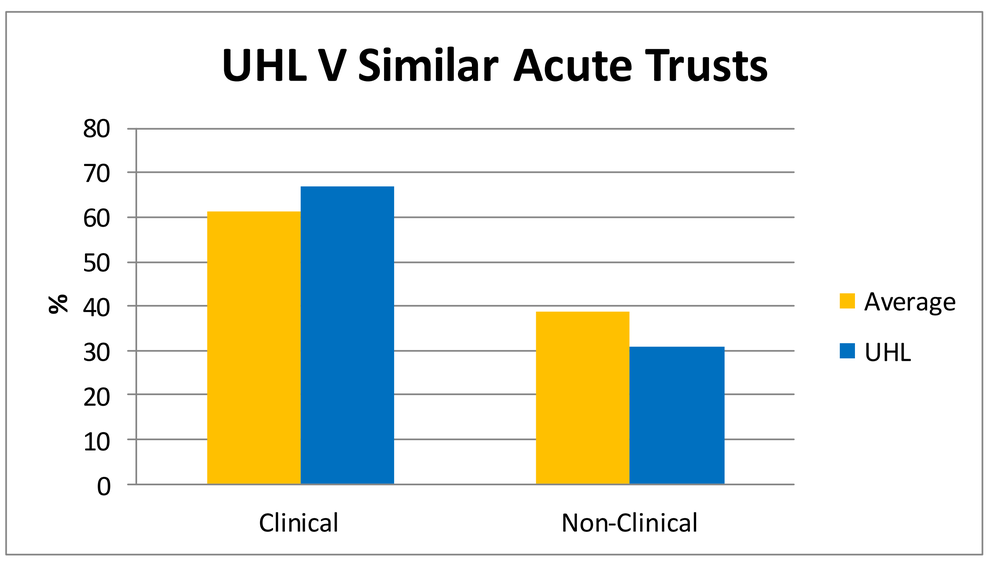
Figure 5 shows the differences in terms of vacant spaces across the three sites. The Glenfield Hospital site has the largest number of vacant spaces due to the recently acquired land swap buildings.

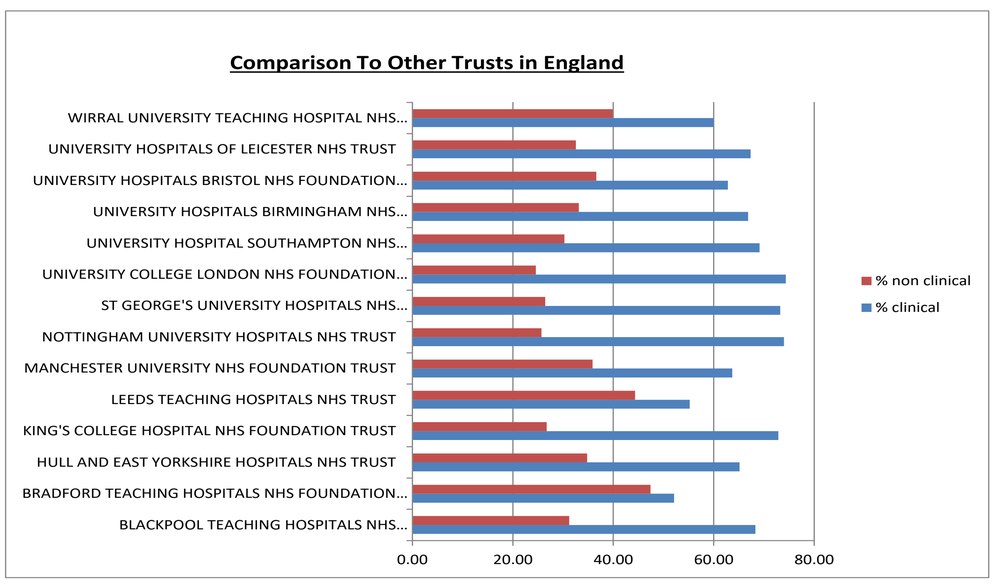
Vacant spaces have been split into two categories;

Vacant habitable – Buildings that are fit for habitation but remain empty at this time.

Vacant not habitable – Buildings that are not fit for habitation due to structural problems and other underlying issues. For this reason the buildings are empty.

Comparisons to similar acute trusts in England





The above graphs show a comparison between the UHL and similar acute Trusts in England. In comparison to other similar Trusts across the country the UHL is the most efficient Trust in terms of clinical space usage with St Georges Healthcare and University College London not far behind.

