Sheffield Teaching Hospitals NHS Foundation Trust

Chief Executive's Briefing

Board of Directors – 26 January 2021

1. COVID-19 Gold Update

As the COVID-19 pandemic continues, the Trust is focused on safely providing urgent and emergency services and levels of planned elective care. Alongside the continued staff testing service this month has additionally focused on ensuring eligible patients and patient facing staff receive the COVID-19 vaccine.

A detailed letter from NHS England providing information of the operational priorities for winter and 2021/22 can be found at Appendix 1.

A presentation of the current situation will be provided in the meeting, particularly in light of the rapidly changing situation and national restrictions.

2. Integrated Performance Report

The Integrated Performance Report (paper Cii), each Director will highlight the key issues for the Board of Directors.

3. Gold Chief Nursing Officer Award

In December, Christine Bryer who worked for the Trust for many years before retiring in 2019, was awarded a Chief Nursing Officer Gold Award by Ruth May, Chief Nursing Officer for England. This award was recognition of the nursing leadership that Chris has provided throughout her career and particularly her work on the Safer Nursing Care Tool, an accredited tool for workforce planning in nursing. The tool was developed over a number of years and STH was a significant contributor in its development.

4. Medical Director (Operations)

Dr Jennifer Hill has been appointed to Executive Medical Director (Operations). Jennifer was appointed to the position on an interim Medical Director (Operations) basis a number of months ago whilst we tested this new model of Medical Director leadership for the organisation. She will take up the permanent position with immediate effect.

I am sure you will join me in congratulating Jennifer on her appointment.

Dr David Hughes will continue to be Executive Medical Director (Development) and will work closely with Jennifer to continue to develop the model of medical leadership and ensuring their portfolios are appropriately connected.

5. Hospital Standardised Mortality Ratio

Over the past three months the Hospital Standardised Mortality Ratio (HSMR) work stream leads reviewed data and information from the Dr Foster information system.

Dr Foster helpfully provided documentation and guidance on key areas of focus. The following actions have been taken:

- Review of pathways with multiple care episodes and a detailed understanding gained of where documentation and clinical coding inaccuracies are occurring
- Initial meetings with clinical colleagues from the Stroke Service (acute cerebrovascular disease), Hepatology Department (liver disease - alcohol related) and Orthopaedic Service (fractured neck of femur) have taken place to further understand the nuances of the services and how this impacts on clinical coding and the reporting of mortality
- Initial meeting held with Palliative Care as there has been a fall in palliative care coding which may be impacting on the overall reporting ratio
- Review of the impact of admission method and source of admission to better understand elective and emergency admission differences. There are clear areas where admission method and source are not being accurately captured and this is impacting on the Dr Foster modelling and HSMR reporting.

During the next three months we aim to continue engagement with clinicians from the three diagnostic groups mentioned above, implement process changes within the Clinical Coding department and work more closely with the clinical teams and produce training support / guidance for admission source and method to improve data accuracy. An update on this work will be provided to the Board of Directors in April 2021.

6. Longley Lane

The NHS Blood & Transplant Service (NHSBT) vacated its Longley Lane site, on the edge of the NGH site, at the end of November 2020. When the Trust first became aware of the NHSBT plan it opened dialogue about acquiring the site given the strategic options it brings. This has ultimately been agreed with NHSBT and DHSC and it is intended that the sale will be completed in January 2021 at a cost of £936k. In agreement with NHSBT and DHSC the Trust has been using the facility since mid-December for the city's Drive Through Phlebotomy service.

There are a range of potential uses for the buildings/site, some short-term COVID related, some medium term and some long-term. Further work will be undertaken on this in the coming months but each business case will need to address the potentially significant running costs.

7. Nursing Associates

This month we welcomed our first ever newly qualified Registered Nursing Associates into the workforce here at Sheffield Teaching Hospitals.

As they complete their training, over 100 Nursing Associates across the South Yorkshire region will join the NMC register and begin their careers in this exciting and important new role. With one of the largest cohorts in the country, nearly half of these new registrants have completed their training here at STH.

The Nursing Associate role was developed in England in response to the 2015 Shape of Caring Review which sought to create a new position in between Support Workers and Nursing staff and widen access for unregistered staff to enter the Nursing profession. As a new role in between Support worker and Registered Nurse, our Nursing Associates will be able to undertake more clinical tasks than a Support Worker whilst still requiring some support from a Registered Nurse for more complex clinical requirements. They will therefore contribute to the core delivery of Nursing care and will be a huge asset to a ward.

