COVERSHEET	
Meeting	Board of Directors' meeting in PUBLIC
Paper Title	Infection Prevention and Control Report
Date of meeting	5th November 2020
Date paper was written	22nd October 2020
Responsible Director	Hayley Flavell, Director of Nursing
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Presenter	Hayley Flavell, Director of Nursing

EXECUTIVE SUMMARY

This report provides an overview of the Infection Prevention and Control key metrics including hospital acquired infections for September 2020. An update on COVID 19 is provided including the recent outbreaks at the Princess Royal Hospital in October 2020.

Key points to note by exception are:

- 1 post 48 hour CDiff case in September 2020
- MRSA screening was above the national target
- 2148 (29%) front line staff have now been vaccinated as part of the annual Flu campaign
- Princess Royal Hospital have reported 4 COVID-19 outbreaks in October 2020, the outbreaks have been reported an serious incident.

The report also provides a summary of the report received following the University Hospital North Midlands IPC Peer Review Visit which took place in August, the positive practices, issues and actions have been included.

An update on the IPC BAF is included, with 53 of the 63 key measures now RAG rated as green and actions in place to achieve or mitigate the risk associated with those measures which remain rated as amber.

The Board of Directors are asked to take assurance from the report.

Previously considered by	NA

The Board (Committee) is asked to:			
☐ Approve	☐ Receive	☐ Note	☑ Take Assurance
To formally receive and discuss a report and approve its recommendations or a	To discuss, in depth, noting the implications for the Board or Trust	For the intelligence of the Board without in-depth discussion required	To assure the Board that effective systems of control are in place

particular course of action	without formally approving it		

Link to CQC domain:				
☑ Safe	☑ Effective	☑ Caring	☑ Responsive	☑ Well-led

Link to strategic objective(s)	*Select the strategic objective which this paper supports* ☐ PATIENT AND FAMILY Listening to and working with our patients and families to improve healthcare ☐ SAFEST AND KINDEST Our patients and staff will tell us they feel safe and received kind care ☐ HEALTHIEST HALF MILLION Working with our partners to promote 'Healthy Choices' for all our communities ☑ LEADERSHIP Innovative and Inspiration Leadership to deliver our ambitions ☐ OUR PEOPLE Creating a great place to work
Link to Board Assurance Framework risk(s)	BAF 561 IF we do not have system-wide effective processes in place THEN we will not achieve national performance standards for key planned activity. BAF 1771 IF we do not have adequate resources, systems and processes in place THEN we cannot successfully manage the response to the outbreak of the COVID-19 virus effectively

Equality Impact Assessment	◉ Stage 1 only (no negative impact identified) ○ Stage 2 recommended (negative impact identified and equality impact assessment attached for Board approval)
Freedom of Information Act (2000) status	◉ This document is for full publication ○ This document includes FOIA exempt information ○ This whole document is exempt under the FOIA
Financial assessment	NA

1.0 INTRODUCTION

This paper provides a report on performance against the 2020/21 objectives for Infection Prevention and Control. It provides an update on hospital acquired infections: Meticillin-Resistant *Staphylococcus aureus* (MRSA) Clostridium Difficile (CDI), Meticillin-Sensitive Staphylococcus (MSSA) Escherichia Coli (E.Coli), Klebsiella and Pseudomonas Aeruginosa bacteraemia for September 2020.

It also provides updates on IPC initiatives and relevant infection prevention incidents.

2.0 KEY QUALITY MEASURES PERFORMANCE

This section of the report provides an update on hospital acquired infections: Clostridium Difficile, MRSA, MSSA, E.coli, Klebsiella and Pseudomonas Aeruginosa bacteraemia.