Infection Prevention and Control board assurance framework

1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
Systems and processes are in place to ensure:			
• infection risk is assessed at the front door and this is documented in patient notes	• Adult and Children's iFive pathway in place • Local SOP's in place • Swabbing and screening: • Emergency admissions • Elective admissions • OP (inc pre-alert) • Physical and telephone triage established • Designated clinic isolation areas for symptomatic patients • Care pathways in ICU / Theatres negative, positive and unconfirmed patients • Reduced face to face patient consultations through use of alternative technologies • Only patients who have self isolated prior to elective admission (and are asymptomatic) are admitted	• Ability to social distance in some waiting areas / triage areas • Decision re post-operative care placement made in the absence of screening test results • Strengthening of local procedure for shielding patients	• Spacing of chairs in waiting / triage areas • Environmental assessments with IP team • Limits of number of patients entering waiting areas / triage areas • All patients in theatres / ITU treated as positive until confirmed otherwise
• patients with possible or confirmed COVID-19 are not moved	• Designated side rooms & cohorting areas identified for suspected COVID patients • Risk assessment of individual patients for	• Bed / side room availability • Speed of swab results • Patients moved from triage	• Daily allocation of fast track swab results • Daily tactical meetings

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
unless this is essential to their care or reduces the risk of transmission	side room allocation • Pathways in place to manage Unknown / Negative / Positive patients and movement only after test results of swabbing are known	areas without swab results	• Clinical risk assessment of patients moved without test results • All ITAPS transfers are planned and managed with a dedicated team ensuring safe care of airway management
• compliance with the national guidance around discharge or transfer of COVID-19 positive patients	• LLR Discharge Coordination Hub established to manage patients on pathways 1-3 • Swabbing flow charts in place for patients being discharged to care homes and community hospitals • Women discharged home with appropriate advice and visited postnatally as per national guidance and local SOP	• Variable assurance regarding documentation and advice given to patients discharged on pathway 0	• 24-48 hour post discharge phone call by care navigators for confirmed positive level 0 patients • Review incidents / complaints relating to discharge of known positive patients for lessons learned
• patients and staff are protected with PPE, as per the PHE national guidance	• All staff have access to appropriate PPE • Local PPE donning and doffing training sessions • Screens in place in reception / clinic areas • Programme of mask fit testing • All staff wearing surgical masks in the work environment unless FFP3 PPE required • PPE safety champions	• Assurance that all staff have received appropriate PPE donning and doffing training • Lack of continuity in national supply of FFP3 PPE • Not all staff mask fit tested • Lack of national availability of full face and half face respirators in varying sizes • Lack of assurance that	• Staff fit checking FFP3 PPE • Use of Hoods • Sisters an Matrons monitoring compliance with PPE • Weekly stock take of PPE supplies • Risk assessment undertaken for staff failing mask fit testing and alternative PPE

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
		cleaning and decontamination of PPE equipment processes are being adhered to	equipment identified
• National IPC guidance is regularly checked for updates and any changes are effectively communicated to staff in a timely way	Information cascaded through: • Tactical meetings (CMG, Trust and system level) • Emails • Daily comms update • INSite • Huddles • Handovers • Closed facebook pages • News letters	• Capacity to digest and act upon information • Capacity to update local SOPs and communicate changes • Capacity to horizon scan	• Information is cascaded verbally as well as through more formal channels
• changes to guidance are brought to the attention of boards and any risks and mitigating actions are highlighted	• Updates presented to TB via the Corporate Risk Register (dedicated entry) • Updates discussed at tactical meetings (CMG, Trust and system level)	• Capacity to digest and act upon information • Capacity to update local SOPs and communicate changes	• Information is cascaded verbally as well as through more formal channels
• risks are reflected in risk registers and the Board Assurance Framework where appropriate	• Risks are captured on the Trust Risk Register (Datix) and escalated through the CMG governance process, risks scoring 15+ discussed at Exec Board	• Not all risks captured on the Risk Register	• Risk Manager to work with CMGs to identify and report risks

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
• robust IPC risk assessment processes and practices are in place for non COVID-19 infections and pathogens	• Adult and Children's iFive pathway in place • Local SOP's in place • Swabbing and screening process in place	• None	• N/A

2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
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	• Appropriately trained staff are assigned to work in COVID19 isolation or cohort areas	• Staff moved to other areas due to: • Nursing and medical workforce gaps • Shielding / self-isolation • Staff in higher risk groups e.g. pregnant, BAME	• Regular review of staff risks assessments • Safe staffing levels managed through Matrons and Silver Nurse on call
• designated cleaning teams with	• Designated cleaning teams assigned to COVID19	• Staff moved to other	• Regular review of staff risks