Having gone on to recruit two additional cohorts in October 2019 and October 2020, we look forward to increasing our Nursing Associate workforce yet further over the next two years; some of whom may even decide to undertake further training and top up to Registered Nurse in the future.

8. Key actions: infection prevention and control and testing

NHS England issued guidance on the 17 November 2020 to Trusts in response to the continuing challenge of nosocomial infections in hospitals, entitled "Key actions: infection prevention and control and testing". This document contains 10 actions, eight for organisations and two for local systems. A gap analysis describing the Trust's position against these actions was discussed at the Healthcare Governance Committee in December and it was agreed that this document should be shared with the Board and is included at Appendix 2.

On the 23 December the document was reissued with some amendments and the Trust has now considered the revised document and made appropriate adjustments to its arrangements for infection, prevention and control.

9. Independent Review of Maternity Services at the Shrewsbury and Telford Hospitals NHS Trust

At the December Healthcare Governance Committee, the Chief Nurse highlighted that Donna Ockenden's first report: "Emerging Findings and Recommendations from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospitals NHS Trust" had been published on 11 December 2020. Subsequently, all Trusts providing maternity services received a letter from NHS England and NHS Improvement setting out the immediate safety actions required from Trusts providing maternity services and the Chief Nurse highlighted to the Healthcare Governance Committee that this work was underway.

The Trust has subsequently responded to this letter providing assurance that it is compliant with the immediate safety actions and is ensuring it addresses all the recommendations associated with this report.

Rosamond Roughton has kindly agreed to undertake the role of Non-Executive Director lead and will be working closely alongside Professor Chris Morley, Chief Nurse in ensuring that our Maternity Service continues to provide high quality care.

10. Clinical Director for Cardiology, Cardiac & Thoracic Surgery

I am delighted to announce the appointment of Nigel Wheeldon as the next Clinical Director for Cardiology, Cardiac & Thoracic Surgery. Nigel has been the Clinical Lead for seven years for Cardiology Services and as well as being a Consultant Cardiologist for 25 years, he is also an Honorary Professor of Inherited Cardiac Conditions. Nigel will take up post from 1 April 2021.

I would also like to take this opportunity to put on record my thanks to Peter for everything he has done in his 9 years as Clinical Director, notably the last two and half-years where he has also acted as Clinical Director in Vascular Services.

11. South Yorkshire and Bassetlaw Integrated Care System (SY&B ICS)

A report from the Chief Executive of SY&B ICS can be found at Appendix 3. This provides a summary update on the work of the SY&B ICS for the month of December 2020 including performance scorecards.

12. Sheffield Accountable Care Partnership

The Board received the most up to date overview of the programme activities for the Sheffield Accountable Care Partnership when it met last month.

Kirsten Major
Chief Executive
26 January 2021

Appendix 1

Skipton House
80 London Road
London
SE1 6LH

To:

- STP and ICS Leaders
- Chief executives of all NHS trusts and foundation trusts
- CCG Accountable Officers
- GP practices and Primary Care Networks
- Providers of community health services
- NHS 111 providers

23 December 2020

CC:

- NHS Regional Directors
- Regional Incident Directors & Heads of EPRR
- Chairs of ICSs and STPs
- Chairs of NHS trusts, foundation trusts and CCG governing bodies
- Local authority chief executives and directors of adult social care
- Chairs of Local Resilience Forums

Dear colleague

Important – for action – Operational priorities for winter and 2021/22

As we near the end of this year, we are writing to thank you and your teams for the way you have responded to the extraordinary challenge of Covid-19 and set out the key priorities for the next phase.

An extraordinary 2020

In the past year we have cared for more than 200,000 of those most seriously ill with Covid-19 in our hospitals. At the same time NHS staff have also worked incredibly hard to keep essential services such as cancer, mental health, general practice, urgent, emergency and community healthcare running and restore non-urgent services that had to be paused. Community nurses, pharmacists, NHS 111 staff and other NHS workers have cared for countless others, and been supported by the wider NHS team, from HR and finance to admin and clerical staff. The number of cancer treatments is above the level at the same time last year. GP appointments are back to around pre-pandemic levels. Mental health services have remained open and more than 400,000 children have accessed mental health services, above the target for 2020/21. Community services are supporting 15 per cent more people than they were at the same point last year. And we have had a record number of people vaccinated against flu, including a higher percentage of NHS staff than in the last three years. It has been an incredible team effort across our health and care system.

