Wirral Community Health and Care NHS Foundation Trust

Infection Prevention and Control Board Assurance Framework

Meeting	Board of Directors		
Date	09/02/2022	**Agenda item**	17
Lead Director	Paula Simpson, Chief Nurse		
Author(s)	Claire Wedge, Deputy Chief Nurse Helen Wilcox, Interim Head of Infection Prevention and Control		

Action required (please tick the appropriate box)

To Approve ☐	**To Discuss** ☐	**To Assure** ☑

Purpose

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

Executive Summary

Board of Directors received an updated IPC BAF in August 2021, to provide assurance that the Trust remained fully complaint with expected IPC standards.

An updated version of the IPC BAF was released on 24 December 2021, version 1.8.

A comprehensive review of the updated IPC BAF has been undertaken, with Appendix 1 outlining changes made to both the key lines of enquiry and evidence available. All changes made since August 2021 are highlighted in red text.

The review has highlighted full compliance across eight standards and partial compliance against two standards.

Timescales to achieve full compliance across all standards are documented for the attention of Trust Board.

Risks and opportunities:

Risk ID 2662 (CX4 Lx3) implementation of National Standards of Healthcare Cleanliness 2021

Quality/inclusion considerations:

Quality Impact Assessment completed and attached No
Equality Impact Assessment completed and attached No
Individualised care delivery is provided by the Trust ensuring compliance with equality and diversity standards for staff and people who use Trust services

Financial/resource implications:

Delivery of high-quality services will support the Trust's financial position, reducing the potential for litigation and regulatory action

Trust Strategic Objectives

Please select the top three Trust Strategic Objectives that this report relates to, from the drop down boxes below.

Our Populations - outstanding, safe care every time	Our Populations – provide more person-centred care	Our Populations - improving services through integration and better coordination

Board of Directors is asked to consider the following action		
Board of Directors are asked to be assured by the updated IPC Board Assurance Framework: version 1.8.		
Report history		
Submitted to	**Date**	**Brief summary of outcome**
Board of Directors	02/12/2020	Assurance noted
Board of Directors	03/02/2021	Assurance noted
Board of Directors	04/08/2021	Assurance noted

Infection Prevention and Control Board Assurance Framework Version 1.8

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 and Mitigating Actions**
Systems and processes are in place to ensure a respiratory season/winter plan is in place: • that includes point of care testing (POCT) methods for seasonal respiratory viruses to support patient triage/placement and safe management according to local needs, prevalence, and care services • to enable appropriate segregation of cases depending on the pathogen. • plan for and manage increasing case numbers where they occur. • a multidisciplinary team approach is adopted with hospital leadership, estates & facilities, IPC Teams and clinical staff to assess and plan for creation of adequate isolation rooms/units as part of the Trusts winter plan.	A system-wide winter plan has been agreed to ensure the Wirral remains responsive to system IPC requirements. The Trust do not provide point of care testing for seasonal respiratory viruses, however, there are mechanisms to access this testing to support safe clinical care as required. Processes to support appropriate isolation of patients ensuring appropriate segregation of cases are embedded where required; this includes Trust Walk in Centres and the Community Intermediate Care Centre (CICC), which is the Trust's in-patient bedded unit. Mechanisms to support rapid escalation to a multi-disciplinary team including estates, facilities and IPC teams have been established. This approach ensures adequate isolation facilities can be rapidly mobilised to support winter plans, ensuring responsiveness to assure safety.	Partial assurance evidenced Existing local risk assessments are being re-reviewed to ensure they continue to reflect and evidence the hierarchy of controls framework. This will be completed by 28/02/22. System-wide discussions are in progress to develop a consistent approach to risk assessing Respiratory Protective Equipment across the Wirral Health and Social care system. The Trust's position will be confirmed by 28/02/22.

Health and care settings continue to apply COVID-19 secure workplace requirements as far as practicable, and that any workplace risk(s) are mitigated for everyone. Organisational /employers risk assessments in the context of managing seasonal respiratory infectious agents are: • based on the measures as prioritised in the hierarchy of controls. including evaluation of the ventilation in the area, operational capacity, and prevalence of infection/new variants of concern in the local area. • applied in order and include elimination; substitution, engineering, administration and PPE/RPE. • communicated to staff. • safe systems of working; including managing the risk associated with infectious agents through the completion of risk assessments have been approved through local governance procedures, for example Integrated Care Systems. • If the organisation has adopted practices that differ from those recommended/stated in the national guidance a risk assessment has been completed and it has been approved through local governance procedures, for example Integrated Care Systems. • risk assessments are carried out in all areas by a competent person with the skills, knowledge, and experience to be able to recognise the hazards associated with respiratory infectious agents. • if an unacceptable risk of transmission remains following the risk assessment,	Covid-19 secure workplace standards continue to be embedded throughout all areas of the organisation to ensure effective risk mitigation. This includes continued implementation of 2m distancing between desk spaces in office environments, cleaning of equipment between usage with clinell wipes and strict adherence to universal wearing of fluid resistant surgical face masks. This is in addition to promoting correct hand hygiene procedures. All Trust risk assessments are based on current national best practice guidance ensuring rapid implementation of control measures to effectively mitigate risk. Risk assessments are based on the hierarchy of controls, ensuring maximum risk mitigation. This systematic assessment process is structured as follows: • Elimination • Substitution • Engineering controls • Administrative controls • Personal Protective Equipment This risk assessment process is also utilised to support the health and social care system to effectively control and mitigate risk when supporting patient transfers within Wirral. The Trusts' IPC team support the development of local risk assessments based on regional and national guidance, for approval through the Wirral system governance. Internal to the organisation, IPC and Covid-19 guidance is submitted and reviewed at the Trust's Clinical Assurance Group, which meets weekly, reporting by exception to the monthly IPC Group. The Trust remains compliant with national guidance and works' collaboratively across the Wirral system to align standards where possible, to ensure a consistent approach.	