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
appropriate training in required techniques and use of PPE, are assigned to COVID-19 isolation or cohort areas	isolation of cohort areas • IP guidance for: • RED/AMBER/GREEN cleaning • PPE to be worn by all staff groups including cleaning teams in OP areas, and general ward environments in single rooms	areas due to: • Workforce gaps • Shielding / self-isolation • Staff in higher risk groups e.g. pregnant, BAME	assessments
• decontamination and terminal decontamination of isolation rooms or cohort areas is carried out in line with PHE and other national guidance			
• 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			
• attention to the cleaning of toilets/bathrooms, as COVID-19 has frequently been found to contaminate surfaces in these			

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
areas			
• 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			
• manufacturers' guidance and recommended product 'contact time'must be followed for all cleaning/ disinfectant solutions/products			
• as per national guidance: - 'frequently			

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
touched' surfaces, eg 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			
• electronic equipment, eg mobile phones, desk phones, tablets, desktops and keyboards should be cleaned at least twice daily			
• 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)			
• linen from possible and confirmed	1) Linen managed in line with the Hospital Linen -		

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
COVID-19 patients is managed in line with PHE and other national guidance and the appropriate precautions are taken	Infection Prevention UHL Policy		
• single use items are used where possible and according to Single Use Policy	• Single use items are used in accordance with local and national policy	• Supply / stock levels can result in non-adherence to local and national policy	• Any reused single use items are cleaned / decontaminated as appropriate • Issues with stock levels escalated to daily Tactical meeting • Alternative items used where possible • SOP developed for vital issues e.g. vial sharing
• reusable equipment is appropriately decontaminated in line with local and PHE and other national policy	• All reusable equipment is appropriately decontaminated	• New items used have been subject to interim cleaning/ decontamination protocols	• Interim local decontaminated protocols developed over the last 3 months need to be clarified with manufacturers
• review and ensure good ventilation in admission and waiting areas to minimise opportunistic	• Ventilation has been reviewed in all admission and waiting areas	• Existing environmental constraints do not allow good ventilation in all admission and waiting areas with major capital /	• Social distancing • Face masks

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
airborne transmission		reconfiguration investment	

3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
Systems and process are in place to ensure:			
• arrangements around antimicrobial stewardship are maintained	• Maintained adherence to local and national Antimicrobial Prescribing Policy and guidelines	• CMG IPOGs ceased to meet during the pandemic	• CMG IPOGs reinstated • Audit of practice and spot checks
• mandatory reporting requirements are adhered to and boards continue to maintain oversight	• Infection Prevention Operational Group (IPOG) for each CMG • Trust Infection Prevention Assurance Committee receive mandatory reports	• CMG IPOGs ceased to meet during the pandemic	• CMG IPOGs reinstated • Audit of practice and spot checks • Regular communications and review of HCAI data

4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
Systems and processes are in place to ensure:			
• implementation of national guidance on visiting patients in a care setting	• Restricted access to wards, units and departments by staff and visitors unless • Measures to support social distancing in public areas • Information for visitors on Trust website		
• 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	• Clear signage in place		
• information and guidance on COVID-19 is available on all Trust websites with easy read versions	• Information available on Trust website	• Information not available in written format in other languages	
• infection status is communicated to the receiving organisation or department when a possible or confirmed COVID-19 patient needs to be moved	• LLR Discharge Coordination Hub established to manage patients on pathways 1-3 • Swabbing flow charts in place for patients being discharged to care homes and community hospitals • Women discharged home with appropriate advice and visited postnatally as per national	• Assurance regarding: • Discharge communication • Communicating swab results post discharge	• Review incidents / complaints relating to discharge of known positive patients for lessons learned • Reiterate importance of good communication to all teams

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
	guidance and local SOP		• Follow 'unknown status' pathway • Segregate and re-swab as necessary

5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
Systems and processes are in place to ensure:			
• frontdoor areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed COVID-19 symptoms and to segregate them from non COVID-19 cases to minimise the risk of cross-infection, as per national guidance	• Triage processes in place	• Space / accommodation to segregate patients • Timeliness of swab results	• Reduced capacity / reduce elective activity • Patients asked to wear masks • Allocation of time slots to prevent overcrowding • Segregate where possible • Manage demand and capacity through Tactical meetings • Manage flow
• mask usage is emphasized for suspected	• Patients provide with / advised to wear face masks	• Patients not always compliant / have underlying condition e.g. asthma	• Staff wearing face masks • Time slots to prevent