The response to the pandemic has also demonstrated our health service's enormous capacity for innovation with rapid development and implementation of new treatments, such as dexamethasone, rolling out of pulse oximetry and at-home patient self-monitoring, and the move to virtual and telephone consultations. We are already in the third week of our world-leading vaccination programme – the largest in NHS history.

We know that this relentless pressure has taken a toll on our people. Staff have gone the extra mile again and again. But we have lost colleagues as well as family and friends to the virus; others have been seriously unwell and some continue to

experience long-term health effects. The response of the NHS to this unprecedented event has been magnificent. We thank you and your teams unreservedly for everything that you have given and achieved and the support you continue to give each other.

You have asked us for a short statement of operational priorities going forward. This letter is therefore intended to help you and your staff over the next few months by:

- ensuring we have a collective view of the critical actions for the remainder of this financial year, and
- signalling the areas that we already know will be important in 2021/22.

Managing the remainder of 2020/21

Given the second wave and the new more transmissible variant of the virus, it is clear that this winter will be another challenging time for the NHS. Our task is five-fold:

A. Responding to Covid-19 demand
B. Pulling out all the stops to implement the Covid-19 vaccination programme
C. Maximising capacity in all settings to treat non-Covid-19 patients
D. Responding to other emergency demand and managing winter pressures
E. Supporting the health and wellbeing of our workforce

In addition, as the UK approaches the end of the transition period with the European Union on 31 December 2020, we will provide updates as soon as the consequences for the NHS become known. We are following a single operational response model for winter pressures, including Covid-19 and the end of the EU transition period. All CCGs and NHS trusts should have an SRO to lead the EU/UK transition work and issues should be escalated to the regional incident centre established for Covid-19, EU transition and winter.

A. Responding to ongoing Covid-19 demand

With Covid-19 inpatient numbers rising in almost all parts of the country, and the new risk presented by the variant strain of the virus, you should continue to plan on the basis that we will remain in a level 4 incident for at least the rest of this financial year and NHS trusts should continue to safely mobilise all of their available surge capacity over the coming weeks. This should include maximising use of the independent sector, providing mutual aid, making use of specialist hospitals and hubs to protect urgent cancer and elective activity and planning for use of funded additional facilities such as the Nightingale hospitals, Seacole services and other community capacity. Timely and safe discharge should be prioritised, including making full use of hospices. Support for staff over this period will need to remain at the heart of our response, particularly as flexible redeployment may again be required.

Maintaining rigorous infection prevention and control procedures continues to be essential. This includes separation of blue/green patient pathways, asymptomatic testing for all patient-facing NHS staff and implementing the ten key actions on infection prevention and control, which includes testing inpatients on day three of their admission.

All systems are now expected to provide timely and equitable access to post-Covid assessment services, in line with the commissioning guidance.

B. Implementing the Covid-19 vaccination programme

On 8 December, after the MHRA confirmed the Pfizer BioNTech vaccine was safe and effective, the biggest and most ambitious vaccine campaign in NHS history began.

The Joint Committee for Vaccination and Immunisation (JCVI) priorities for roll out of the vaccine have been accepted by Government, which is why the priority for the first phase of the vaccination is for individuals 80 years of age and over, and care home workers, with roll out to care home residents now underway. It is critical that vaccinations take place in line with JCVI guidance to ensure those with the highest mortality risk receive the vaccine first. To minimise wastage, vaccination sites have been ensuring unfilled appointments are used to vaccinate healthcare workers who have been identified at highest risk of serious illness from Covid-19. Healthcare providers have been undertaking staff risk assessments throughout the pandemic to identify these individuals and it remains important that this is organised across the local healthcare system to ensure equitable access.

If further vaccines are approved by the independent regulator, the NHS needs to be prepared and ready to mobilise additional vaccination sites as quickly as possible. In particular, Covid-19 vaccination is the highest priority task for primary care networks including offering the vaccination to all care home residents and workers. All NHS trusts should be ready to vaccinate their local health and social care workforce very early in the new year, as soon as we get authorisation and delivery of further vaccine.