the extended use of Respiratory Protective Equipment (RPE) for patient care in specific situations should be considered. • ensure that patients are not transferred unnecessarily between care areas unless, there is a change in their infectious status, clinical need, or availability of services. The Trust Chief Executive, the Medical Director of the Chief Nurse has oversight of daily sitrep in relation to Covid-19, other seasonal respiratory infections, and hospital onset cases There are check and challenge opportunities by the executive/senior leadership teams of IPC practice in both clinical and non-clinical areas Resources are in place to implement and measure adherence to good IPC practice. This must include all care areas and all staff (permanent, agency and external contractors) The application of IPC practices within this guidance is monitored, eg: • hand hygiene • PPE donning and doffing training • Cleaning and decontamination The IPC Board Assurance Framework is reviewed, and evidence of assessments are made available and discussed at Trust board.	Risk assessments have been completed and are currently being reviewed to ensure they remain aligned to all relevant guidance. The Trust has established a Task and Finish group to review the risk assessment process for Respiratory Protective Equipment. Based on current analysis, use of FFP3 masks has been agreed and implemented when delivering neutralising monoclonal antibodies for Covid-19 (nMABs). To ensure consistency across the Wirral health and social care system, the Trust have proactively commenced discussions with commissioners and providers to agree the standards and principles for risk assessing Respiratory Protective Equipment. This will ensure an equitable approach system-wide. Infectious status is carefully considered in advance of any patient moves. The Trust effectively manage IPC risk for admissions into Care Homes on behalf of the Wirral system and have developed guidance for approval at the Outbreak Control group by system leaders. A process for submitting national daily Covid-19 returns to NHS E/I has been implemented regarding the collective Covid status of the patients within CICC. In the event of an outbreak, Board is kept updated via the Chief Nurse and regular IPC assurance reports. In addition, the Chief Nurse and Medical Director have check and challenge opportunities for IPC throughout the Trust's governance framework, including the monthly Standards Assurance Framework for Excellence (SAFE) meeting and Infection Prevention and Control Group. These groups report directly to the Quality and Safety Committee, which includes membership of non-executive and executive directors. Assurance mechanisms are embedded within the Trust's governance structure including monitoring hand hygiene compliance, IPC training and cleaning standards.	

The Trust Board has oversight of ongoing outbreaks and action plans. The Trust is not reliant on a particular mask type and ensure that a range of predominantly UK Make FFP3 masks are available to users as required	Procurement monitor FFP3 mask usage throughout the Trust, ensuring that there are sufficient supplies to assure staff safety; this is reported to silver command weekly. Current FFP3 stocks are predominately UK made.	
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 and Mitigating Actions**
Systems and processes are in place to ensure that: • the Trust has a plan in place for the implementation of the National Standards of Healthcare Cleanliness and this plan is monitored at board level. • the organisation has systems and processes in place to identify and communicate changes in the functionality of areas/rooms • cleaning standards and frequencies are monitored in clinical and non-clinical areas with actions in place to resolve issues in maintaining a clean environment. • increased frequency of cleaning should be incorporated into the environmental decontamination schedules for patient isolation rooms and cohort areas. • Where patients with respiratory infections are cared for: cleaning and decontamination are carried out with	The Trust are currently working in partnership with Cheshire and Wirral Partnership NHS Foundation Trust, who provide cleaning services across WCHC sites to ensure there are robust plans in place to ensure implementation of the National Standards of Healthcare Cleanliness. Progress is tracked monthly at the Infection Prevention and Control Group and reported to Trust Board via the Quarterly IPC reports, reviewed and approved by the Quality and Safety Committee. Due to the extent of the work involved, and assurance required from sub-contractors, implementation by 01 November 2022 is currently on the Trust's risk register: ID 2662. Progress against the developed action plan is tracked monthly at the IPC group. Within the Trust's in-patient Community Intermediate Care Centre, the facilities contract including cleaning is provided by CWP; practice is fully aligned to national decontamination guidance in accordance with national guidance. This includes all standards for cleaning as outlines in the IPC BAF version 1.8.	Partial assurance evidenced The Head of Estates is obtaining additional assurance relating to the ventilation system at the Trust's in-patient bedded facility. This will be completed by 18/02/22

neutral detergent or a combined solution followed by 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) are consulted on this to ensure that this is effective against enveloped viruses. • manufacturers' guidance and recommended product 'contact time' is followed for all cleaning/disinfectant solutions/products. • a minimum of twice daily cleaning of: - patient isolation rooms. - cohort areas. - Donning & doffing areas - 'Frequently touched' surfaces eg, door/toilet handles, patient call bells, over bed tables and bed rails. - where there may be higher environmental contamination rates, including: • toilets/commodes particularly if patients have diarrhoea. • A terminal/deep clean of inpatient rooms is carried out: - following resolutions of symptoms and removal of precautions. - when vacated following discharge or transfer (this includes removal and disposal/or laundering of all curtains and bed screens); - following an AGP if room vacated (clearance of infectious particles		

after an AGP is dependent on the ventilation and air change within the room). • reusable non-invasive care equipment is decontaminated: - between each use. - after blood and/or body fluid contamination - at regular predefined intervals as part of an equipment cleaning protocol - before inspection, servicing, or repair equipment. • Compliance with regular cleaning regimes is monitored including that of reusable patient care equipment. • As part of the Hierarchy of controls assessment: ventilation systems, particularly in, patient care areas (natural or mechanical) meet national recommendations for minimum air changes refer to country specific guidance. In patient Care Health Building Note 04-01: Adult in-patient facilities. • the assessment is carried out in conjunction with organisational estates teams and or specialist advice from ventilation group and or the organisations, authorised engineer. • a systematic review of ventilation and risk assessment is undertaken to support location of patient care areas for respiratory pathways • where possible air is diluted by natural ventilation by opening windows and doors where appropriate • where a clinical space has very low air changes and it is not possible to	The Head of Estates team is currently working with WUTH and Propcare, who manage ventilation systems at the Trust's in-patient unit, to ensure risks assessments and assurance mechanisms continue to be robustly implemented and can be fully evidenced. Oversight for the management of ventilation has been incorporated into the Terms of Reference for the Trust's Health and Safety group.	