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
individuals			overcrowding • Social distancing
• ideally segregation should be with separate spaces, but there is potential to use screens, eg to protect reception staff	• Screen in situ • Segregation in ward areas	• Environmental constraints prevent segregation in some areas	
• for patients with new-onset symptoms, it is important to achieve isolation and instigation of contract tracing as soon as possible	• Patients isolated or cohorted where appropriate and swabbed daily	• Lack of side rooms on all wards	• Use of cohorting • Daily swabbing of all contact for 7 days • Bay restricted
• patients with suspected COVID-19 are tested promptly	• Patients are tested promptly as per national and local guidance • Dally allocation of rapid testing	• Occasions where patient may not swabbed before arrival at receiving destination e.g. trauma	• Patient swabbed by receiving destination
• patients that test negative but display or go on to develop symptoms of COVID-19 are segregated and promptly re-tested	• Patients isolated or cohorted where appropriate, swabbed daily and other diagnostics used e.g. chest x-ray	• Lack of side rooms on all wards	• Use of cohorting • Daily swabbing of all contact for 7 days • Bay restricted • Elective patients displaying

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
			symptoms are not admitted
• patients that attend for routine appointments who display symptoms of COVID-19 are managed appropriately	• Elective patients displaying symptoms are not admitted / seen		

6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
Systems and processes are in place to ensure:			
• all staff (clinical and non- clinical) have appropriate training, in line with latest PHE and other guidance, to ensure their personal safety and working environment is safe	• Staff receive training as appropriate and are aware of relevant guidelines via daily comms the Trust Intranet	• Gaps in some training records e.g. administrative staff	
• all staff providing patient care are trained in the selection and use of PPE appropriate	• Combination of face to face e-learning and formal update training covering the use of PPE and donning and doffing	• Gaps in some training records • Lack of continuity of PPE supply	• Staff self fit checking • Addressed stability of mask supply • Increased capacity of mask

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
for the clinical situation and on how to safely don and doff it • a record of staff training is maintained	• Training records held on HELM	not all staff mask fit tested • Gaps in some training records • Training records held in a variety of locations	fir testing • Local records held
• appropriate arrangements are in place that any reuse of PPE in line with the CAS alert is properly monitored and managed	• Appropriate cleaning / decontamination of reused PPE	• New items used have been subject to interim cleaning/ decontamination protocols	• Interim local decontaminated protocols developed over the last 3 months need to be clarified with manufacturers
• any incidents relating to the re-use of PPE are monitored and appropriate action taken	• Incidents reported via Datix	• Thematic review of incidents	• Incidents reviewed at CMG COVID operational groups • Incidents reviews on a individual basis with members of staff
• adherence to PHE national guidance on the use of PPE is regularly audited	• Matrons and team leaders monitor the appropriate use of PPE	• No formal audits undertaken	• Formal audits to commence as part of restoration plans
• staff regularly undertake hand hygiene and	• Hand hygiene audits undertaken	• Results of hand hygiene audits not formally reviewed	• CMG IPOGs reinstated

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
observe standard infection control precautions			
• 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	• Hand dryers predominantly in non-clinical areas	• Some hand dryers in staff and public toilets	• Provide hand towels
• guidance on hand hygiene, including drying, should be clearly displayed in all public	• Guidance displayed		
• staff understand the requirements for uniform laundering where this is not provided for on site	• Staff are aware of the uniform laundering requirements	• Lack of assurance regarding staff laundering in their own homes	

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
• 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	• Staff are aware of the symptoms • Guidance available on the Trust Intranet		

7. **Provide or secure adequate isolation facilities**

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
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	• Pathways and flowcharts in place to ensure appropriate management • Designated side rooms & cohorting areas identified for suspected COVID patients • Risk assessment of individual patients for side room allocation • Pathways in place to manage Unknown / Negative / Positive patients	• Bed / side room availability • Speed of swab results • Reduced bed base • Environmental constraints	• Risk assessment for cohorting patients • All cohorting and flow pathways for ICUs and Theatres have been reviewed with IP. • Some surgery transferred out of Acute Trust to Alliance & Private sector
• areas used to cohort patients with suspected or	• Guidance followed and compliant • Base wards specifically designated for Covid +ve patients are available	• Reduced bed base • Environmental constraints relating to	• Risk assessment of patients • Cohorting and flow pathways