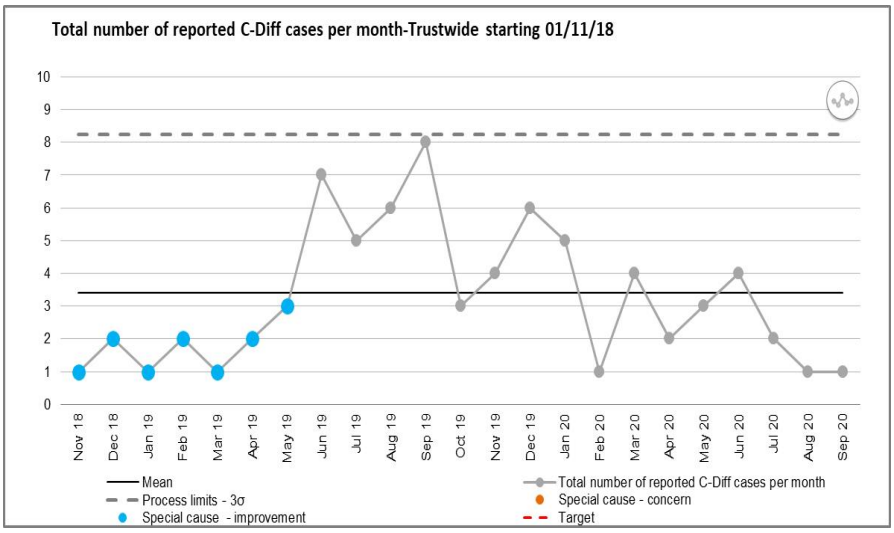
2.1 MRSA Bacteraemia

The Target for MRSA bacteraemias remains 0 for 2020/21. There were no MRSA bacteraemia infections reported in August 2020. The last MRSA bacteraemia was in April 2019.

MRSA Bacteraemia	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sept 20	Annual Target
Number of Cases	0	0	0	0	0	0	0