increase dilution effectively, alternative technologies are considered with Estates/ventilation group. • when considering screens/partitions in reception/ waiting areas, consult with estates/facilities teams, to ensure that air flow is not affected, and cleaning schedules are in place.		
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 and Mitigating Actions**
Systems and process are in place to ensure that: • arrangements for antimicrobial stewardship are maintained • previous antimicrobial history is considered • the use of antimicrobials is managed and monitored: - to reduce inappropriate prescribing. - to ensure patients with infections are treated promptly with correct antibiotic. • mandatory reporting requirements are adhered to, and boards continue to maintain oversight. • risk assessments and mitigations are in place to avoid unintended consequences from other pathogens.	The Trust has developed Strategic Principles for Antimicrobial Stewardship, reporting on a Triannual basis to the sub-Board Quality and Safety Committee in accordance with the Trust's robust governance and assurance framework The aims of the strategy are to: • Reduce the need for exposure to antibiotics • Optimise the use of antibiotics • Raise public awareness to encourage self-care and reduce expectations of receiving antibiotics • Work in collaboration with other healthcare partners throughout Wirral At the Trust's CICC in-patient facility, a weekly GP ward round is conducted providing an opportunity to review antimicrobial prescribing. In addition, Pharmacy support is provided to the ward from WUTH ensuring alignment to the Wirral system-wide antimicrobial stewardship strategy. This ensures monitoring of antimicrobials to reduce inappropriate prescribing and to ensure patients with infections are treated appropriately.	Full assurance evidenced

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 and Mitigating Actions**
Systems and processes are in place to ensure that: • visits from patient's relatives and/or carers (formal/informal) should be encouraged and supported whilst maintaining the safety and wellbeing of patients, staff and visitors • national guidance on visiting patients in a care setting is implemented. • restrictive visiting may be considered appropriate during outbreaks within inpatient areas This is an organisational decision following a risk assessment. • there is clearly displayed, written information available to prompt patients' visitors and staff to comply with handwashing, wearing of facemask/face covering and physical distancing. • if visitors are attending a care area with infectious patients, they should be made aware of any infection risks and offered appropriate PPE. This would routinely be an FRSM. • visitors with respiratory symptoms should not be permitted to enter a care area. However, if the visit is considered essential for compassionate (end of life) or other	The Trust recognises the importance of supporting in-patient visiting, proactively contributing to the wellbeing and delivery of person-centred care. A Standard Operating Procedure for visiting has been developed for implementation at CICC, following approval at the Trust's Clinical Assurance Group. The document is aligned to current NHS visiting guidance: C1519: Visiting healthcare inpatient settings during the Covid-19 pandemic: principles 1 January 2022, Version 3, and will be reviewed as guidance is updated. Due to the location of CICC within the Clatterbridge Cancer Centre site, visiting is strictly risk assessed with timed appointments being implemented. Visiting is currently only routinely permitted in exceptional circumstances; however, each request is individually assessed to support personalised care delivery. During an outbreak situation additional mechanism are implemented to risk assess all people entering the ward environment. There is an expectation that visitors to the ward will wear appropriate levels of PPE in accordance with an individualised risk assessment, be asymptomatic and have evidence of a negative lateral flow test on the day of the visit. In addition, vaccination status is considered as part of the individualised risk assessment. Visits are facilitated in single occupancy rooms, which can include a day room for patients located in a bay.	Full assurance evidenced

care reasons (eg, parent/child) a risk assessment may be undertaken, and mitigations put in place to support visiting wherever possible. • visitors are not present during AGPs on infectious patients unless they are considered essential following a risk assessment eg, carer/parent/guardian. • Implementation of the Supporting excellence in infection prevention and control behaviors Implementation Toolkit has been adopted C1116-supporting-excellence-in-ipc-behaviours-imp-toolkit.pdf (england.nhs.uk)	Provision of AGPs is minimal at CICC, however where applicable, this would be risk assessed in accordance with the hierarchy of controls, to assure the safety of visitors. The 'Supporting excellence in infection prevention and control behaviours' Implementation Toolkit has been fully considered and is part of the work plan with the Infection Prevention Control Champions.	
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 and Mitigating Actions**
Systems and processes are in place to ensure that: • signage is displayed prior to and on entry to all health and care settings instructing patients with respiratory symptoms to inform receiving reception staff, immediately on their arrival. • infection status of the patient is communicated to the receiving organisation, department or transferring services, when a possible or confirmed seasonal respiratory infection needs to be transferred. • staff are aware of agreed template for screening questions to ask.	Robust systems and processes have been embedded across the Trust to ensure prompt identification of people who have or are at risk of developing an infection, ensuring they receive timely, appropriate treatment to reduce the risk of transmitting infection. Actions implemented to achieve this aim, include continued implementation of signage on entry to all Trust buildings clearly outlining expected IPC standards. This includes immediate reporting of respiratory symptoms when accessing care. This is further supported by the implementation of consistent triage questions across all services, ensuring infection risk is promptly identified and appropriately managed.	Full assurance evidenced