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
confirmed COVID-19 are compliant with the environmental requirements set out in the current PHE national guidance	• Designated areas and pathways	ventilation • False negative results	
• patients with resistant/alert organisms are managed according to local IPC guidance, including ensuring appropriate patient placement	• Pre-covid IPC pathways remain in place and adhered to • Patient Centre monitored for alerts	• Environmental constraints relating to ventilation • Side room capacity	• Risk assessment of patients • Cohorting and flow pathways

8. **Secure adequate access to laboratory support as appropriate**

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
There are systems and processes in place to ensure:			
• testing is undertaken by competent and trained individuals	• Swabbing undertaken by trained qualified staff • OH referrals made • UKAS accredited Laboratories	• Need specific training tool and monitoring of training compliance	• Observation of staff by senior clinical team

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
• patient and staff COVID-19 testing is undertaken promptly and in line with PHE and other national guidance	• Process in place and swabs taken promptly • OH referrals made	• Delays in results	• Risk assessment • Staff vigilance
• screening for other potential infections takes place	• In-line with policy		

9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
Systems and processes are in place to ensure that:			
• staff are supported in adhering to all IPC policies, including those for other alert organisms	• changes to policy communicated • Safety huddles • IP Link staff support and monthly IPOG. • Audits and Metrics monitored by Matrons	• Metrics and audits not completed in all areas during surge	• NIC check practices each shift • IP spot checks as well as Matron confirm and challenge
• any changes to the PHE national guidance on PPE are quickly identified and effectively	• EPRR process • Daily tactical meetings • Communications cascade	• Frequency and rapidity of changing guidance nationally makes effective cascade a challenge	• Daily communications • Safety huddles • Safety briefings • Manager of the day role

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
communicated to staff			
• all clinical waste related to confirmed or suspected COVID-19 cases is handled, stored and managed in accordance with current national guidance	• Adherence spot checked weekly by matron team	• No formal audits undertaken	• Staff education
• PPE stock is appropriately stored and accessible to staff who require it	• storage has been reviewed on each site • Stores team leader and support worker team ensure adequate stocks in place • guidance for access to stores from Materials Handling is provided • audits of store rooms • stock records • staff feedback and incidents	• inconsistency of supply on a national level	• Daily stock level review • Escalation process

10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
Appropriate systems and processes are in place to ensure:			
• staff in 'at-risk' groups are identified and managed	• Redeployment of vulnerable staff to work in a low-risk environment & home working where possible. • risk assessments undertaken, including	• Staff may fail to identify they have received shielding letter	• Regular communication • remain vigilant • risk assessing staff

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
appropriately including ensuring their physical and psychological wellbeing is supported	national BAME staff risk assessment • Vulnerable staff have shielded as per national guidance • OH support sought		
• staff required to wear FFP reusable respirators undergo training that is compliant with PHE national guidance and a record of this training is maintained	• Initial and refresher training for donning and doffing PPE available for all staff • Mask fit testing available with records on HELM	• No formal trust wide training records	• Mask fit testing and self-checking • Respirators allocated for individual use to maintain integrity and fit • Local training records
• 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	• redeployment has been undertaken for a period of time rather than on a daily basis where possible	• Staff sickness and vacancies remain a challenge and staff are moved to ensure patient safety	• Staff for COVID +Ve areas are kept separate
• all staff adhere to	• Surgical masks worn across hospital sites	• Some environmental	• Masks worn across all sites

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
national guidance on social distancing (2 metres) wherever possible, particularly if not wearing a facemask and in non-clinical areas	• New signage for social distancing in corridors and communal areas • HON and Matron walkarounds to ensure compliance	challenges in office areas	• Shifts and rotas reviewed to mitigate
• consideration is given to staggering staff breaks to limit the density of healthcare workers in specific areas	• Discussed with ward managers • Also reminded to stagger over 7 days	• Difficult to mandate	• Regular matron oversight
• staff absence and well-being are monitored and staff who are self-isolating are supported and able to access testing	• Process for staff that cannot attend work including staff absence reporting system for Covid-19 • Line managers in regular contact with staff who are self-isolating • Smart Absence recording	• Records of out of area tests	• Keep in touch regularly with staff who are sick or shielding
• staff that test positive have adequate information and support to aid their recovery and return to work	• Staff testing programme established and guidance entered on Insite under FAQs • OH support and advice • Written information at test centres	• Record keeping not consistent	• Keep in touch regularly with staff who are sick or shielding