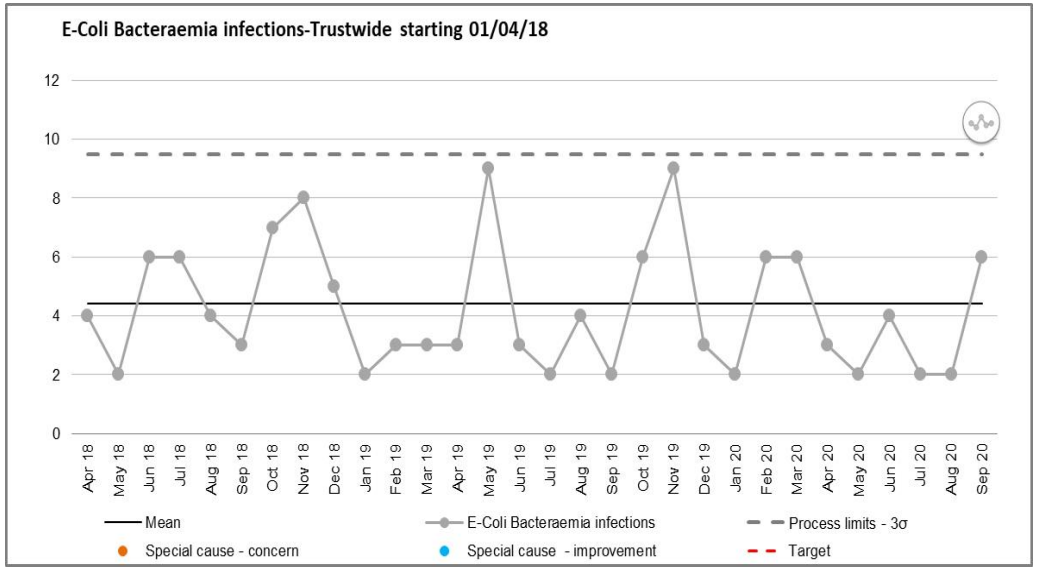
2.2 Clostridium Difficile

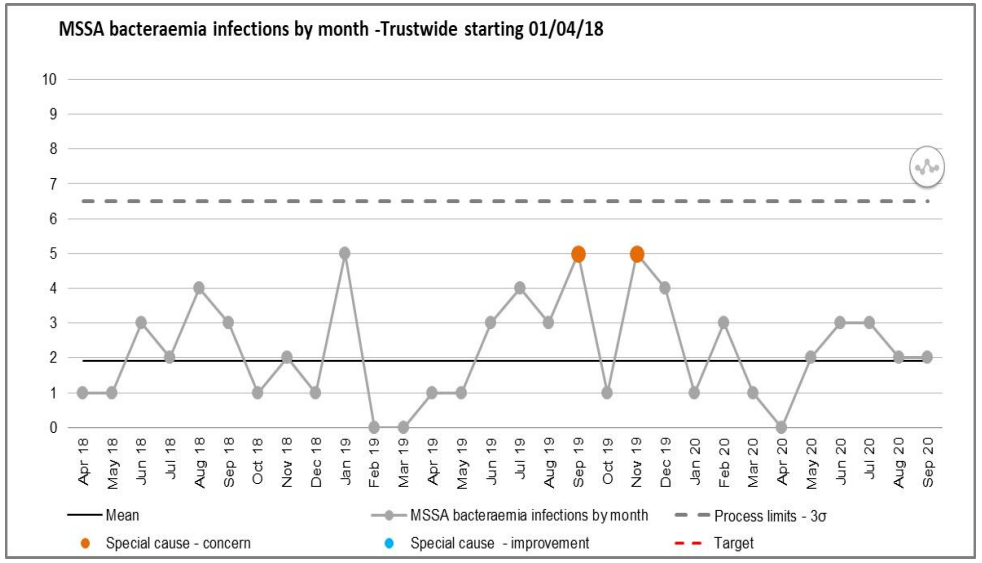
The target agreed with the CCG for this year is no more than 43 cases (same target as the previous year). Year to date there have been 12 cases of CDiff; the Trust remains below the trajectory YTD. Total number of C-Diff cases reported per month is shown:



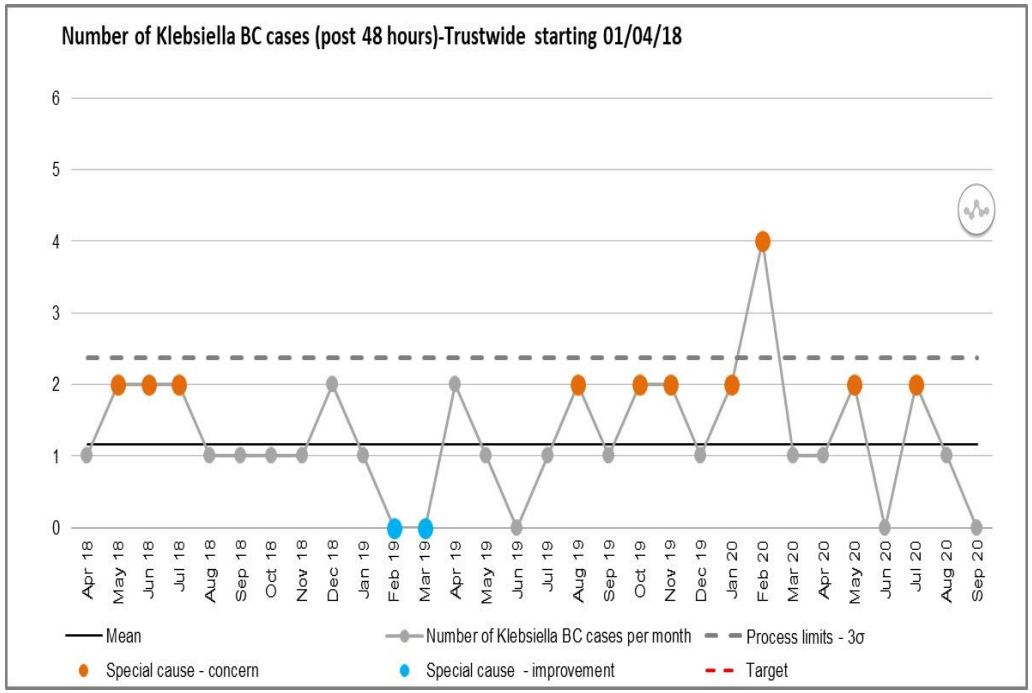
There was 1 cases of C difficile attributed to the Trust in September 2020. This case was a Post 48 hour case. The RCA is being undertaken to enable any deficits in care and learning to be identified and shared. Themes identified to date from the RCAs undertaken continue to include: timeliness of obtaining a stool sample, this has been disucssed with the senior nursing teams to re-enforce expecations in their clinical areas, and antibiotic prescribing.