• screening for COVID-19 is undertaken prior to attendance wherever possible to enable early recognition and to clinically assess patients prior to any patient attending a healthcare environment. • front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed COVID-19/ other respiratory infection symptoms and segregation of cases to minimise the risk of cross-infection as per national guidance. • triage is undertaken by clinical staff who are trained and competent in the clinical case definition and patient is allocated appropriate pathway as soon as possible. • there is evidence of compliance with routine patient testing protocols in line with trust approved hierarchies of control risk assessment and approved. • patients with suspected or confirmed respiratory infection are provided with a surgical facemask (Type II or Type IIR) to be worn in multi-bedded bays and communal areas if this can be tolerated. • patients with respiratory symptoms are assessed in a segregated area, ideally a single room, and away from other patients pending their test result. • patients with excessive cough and sputum production are prioritised for placement in single rooms whilst awaiting testing. • patients at risk of severe outcomes of respiratory infection receive protective IPC measures depending on their	The Trust has established robust mechanisms to identify individuals most at risk of developing infections; this is a continuous process to monitor for deteriorating conditions which may increase level of vulnerability. There is a mechanism on SystmOne to screen patients prior to conducting a visit or attending for clinic appointments. Systems and process have been developed across Trust Walk-in and Urgent Treatment Care Centres to effectively utilise triage to ensure risk of cross-infection is minimised in accordance with national guidance. Trust guidance clearly details that fluid resistant surgical face masks should be considered for all patients, subject to an assessment of clinical appropriateness. Clinical triage questions have been disseminated across Trust services and are systematically implemented to ensure patients are allocated to the appropriate pathway at the earliest opportunity. These are reviewed on release of new national and regional guidance, to ensure adherence to current best practice guidance. The Trust has implemented contract tracing mechanisms to support the national test and trace process. In addition, the Trust has participated in a system-wide contact tracing review process, to ensure there is a clear, consistent approach across the local health and care system to rapidly initiate contact tracing as required. At the Trust's CICC in-patient facility a robust screening and triage process has been developed and implemented to ensure prompt identification of any potential infection risk. The admission criteria for the ward has been developed in-line with national guidance to ensure that admissions are only facilitated where individuals have tested negative for Covid-19, or when 14 days post positive Covid-19 test result or exposure, where the person has been asymptomatic for 48hrs.	

medical condition and treatment whilst receiving healthcare eg, priority for single room isolation and risk for their families and carers accompanying them for treatments/procedures must be considered. • where treatment is not urgent consider delaying this until resolution of symptoms providing this does not impact negatively on patient outcomes. • face masks/coverings are worn by staff and patients in all health and care facilities. • where infectious respiratory patients are cared for physical distancing remains at 2 metres distance. • patients, visitors, and staff can maintain 1 metre or greater social & physical distancing in all patient care areas; ideally segregation should be with separate spaces, but there is potential to use screens, eg, to protect reception staff. • patients that test negative but display or go on to develop symptoms of COVID-19 are segregated and promptly re-tested and contacts traced promptly. • isolation, testing and instigation of contact tracing is achieved for all patients with new-onset symptoms, until proven negative. • patients that attend for routine appointments who display symptoms of COVID-19 are managed appropriately	Inpatients are required to wear face masks and maintain 2 metre distancing at all times. As part of the admission to CICC, patients are requested to remain on the ward to reduce the risk of their exposure to Covid-19 community transmission which may result in forward transmission within the ward environment. A robust swabbing process has been implemented to ensure rigorous monitoring of individual Covid-19 status on the wards. In the eventuality that a patient at CICC tests positive for Covid-19, policies and procedures will be implemented, ensuring the individual is immediately transferred or remains in a single occupancy room with isolation precautions. Patients who become symptomatic with Covid-19 symptoms will be isolated in a single occupancy room immediately with isolation precautions and be tested for Covid-19. Staff working at CICC have received training on IPC precautions designed to limit the spread of infection. IPC precautions will be further supported by staff cohorting, providing dedicated equipment for patients with a known or suspected infection and enhancing cleaning schedules for the ward environment and high frequency touch points. All patients at CICC are screened for COVID-19 and MRSA on admission as part of the screening plan. IPC Policy 20 for Patient In-Bedded Units Managed by WCHC – Isolation including contact droplet and airborne precautions. SystmOne includes Symptoms; Diagnosis and Treatment template	

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 and Mitigating Actions**
Systems and processes are in place to ensure that: • appropriate infection prevention education is provided for staff, patients, and visitors. • training in IPC measures is provided to all staff, including: the correct use of PPE including an initial face fit test/and fit check each time when wearing a filtering face piece (FFP3) respirator and the correct technique for putting on and removing (donning/doffing) PPE safely. • all staff providing patient care and working within the clinical environment are trained in the selection and use of PPE appropriate for the clinical situation and on how to safely put it on and remove it; • adherence to national guidance on the use of PPE is regularly audited with actions in place to mitigate any identified risk. • gloves are worn when exposure to blood and/or other body fluids, non-intact skin or mucous membranes is anticipated or in line with SICP's and TBP's. • the use of hand air dryers should be avoided in all clinical areas. Hands should be dried with soft, absorbent, disposable paper towels from a dispenser which is located close to the	The Trust has developed robust systems and processes to ensure compliance with health and safety legislation to assure safety in the workplace. Where possible, contact between patients and staff is minimised to reduce the risk or transmission by appropriate use of the environment and estate. Assurance mechanisms include monitoring of mandatory training compliance including IPC Level 1 and Level 2 e-learning and Health and Safety Training. In addition, staff who may potentially be required to wear a FFP3 respirator to deliver clinical care, have been identified and fit tested against a range of RPE. This information is held centrally in the Trust and accessible for individual use as required. An extensive range of training resources have been developed to ensure staff are competent in correct donning/doffing techniques and selection of PPE. In addition, a Covid-19 clinical audit programme has been established as a rapid assurance mechanism to identify areas for improvement. Audit results are recorded on the Trusts' SAFE system and reviewed monthly at the SAFE steering group and action taken accordingly to mitigate any identified risk. The Covid-19 assurance framework includes CAS alerts which are also recorded centrally on the Trusts' SAFE system, supporting data triangulation. Appropriate hand washing facilities are available within each clinical area, to support effective decontamination; hand air dryers are not located within clinical areas.	Full assurance evidenced