C. Maximising capacity in all settings to treat non-Covid-19 patients

Systems should continue to maximise their capacity in all settings. This includes making full use of the £150m funding for general practice capacity expansion and supporting PCNs to make maximum use of the Additional Roles Reimbursement Scheme, in order to help GP practices maintain pre-pandemic appointment levels. NHS trusts should continue to treat as many elective patients as possible, restoring services to as close to previous levels as possible and prioritising those who have been waiting the longest, whilst maintaining cancer and urgent treatments.

To support you to maximise acute capacity, as set out in Julian Kelly and Pauline Phillip's letter of 17 December, we have also extended the national arrangement with the independent sector through to the end of March, to guarantee significant access to 14 of the major IS providers. NHS trusts have already been notified of the need for a Q4 activity plan for their local IS site by Christmas; this should be coordinated at system level. If you need it, we can also access further IS capacity within those providers subject to the agreement of the national team. However, we will need to return to local commissioning from the beginning of April and local systems, in partnership with their regional colleagues, will need to prepare for that.

The publication of the Ockenden Review of maternity services is a critical reminder of the importance of safeguarding clinical quality and safety. As set out in our letter of 14 December there are twelve urgent clinical priorities that need to be implemented. All Trust Boards must consider the review at their next public meeting along with an assessment of their maternity services against all the review's immediate and essential actions. The assessment needs to be reported to and assured by local systems, who should refresh their local programmes to make maternity care safer, more personalised and more equitable.

D. Responding to emergency demand and managing winter pressures

Alongside providing £80m in new funding to support winter workforce pressures, we are asking systems to take the following steps to support the management of urgent care:

- Ensure those who do not meet the 'reasons to reside' criteria are discharged promptly. We know that maximising capacity over the coming weeks and months is essential to respond to seasonal pressures. We are asking all systems to improve performance on timely and safe discharge, as set out in today's letter, as well as taking further steps that will improve the position on 14+ and 21+ day length of stay, aided by 100% completion of discharge and reasons to reside data.

- Complete the flu vaccination programme, including vaccinating our staff against flu and submitting vaccination uptake data to the National Immunisation and Vaccination system (NIVS).

- To minimise the effects of emergency department crowding, continue to develop NHS 111 as the first point of triage for urgent care services in your locality, with the ability to book patients into the full range of local urgent care services, including urgent treatment centres, same day emergency care and speciality clinics as well as urgent community and mental health services.

- Maximise community pathways of care for ambulance services referral, as a safe alternative to conveyance to emergency departments. Systems should also ensure sufficient arrangements are in place to avoid unnecessary conveyance to hospital, such as the provision of specialist advice, including from emergency departments, to paramedics as they are on scene.

E. Supporting the health and wellbeing of our workforce

Our NHS people continue to be of the utmost importance, and systems should continue to deliver the actions in their local People Plans. Please remind all staff that wellbeing hubs have been funded and will mobilise in the new year in each system.

Planning for 2021/22

The Spending Review announced further funding for the NHS for 2021/22 but in the new year, once we know more about the progress of the pandemic and the impact of the vaccination programme, the Government will consider what additional funding will be required to reflect Covid-19 cost pressures.

In the meantime, systems should continue to:

- **Recover non-covid services**, in a way that reduces variation in access and outcomes between different parts of the country. To maximise this recovery, we will set an aspiration that all systems aim for top quartile performance in productivity on those high-volume clinical pathways systems tell us have the greatest opportunity for improvements: ophthalmology, cardiac services and MSK/orthopaedics. The Government has provided an additional £1bn of funding for elective recovery in 2021/22. In the new year we will set out more details of

how we will target this funding, through the development of system-based recovery plans that focus on addressing treatment backlogs and long waits and delivering goals for productivity and outpatient transformation. In the meantime we are asking you to begin preparatory work for this important task now, through the appointment of a board-level executive lead per trust and per system for elective recovery.

- Strengthen delivery of local **People Plans**, and make ongoing improvements on: equality, diversity and inclusion of the workforce; growing the workforce; designing new ways of working and delivering care; and ensuring staff are safe and can access support for their health and wellbeing.

- Address the **health inequalities** that covid has exposed. This will continue to be a priority into 2021/22, and systems will be expected to make and audit progress against the eight urgent actions set out on 31 July as well as reduce variation in outcomes across the major clinical specialties and make progress on reducing inequalities for people with learning disabilities or serious mental illness, including ensuring access to high-quality health checks.