sink but beyond the risk of splash contamination as per national guidance. • staff maintaining physical and social distancing of 1 metre or greater wherever possible in the workplace • staff understand the requirements for uniform laundering where this is not provided for onsite. • all staff understand the symptoms of COVID-19 and take appropriate action if they or a member of their household display any of the symptoms (even if experiencing mild symptoms) in line with national guidance. • to monitor compliance and reporting for asymptomatic staff testing • there is a rapid and continued response to ongoing surveillance of rates of infection transmission within the local population and for hospital/organisation onset cases (staff and patients/individuals). • positive cases identified after admission who fit the criteria for investigation should trigger a case investigation. Two or more positive cases linked in time and place trigger an outbreak investigation and are reported.	Throughout Trust services, a 2-metre social distancing standard is expected where possible, in addition to wearing of fluid resistant surgical face masks. Action cards for laundering uniforms has been produced for Trust staff. Clear guidance has been developed for all Trust staff, clearly outlining the action required in the eventuality that a member of their household displays symptoms that may be associated with Covid-19. A Covid-19 exemption risk assessment has also been developed, to support staff to safely return to the workplace when appropriate following contact with a person who is positive for Covid-19. This is providing certain criteria can be evidenced, including vaccination status, negative PCR test results, being asymptomatic and conducting daily lateral flow tests in accordance with national guidance. Identification of a single positive case within CICC would trigger a review by IPC to identify source of transmission. Two or more linked positive cases trigger an outbreak investigation and is subject to external reporting to ensure transparency. Outbreaks are routinely reported to colleagues from the Wirral Public Health Team and the North-West UK Health and Security Agency (UKHSA) to join membership of the outbreak control team.	
7. Provide or secure adequate isolation facilities		
Key lines of enquiry	**Evidence**	**Gaps in Assurance and Mitigating Actions**
Systems and processes are in place to ensure: • that clear advice is provided, and monitoring is carried out of inpatients compliance with wearing face masks	All patients are the Trust's in-patient bedded facility are asked to wear a face mask when moving around the ward or when in receipt of close contact care. This is providing PPE can be	Full assurance evidenced

(particularly when moving around the ward or healthcare facility) providing it can be tolerated and is not detrimental to their (physical or mental) care needs. • separation in space and/or time is maintained between patients with and without suspected respiratory infection by appointment or clinic scheduling to reduce waiting times in reception areas and avoid mixing of infectious and non-infectious patients. • patients who are known or suspected to be positive with a respiratory pathogen including COVID-19 where their treatment cannot be deferred, their care is provided from services able to operate in a way which minimise the risk of spread of the virus to other patients/individuals. • patients are appropriately placed ie, infectious patients in isolation or cohorts. • ongoing regular assessments of physical distancing and bed spacing, considering potential increases in staff to patient ratios and equipment needs (dependent on clinical care requirements). • standard infection control precautions (SIPC's) are used at point of care for patients who have been screened, triaged, and tested and have a negative result • the principles of SICPs and TBPs continued to be applied when caring for the deceased	tolerated and is not detrimental to their physical or psychological care. Where masks cannot be tolerated by patients, individualised risk assessments will be conducted as required. Systems and processes have been developed to ensure that the designated isolation rooms within Trust Walk-In and Urgent Treatment Care Centres are appropriately used for suspected Covid-19 patients. At the Trust's CICC rehabilitation facility, guidance has been developed to ensure the prompt identification and implementation of patient isolation as required. Trust guidance is continually reviewed at the Clinical Assurance Group meeting, ensuring it reflects current national guidance. Where isolation is required, staff cohorting will be implemented to effectively minimise the risk of transmission, supporting isolation precautions.	

8. Secure adequate access to laboratory support as appropriate		
Key lines of enquiry	**Evidence**	**Gaps in Assurance and Mitigating Actions**
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; • regular monitoring and reporting of the testing turnaround times with focus on the time taken from the patient to time result is available; • regular monitoring and reporting that identified cases have been tested and reported in line with the testing protocols (correctly recorded data); • screening for other potential infections takes place; • that all emergency patients are tested for COVID-19 on admission; • that those inpatients who go on to develop symptoms of COVID-19 after admission are retested at the point symptoms arise; • that emergency admissions who test negative on admission are retested on day 3 of admission, and again between 5-7 days post admission;	The Trust has identified a group of senior staff who have received training in Covid-19 sampling with competencies assessed by external specialists. All staff receive training in swabbing and are supported to achieve the correct technique and competency. A training pack is available to supplement the training, supporting continuous professional development. Robust systems are in place to access laboratories for processing samples. The Trust has implemented national guidance for Covid-19 swabbing at the CICC in-patient rehabilitation facility. The Trust does not have emergency or elective admission to our inbedded unit. Swabbing pathways on discharge are embedded. The Trust do not provide elective surgery.	Full assurance evidenced

• that sites with high nosocomial rates should consider testing COVID negative patients daily; • that those being discharged to a care home are tested for COVID-19 48 hours prior to discharge (unless they have tested positive within the previous 90 days) and result is communicated to receiving organisation prior to discharge; • that patients being discharged to a care facility within their 14 day isolation period are discharged to a designated care setting, where they should complete their remaining isolation; • that all Elective patients are tested 3 days prior to admission and are asked to self-isolate from the day of their test until the day of admission. • there is an assessment of the need for a negative PCR and 3 days self-isolation before certain elective procedures on selected low risk patients who are fully vaccinated, asymptomatic, and not a contact of case suspected/confirmed case of COVID-19 within the last 10 days. Instead, these patients can take a lateral flow test (LFT) on the day of the procedure as per national guidance.		

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 and Mitigating Actions**
Systems and processes are in place to ensure that:	The Trust has an extensive and robust IPC policy framework to ensure full adherence to the IPC Code of Practice and Regulation 12 of the Health and Social Care Act 2008	Full assurance evidenced

• the application of IPC practices are monitored and that resources are in place to implement and measure adherence to good IPC practice. This must include all care areas and all staff (permanent, agency and external contractors). • staff are supported in adhering to all IPC policies, including those for other alert organisms. • safe spaces for staff break areas/changing facilities are provided. • staff are supported in adhering to all IPC policies, including those for other alert organisms; • any changes to the PHE national guidance on PPE are quickly identified and effectively communicated to staff; • all clinical waste and linen/laundry related to confirmed or suspected COVID-19 cases is handled, stored and managed in accordance with current national guidance; • PPE stock is appropriately stored and accessible to staff who require it.	(regulated Activities) Regulations 2014. This has been subject to a comprehensive review and updated accordingly to accommodate IPC national standards at the new CICC in-patient rehabilitation facility. Mechanism to monitor adherence to IPC practices is achieved via an IPC clinical audit programme, within the Trust's SAFE system to evidence compliance with the fundamental principles of IPC to prevent and control infections. Audit results are tracked monthly through the Trust's governance system. Staff are supported with IPC compliance by the provision of a safe working environment; this includes break areas and changing facilities where required. A comprehensive audit programme has also been developed for CICC; this is tracked and monitored at the CICC governance meeting on a monthly basis, supported by an escalation process for immediate visibility and responsive action if improvements in standards are required. Changes to PHE national guidance or PPE are escalated in the first instance to the Trust's daily Tactical command group, prior to review at the Clinical command meeting. A predictive methodology has been established to forecast use of PPE; this is reviewed daily at the Tactical command group and weekly by the Strategic command group in accordance with the Trust's Covid-19 command and control structure.	

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 and Mitigating Actions**
Appropriate systems and processes are in place to ensure that: • staff seek advice when required from their IPCT/occupational health	The Trust's IPC Team are accessible to all Trust staff when specialist IPC support is required. In addition, a range of guidance and policy documents have been produced to ensure staff have access to up-to-date IPC guidance to support their practice. Guidance is followed by all staff including bank, agency and locums.	Full assurance evidenced

department/GP or employer as per their local policy. • bank, agency, and locum staff follow the same deployment advice as permanent staff. • staff who are fully vaccinated against COVID-19 and are a close contact of a case of COVID-19 are enabled to return to work without the need to self-isolate (see Staff isolation: approach following updated government guidance) • staff understand and are adequately trained in safe systems of working, including donning, and doffing of PPE. • a fit testing programme is in place for those who may need to wear respiratory protection. • where there has been a breach in infection control procedures staff are reviewed by occupational health. Who will: - lead on the implementation of systems to monitor for illness and absence. - facilitate access of staff to antiviral treatment where necessary and implement a vaccination programme for the healthcare workforce - lead on the implementation of systems to monitor staff illness, absence and vaccination against seasonal influenza and COVID-19 - encourage staff vaccine uptake. • staff who have had and recovered from or have received vaccination for a specific respiratory pathogen continue to follow the infection control precautions,	Referral to Occupational Health is available for Trust staff when deemed appropriate to support health and well-being. A Covid-19 exemption risk assessment has also been developed, to support staff to safely return to the workplace when appropriate following contact with a person who is positive for Covid-19. This is providing certain criteria can be evidenced, including vaccination status, negative PCR test results, being asymptomatic and conducting daily lateral flow tests in accordance with national guidance. Through the Trust's governance structure, appropriate systems and process have been developed to assure the safety of staff in relation to Occupational Health needs. All staff are required to continue with infection control precautions, including PPE as outlined in national guidance.	

including PPE, as outlined in national guidance. • a risk assessment is carried for health and social care staff including pregnant and specific ethnic minority groups who may be at high risk of complications from respiratory infections such as influenza and severe illness from COVID-19. - A discussion is had with employees who are in the at-risk groups, including those who are pregnant and specific ethnic minority groups; - that advice is available to all health and social care staff, including specific advice to those at risk from complications. - Bank, agency, and locum staff who fall into these categories should follow the same deployment advice as permanent staff. - A risk assessment is required for health and social care staff at high risk of complications, including pregnant staff. • vaccination and testing policies are in place as advised by occupational health/public health. • staff in 'at-risk' groups are identified using an appropriate risk assessment tool and managed appropriately including ensuring their physical and wellbeing is supported; • that risk assessments are undertaken and documented for any staff members in an at risk or shielding groups, including Black, Asian and Minority Ethnic and pregnant staff;	Risk assessments are completed for staff members who may be at high risk of complications from respiratory infections, including influenza and severe illness from Covid-19. A process has been developed to identify 'at-risk' groups, ensuring appropriate management of physical and psychosocial wellbeing. This includes compliance with national guidance in relation to Vitamin D for BAME staff. The established governance framework supports responsive action in relation to newly released guidance ensuring an appropriate rapid review and assessment of risk to ensure recommendations are made to Silver Command. Fit Testing Kits have been rolled out to every DN Team and there are also Fit Testers available to visit any services if staff require fit testing/re-test. The weekly Situation Report includes mask availability –any issues in availability are identified and staff are provided with alternative products. The Fit Test Mask List is available on the StaffZone to support with the supply of FFP3 masks across the trust. A record is kept centrally of all staff who fail a fit test and associated risk is proactively managed in the eventuality that fit testing cannot be achieved.	