- Accelerate the planned expansion in **mental health** services through delivery of the Mental Health Investment Standard together with the additional funding provided in the SR for tackling the surge in mental health cases. This should include enhanced crisis response and continuing work to minimise out of area placements.

- Prioritise investment in **primary and community care**, to deal with the backlog and likely increase in care required for people with ongoing health conditions, as well as support prevention through vaccinations and immunisations. Systems should continue to focus on improving patient experience of access to general practice, increasing use of online consultations, and supporting the expansion of capacity that will enable GP appointments to increase by 50 million by 2023/24.

- Build on the development of effective **partnership working at place and system level**. Plans are set out in our Integrating Care document.

These priorities should be supported through the use of data and digital technologies, including the introduction of a minimum shared care record in all systems by September 2021 to which we will target some national funding, and improved use of remote monitoring for long term conditions.

The 2021/22 financial framework

For the reasons set out above, we won't know the full financial settlement for the NHS until much closer to the beginning of the new financial year, reflecting, in particular, uncertainty over direct Covid-19 costs. We will, however, need to start work early in the new year to lay the foundation for recovery. The underlying financial framework for 2021/22 will therefore have the following key features:

- Revenue funding will be distributed at system level, continuing the approach introduced this year. These **system revenue envelopes will be consistent with the LTP financial settlement**. They will be based on the published CCG allocation and the organisational Financial Recovery Fund each system would

have been allocated in 2021/22. There will be additional funding to offset some of the efficiency and financial improvements that systems were unable to make in 2020/21.

- Systems will **need to calculate baseline contract values to align with these financial envelopes** so there is a clear view of baseline financial flows. Our planning guidance will suggest that these should be based on 2019/20 outturn contract values adjusted for non-recurrent items, 2020/21 funding growth and service changes, not on the nationally-set 2020/21 block contracts.
- Systems and organisations should start to develop plans for **how Covid-19 costs can be reduced and eliminated** once we start to exit the pandemic.
- **System capital envelopes** will also be allocated based on a similar national quantum and using a similar distributional methodology to that introduced for 2020/21 capital planning.

We will aim to circulate underlying financial numbers early in the new year. We will then provide fuller planning guidance once we have resolved any further funding to reflect the ongoing costs of managing Covid-19. Further detail of non-recurrent funding announced in the recent Spending Review for elective and mental health recovery will also be provided at that point.

Conclusion

This year has arguably been the most challenging in the NHS's 72-year history. But even in these most testing times, people across the service have responded with passion, resilience and flexibility to deal with not only the virus but also the needs of patients without Covid-19. The rollout of the vaccine will bring hope to 2021 and we will need to maintain the energy and effort to meet the needs of all we serve throughout the year. Thank you for all that you have done and continue to do to achieve this.

With best wishes,

Amanda Pritchard
Chief Executive, NHS Improvement and NHS Chief Operating Officer

Julian Kelly
NHS Chief Financial Officer

Appendix 2

Sheffield Teaching Hospitals NHS
NHS Foundation Trust

EXECUTIVE SUMMARY

REPORT TO HEALTHCARE GOVERNANCE COMMITTEE

HELD ON 21 DECEMBER 2020

Subject	Gap Analysis in relation to NHS England Document: Key actions: infection prevention and control and testing
Supporting TEG Member	Chris Morley – Chief Nurse
Author	Karen Jessop – Deputy Chief Nurse
Status[1]	N

PURPOSE OF THE REPORT

- To note the requirements of the NHS England document; Key actions: infection prevention and control and testing.
- To describe the Trust position in relation to the requirements in this document.
- To highlight the areas where the Trust has not been able to comply with these requirements in full.

KEY POINTS

- NHS England issued this document on the 17th November in response to the continuing challenge of nosocomial infections in hospitals (Appendix 1).
- The document contains 10 actions, 8 for organisations and 2 for systems.
- A gap analysis (Appendix 2) against this document has been undertaken and the Trust is either currently compliant or will be during December for six of the eight actions for organisations.
- Of the two remaining actions, the Trust will be able to comply with the requirement to swab patients 3 days after admission, once the rollout of lateral flow testing for staff is complete. As this will reduce the laboratory capacity required to provide a service for asymptomatic staff swabbing. This capacity can then be used for the day 3 post admission swabbing for patients in addition to that which already takes place at day 5.
- The action which cannot be implemented is the requirement for 2 negative swabs before moving patients within the organisation, there are measures in place to mitigate this risk, and when balanced with the need to maintain patient flow and patient safety, it is thought they are sufficient.