• staff required to wear FFP reusable respirators undergo training that is compliant with PHE national guidance and a record of this training is maintained and held centrally; • staff who carry out fit test training are trained and competent to do so; • all staff required to wear an FFP respirator have been fit tested for the model being used and this should be repeated each time a different model is used; • a record of the fit test and result is given to and kept by the trainee and centrally within the organisation; • those who fail a fit test, there is a record given to and held by trainee and centrally within the organisation of repeated testing on alternative respirators and hoods; • members of staff who fail to be adequately fit tested a discussion should be had, regarding re deployment opportunities and options commensurate with the staff members skills and experience and in line with nationally agreed algorithm; • a documented record of this discussion should be available for the staff member and held centrally within the organisation, as part of employment record including Occupational health; • following consideration of reasonable adjustments e.g. respiratory hoods, personal re-usable FFP3, staff who are		

unable to pass a fit test for an FFP respirator are redeployed using the nationally agreed algorithm and a record kept in staff members personal record and Occupational health service record; • that where fit testing fails, suitable alternative equipment is provided. Reusable respirators can be used by individuals if they comply with HSE recommendations and should be decontaminated and maintained according to the manufacturer's instructions. • boards have a system in place that demonstrates how, regarding fit testing, the organisation maintains staff safety and provides safe care across all care settings. This system should include a centrally held record of results which is regularly reviewed by the board; • consistency in staff allocation should be maintained, reducing movement of staff and the crossover of care pathways between planned/elective care pathways and urgent/emergency care pathways as per national guidance; • all staff to adhere to national guidance and are able to maintain 2 metre social & physical distancing in all patient care areas if not wearing a facemask and in non-clinical areas; • health and care settings are COVID-19 secure workplaces as far as practical, that is, that any workplace risk(s) are mitigated maximally for everyone;		

• staff are aware of the need to wear facemask when moving through COVID-19 secure areas; • staff absence and well-being are monitored and staff who are self-isolating are supported and able to access testing; • staff who test positive have adequate information and support to aid their recovery and return to work.		

Wirral Community Health and Care NHS Foundation Trust

Mortality Report: Learning from Deaths Framework Quarter 3: 01 October 2021 – 31 December 2021

Meeting	Board of Directors		
Date	09/02/2022	**Agenda item**	**18**
Lead Director	Nick Cross, Medical Director		
Author(s)	Nick Cross, Medical Director		

Action required (please tick the appropriate box)

To Approve ☑	**To Discuss** ☐	**To Assure** ☑

Purpose

The purpose of this paper is to seek approval from Public Board in relation to the implementation of the Learning from Deaths framework and subsequent publication on the Trust website.

Executive Summary

This quarterly report provides evidence that learning from deaths is firmly embedded as a priority across the Trust, ensuring full adherence to the NQB Learning from deaths framework. It provides anonymised details of the numbers of unexpected deaths which have occurred within the Trust throughout Q3 2021/22, along with a summary of thematic learning identified during investigation into these cases. Attached as an appendix is a report detailing this information for purposes of publication of the Trust website. The report has been shared and approved virtually by the Quality and Safety Committee.

Risks and opportunities:
Not applicable

Quality/inclusion considerations:
Quality Impact Assessment completed and attached No
Equality Impact Assessment completed and attached No
A QIA and EIA is not applicable in this particular case

Financial/resource implications:
Not applicable

Trust Strategic Objectives
Please select the top three Trust Strategic Objectives that this report relates to, from the drop down boxes below.

Our Populations - outstanding, safe care every time	Our Populations – provide more person-centred care	Our Populations - improving services through integration and better coordination

Committee action

The board of Directors is asked to be assured that 1: processes are in place to meet our statutory obligations surrounding Learning from Deaths and 2: that processes are in place to engagement with families and meet our Duty of Candour obligations.

Report history

Submitted to	Date	Brief summary of outcome
Quality and Safety Committee	28/01/22	Committee approved

Wirral Community Health and Care NHS Foundation Trust

Mortality Report: Learning from Deaths Framework
Quarter 3: 01 October 2021 – 31 December 2021

Purpose

1. The purpose of this paper is to provide assurance to the members of the Quality and Safety Committee in relation to the implementation of the Learning from Deaths framework.

Executive Summary

2. Wirral Community Health and Care NHS Foundation Trust (WCHC) Board recognises that effective implementation of the Learning from deaths framework (National Quality Board, March 2017), is an integral component of the Trusts' learning culture, driving continuous quality improvement to support the delivery of high-quality sustainable services to patients and service users.

3. In December 2016, the Care Quality Commission (CQC) published its report: Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England. The recommendations of this report were accepted by the Secretary of State and incorporated into a Learning from Deaths framework by the National Quality Board (NQB) in March 2017.

4. The Learning from Deaths framework aims to address the key findings of the CQC report, ensuring a consistent approach to learning from deaths across the NHS, assuring a transparent culture of learning by delivering a commitment to continuous quality improvement, particularly in relation to the care of vulnerable people.

5. The key findings of the CQC report were as follows:

   - Families and carers are not treated consistently well when someone they care about dies.
   - There is variation and inconsistency in the way that system partners become aware of deaths in their care.
   - Trusts are inconsistent in the approach they use to determine when to investigate deaths.
   - The quality of investigations into deaths is variable and generally poor.
   - There are no consistent frameworks that require boards to keep deaths in their care under review and share learning from these.

6. This quarterly report provides evidence that learning from deaths is firmly embedded as a priority across the Trust, ensuring full adherence to the NQB Learning from deaths framework.

7. WCHC compliance with the NQB framework has been self-assessed by an internal review of the Board Leadership requirements as outlined in the National Guidance on Learning from Deaths (NQB, March 2017). The RAG rating for this process has been included in the inaugural Learning from Deaths report.

WCHC Learning from deaths governance framework

8. All reported deaths which have occurred in a places where we are commissioned to deliver services, are discussed at both the Quality and Governance Multi-disciplinary Safety Huddle and at the weekly Clinical Risk Management Group (CRMG). Further investigations are commissioned on the basis of the events surrounding the death and on the results of the Mortality Screening Tool. The principles around Duty of Candour are also overseen within this group.

9. Pending investigations are monitored against progress and timelines and expediated where necessary. Any reports (ie Root Cause Analysis - RCA) and associated action plans are quality assured at CRMG. This includes cases which are under investigation by the coroner.

10. Lessons learnt and learning themes from Learning from Deaths cases are reviewed at the Trust's quarterly Mortality Review Group which is chaired by the Executive Medical Director and who is responsible for the Learning from Deaths agenda.

11. Minutes from the Mortality Review Group are submitted to the Standards Assurance Framework for Excellence (SAFE) Steering Group, which in turn reports directly to the Quality and Safety Committee and finally to the Board.

12. A report is produced which summarises the details of the unexpected deaths which have occurred within the preceding quarter, along with details of any thematic learning. This is ratified by the Quality and Safety Committee prior to being presented to Public Board, again on a quarterly basis.

13. In accordance with the Learning from Deaths framework, the Trust ratified and published a Learning from Deaths Policy during September 2017.

14. The policy provides a framework for how the Trust will evaluate those deaths that from part of our mortality review process, the criteria for review and quarterly and annual reporting mechanisms.

15. The Trust's Datix incident reporting system has been aligned to the Learning from Deaths Policy to ensure prompt communication to the Executive Medical Director, Director and Deputy Director of Nursing for all reported unexpected deaths. This includes integrating the Mortality Screening Tool with Datix.

16. The Incident Management Policy - GP08 has been updated and cross references the newly implemented Learning from Deaths Policy, ensuring a consistent approach to implementation. The revised policy contains arrangements for staff to follow in the event of an unexpected death of an adult and in the event of an unexpected death of a child.

17. The Trust continues to work with our system partners to devise systems whereby Learning from Deaths can take place in a consistent way across all major health and social care providers. This includes working with the UK Health Security Agency and the Local Authority to analyse the effect of COVID-19 by utilising a population-based approach to identify areas of inequality and its association with deaths due to this disease.

18. The Learning from Deaths report is based on the template devised by the National Quality Board. This report will be published on the Trust's website in keeping with our statutory obligations.

Bereaved Families

19. Families will be treated as equal partners following a bereavement and will always receive a clear, honest, compassionate and sensitive response in a supportive environment and receive a high standard of bereavement care which respects confidentiality, values, culture and beliefs, including being offered appropriate support.

20. Families are informed of their right to raise concerns about the quality of care provided to their loved one and their views help to inform decisions about whether a review or investigation is needed.

21. Families will receive timely, responsive contact and support in all aspects of an investigation process, in line with duty of candour and with a single point of contact and liaison.

22. Families are partners in an investigation to the extent, and at whichever stages, that they wish to be involved and voice their experiences of the death of their loved one, as they offer a unique and equally valid source of information and evidence that can better inform investigations; bereaved families and carers who have experienced the investigation process help us to embed the learning to continually improve patient safety.

Q3 2021/22 WCHC Reported deaths (Datix incident reporting)

23. During Q3 there were a total of 11 reported deaths none of which were within scope for reporting.

24. During Q3 there were 2 deaths which met the criteria for StEIS reporting. These cases were reported by our Trust on behalf of the Local Authority, given our role to investigate certain specific deaths on behalf of the system. Neither case however related to care delivered by Trust services and therefore they have not been included within the scope of this report.

Recording data on Structured Judgement Reviews:		
Total Number of Deaths in scope	0	
October – nil return November – nil return December – nil return There are no outstanding cases from the previous quarter (Q2)		
Total Number of Deaths considered to have more than 50% chance of being avoidable	0	
Recording data on LeDeR reviews: - Please note that these are undertaken by the mental health trust		
Total Number of Deaths in scope	0	
Total Deaths reviewed through LeDeR methodology	0	
Total Number of deaths considered to have been potentially avoidable	0	
Recording data on SUDIC reviews:		
Total Number of Child Deaths	3	
Total Deaths reviewed through SUDiC methodology	3	

Summary of Thematic Learning

25. Each unexpected death reported during Q3 has been analysed and investigated appropriately, to identify if care provided by the Trust resulted in harm or contributed to the death, and if any relevant learning exists for the Trust and the wider health and social care system.

26. Of the total deaths reported in Q3, after investigation, none of these were within scope of this report and consequently there were no lessons identified which the Trust and system partners could learn from.

Recommendations

27. The Quality and Safety Committee is asked to be assured that quality governance systems are in place to ensure continuous monitoring and learning from deaths in accordance with Trust policy.

28. The Quality and Safety Committee is asked to be assured the Trust is actively involved in supporting the system-wide development of processes reporting and learning from deaths.

30. The Quality and Safety Committee is asked to approve Appendix 1 to proceed through to Public Board

Dr Nick Cross
Executive Medical Director
28 January 2022

Appendix 1

Learning from Deaths Q3 21/22 Report

The following data represents the high-level reporting of deaths which occurred within our services over the period of Quarter 3 2021/22.

A more detailed report has been ratified and approved by the Quality and Safety Committee as per the Learning from Deaths Policy.

There were 11 deaths reported to the Trust and all have been reviewed in accordance with Trust policy. On this occasion, none of the deaths were within scope of this report during this period. This is because the deaths were not associated with any care delivered or harm caused by services provided by the Trust. Duty of Candour was not applicable to any of these cases.

There were 3 child deaths, which were appropriately reported, scrutinised, and followed the SUDiC process. There was no learning for the Trust identified following the investigative process.

We continue to promote shared learning across the health and care sectors and work collaboratively with our system partnership to identify and address the impact of Covid-19 within all the communities in which we provide services, focusing on addressing health inequalities on a population-based approach.

Dr Nick Cross
Executive Medical Director
Wirral Community Health and Care NHS Foundation Trust

28 January 2022