IMPLICATIONS[2]

AIM OF THE STHFT CORPORATE STRATEGY 2017-2020		TICK AS APPROPRIATE
1	Deliver the Best Clinical Outcomes	✓
2	Provide Patient Centred Services	✓
3	Employ Caring and Cared for Staff	✓
4	Spend Public Money Wisely	
5	Deliver Excellent Research, Education & Innovation	

RECOMMENDATIONS

For HCGC to note the attached gap analysis and approve the identified actions to reduce or mitigate the risks identified.

APPROVAL PROCESS

Meeting	Date	Approved Y/N
COVID 19 Gold Command	14/12/20	
HCGC	21/12/20	

[1] Status: A = Approval
A* = Approval & Requiring Board Approval
D = Debate
N = Note

[2] Against the five aims of the STHFT Corporate Strategy 2017-20

17 November 2020

Key actions: infection prevention and control and testing

Organisations

It is the board's responsibility to ensure that:

1. Staff consistently practice good hand hygiene and all high touch surfaces and items are decontaminated multiple times every day – once or twice a day is insufficient.

2. Staff maintain social distancing in the workplace, when travelling to work (including avoiding car sharing) and to remind staff to follow public health guidance outside of the workplace.

3. Staff wear the right level of PPE when in clinical settings, including use of face masks in non-clinical settings.

4. Patients are not moved until at least two negative test results are obtained, unless clinically justified.

5. Daily data submissions have been signed off by the Chief Executive, the Medical Director or the Chief Nurse, and the Board Assurance Framework is reviewed and evidence of reviews is available.

6. Where bays with high numbers of beds are in use, these must be risk assessed, and where 2m can't be achieved, physical segregation of patients must be considered, and wards are effectively ventilated.

Online COVID-19 guidance

www.england.nhs.uk/coronavirus | GOV.UK | NHS.UK

7 **Staff testing:**

a. Twice weekly lateral flow antigen testing for NHS patient facing staff is implemented. Whilst lateral flow technology is the main mechanism for staff testing, this can continue to be used alongside PCR and LAMP testing.
b. If your trust has a high nosocomial rate you should undertake additional targeted testing of all NHS staff, as recommended by your local and regional infection prevention and control team. Such cases must be appropriately recorded, managed and reported back.

8 **Patient testing:**

a. All patients must be tested at emergency admission, whether or not they have symptoms.
b. Those with symptoms of COVID-19 must be retested at the point symptoms arise after admission.
c. Those who test negative upon admission must have a second test 3 days after admission, and a third test 5-7 days post admission.
d. All patients must be tested 48 hours prior to discharge directly to a care home and must only be discharged when their test result is available. Care home patients testing positive can only be discharged to CQC-designated facilities. Care homes must not accept discharged patients unless they have that person's test result and can safely care for them.
e. Elective patient testing must happen within 3 days before admission and patients must be asked to self-isolate from the day of the test until the day of admission.

Systems

Local systems must:

9 Assure themselves, with commissioners, that a trust's infection prevention and control interventions (IPC) are optimal, the Board Assurance Framework is complete, and agreed action plans are being delivered.

10 Review system performance and data; offer peer support and take steps to intervene as required.

Online COVID-19 guidance

www.england.nhs.uk/coronavirus | GOV.UK | NHS.UK

Appendix 2
IPC Gap Analysis

	IPC ACTION RECOMMENDED	STH POSITION	IDENTIFIED GAP AND/OR ACTION
1)	Staff consistently practice good hand hygiene and all high touch surfaces and items are decontaminated multiple times every day	Communicated as part of PPE guidance and regular updates Regular audits by ICNs Domestic staff increased to support increased cleaning	Nil
2)	Staff maintain social distancing in the workplace, when travelling to work (including avoiding car sharing and remind staff to follow public health guidance outside of the workplace	Communications organisation wide have been developed to support these requirements All areas have been required to complete a "covid safe" risk assessment and are in the process of reviewing that currently (6 month r/v) Guidance has been provided on how to car share with approval from the Clinical Expert Group (CEG). STH Test and Trace Team provide advice and support to staff regarding relevant guidance Car sharing guidance already exists to support training needs of students on community placement and to enable the GP collaborative to function	Specific CEG approved guidance being issued for car sharing, in preference over use of public transport for staff that need to car share .
3)	Staff wear the right level of PPE when in clinical settings, including use of face masks in non-clinical settings	Full PPE guidance provided by CEG and available on the COVID intranet site and micro guide PPE champions system in place, led by CEG	COVID infection control accreditation module has been deployed with 29 audits undertaken since October; module will be added to QUEST in January 2021.

		All areas clinical and non-clinical have a PPE champion and non-clinical areas have a link to a clinical care group for advice and support if required. CEG review all guidance Regular audits undertaken by infection control nurses (ICNs) COVID safe risk assessment includes PPE guidance for non-clinical areas	
4)	Patients are not moved until at least two negative test results are obtained, unless clinically justified	Patients are assessed on admission to the Trust, and assigned to either a symptomatic or asymptomatic pathway and cohorted with other patients on the same pathway. For both pathways, patients are tested on admission, if they are positive they are moved to a cohort ward with other positive cases, if they are negative they are moved to a grey ward, and assumed not to have COVID 19, these patients are tested again at day 5 in case they were incubating COVID 19 on admission.	If the guidance was implemented as stated patient flow would be significantly impacted. The view from CEG is that this should apply to symptomatic patients only. Laboratory Medicine continue to test the validity of the point of care tests available and once completed these could be used to mitigate the risks of asymptomatic transmission of COVID19 further. All admission patients are screened for COVID-19 the day 3 test once in place should mitigate the requirement for 2 negative screens A review of the risk assessment for nosocomial infection will be undertaken to ensure that it includes the issue of moving patients who could be incubating COVID 19.

5)	Daily data submissions have been signed off by the Chief Executive, the Medical Director or the Chief Nurse, and the Board Assurance Framework is reviewed and evidence of reviews is available.	System in place for sign off of daily data submissions reviewed by the Chief Executive, the Medical Director or the Chief Nurse and confirmed as robust. STH practice assessed against the BAF and presented to the Trust Executive Group	6 month progress review against the BAF is currently in progress to be presented to COVID TEG in January 2021.
6)	Where bays with high numbers of beds are in use, these must be risk assessed and where 2 m can't be achieved, physical segregation of patients must be considered, and wards are effectively ventilated	Social distancing in place for assessment areas on asymptomatic pathways, by closing of bed spaces All bed spacing in the Trust has been reviewed and action taken to ensure compliance (e.g. furniture removal/rearranging) Rediroom installation approved for area of higher risk such as the Respiratory support unit Air handling reviewed trust wide and advice taken from IPC consultants regarding usage of ward and a hierarchy of usage based on knowledge of ventilation in place.	Plan in place to install plastic screen curtains to ensure beds can safely be put back into action. These will initially be used in all direct admitting areas. Rediroom installation unsuccessful due to estate constraints
7)	Staff testing: a) Twice weekly lateral flow antigen testing for NHS patient facing staff is implemented. Whilst lateral flow technology is the main mechanism for staff testing, this can continue to be used alongside PCR and Lamp testing. b) If your trust has a high nosocomial	This is being rolled out in December 2020. Full outbreak system in place, led by Consultant	Standard operating procedures and logistic plans in place allowing lateral flow testing (LFT) to be rolled out to patient facing staff during December.. This will become the main method of asymptomatic staff testing. Any positive cases will need a laboratory swab before being logged nationally.

	rate you should undertake additional targeted testing of all NHS staff, as recommended by your local and regional infection prevention and control team. Such cases must be appropriately recorded, managed and reported back.	in Microbiology including relevant staff swabbing	
8)	Patient testing: a) All patients must be tested at emergency admission, whether or not they have symptoms b) Those who test negative upon admission must have a second test 3 days after admission and a third test 5-7 days post admission c) All patients must be tested 48 hours prior to discharge directly to a care home and	In place Day 5 testing in place In place	Day 3 testing planned, following deployment of LFT for staff, as the laboratory will have capacity to process the additional swabs Day 3 processes will need adding to e-whiteboards Digital team in process of creating reporting mechanism and visual reminders on e-whiteboards for Day 5 testing, Day 3 will be added when rolled out.