2.3 E.Coli Bacteraemia The Number of E.Coli cases are shown:	**2.4 MSSA Bacteraemia**
There were six cases of post 48 Ecoli Bacteraemia in September 2020. Two of the 6 cases were considered to be device/intervention related and both were due to an infected biliary stent. The remaining 4 were not device related, the sources were considered to be lower urinary tract infection, and biliary.	All hospital attributed (> 2 days from admission) are reviewed by the consultant microbiologist. There were two cases of Post 48 hours MSSA Bacteremia in September 2020, one of which was considered to be device/intervention related with the cause considered to be an infected cannula. From October 2020, the decision has been made by the DIPC that any device related MSSA bacteremia will have a RCA completed.



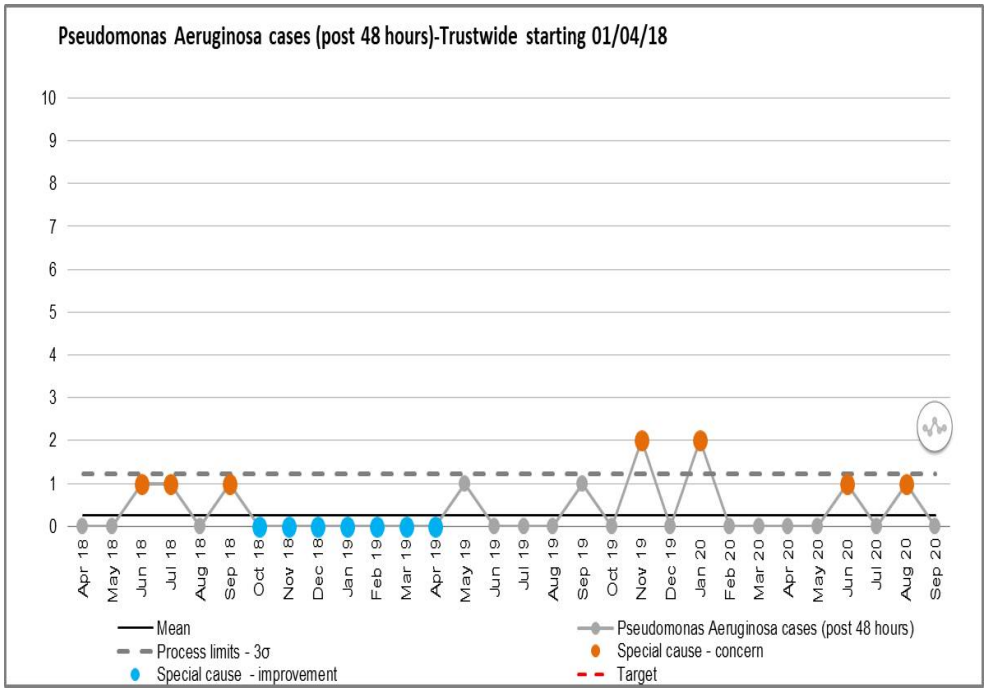


2.5 Klebsiella Bacteraemia (Post 48 Hours)



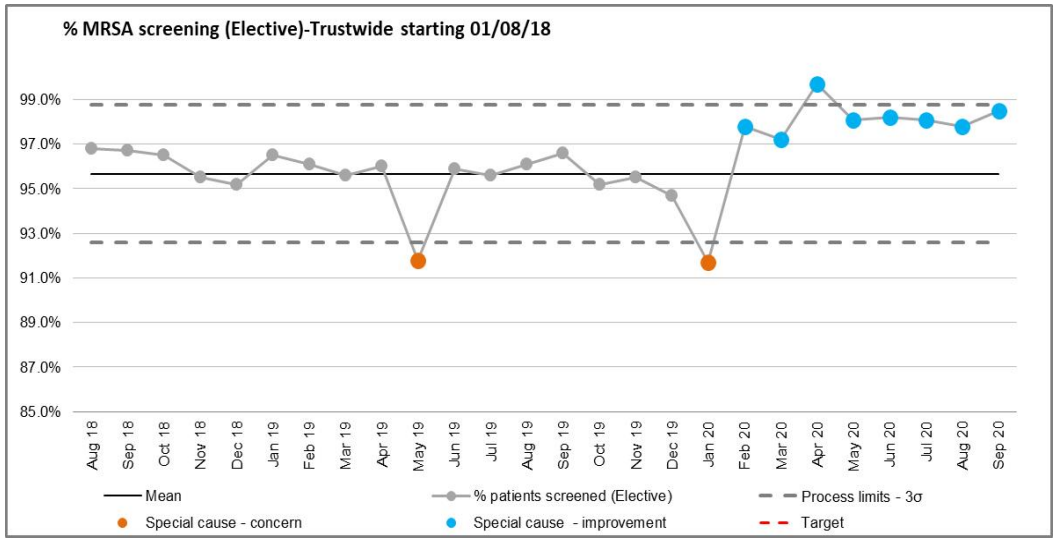
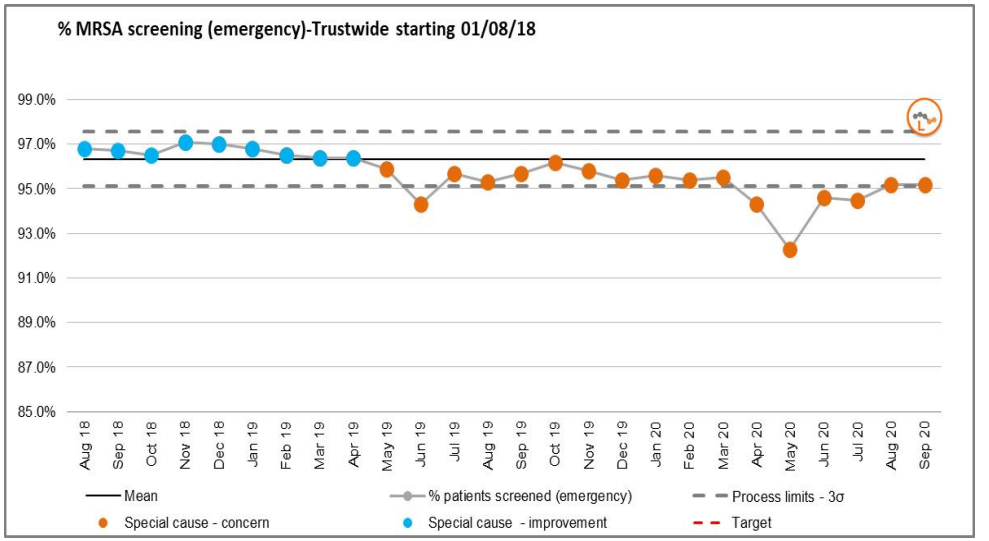
There were no cases of Post 48 hour Klebsiella Bacteraemia in September 2020.

2.6 Pseudomonas Aeruginosa (Post 48 Hours)



There were no cases of post 48 hour Pseudomonas aeruginosa in August 2020.

2.7 MRSA Screening

MRSA Elective Screening	MRSA Non-Elective Screening
	
MRSA Elective screening was above the 95% in September 2020 with a compliance of 98.5%. Elective MRSA screening continues to show special cause improvement, and has been above 97% since February 2020. However this is in the context of the significant reduction in elective activity during the COVID pandemic	In September 2020, 95.2% of cases were screened, which was above the 95% national target for the 2nd consecutive month. These results are discussed at the IPC Committee with the Head of Nursing for Emergency Care to ensure all staff are reminded of undertaking this in the Emergency Department before the patient is admitted; it has also been discussed with the other Heads of Nursing who cover the adult inpatient areas to ensure that if screening is not completed in ED this is actions once the patient arrives on the ward. Moving forward, the restructuring of the IPC governance arrangements with the introduction of an IPC Operational Group will enable a more focused approach to the operation al delivery of improvements through this Group.

2.8 Periods of Increased Incidence

C.Diff

There was a potential outbreak of 2 cases of C diff on Ward 11 in September 2020. An outbreak investigation was commenced, and the samples have been sent for typing. During the investigation it was identified that one of the rooms had not been HPV cleaned following discharge, this was not likely to the cause of the infection in the second patient though. There was also a lack of IPC knowledge on the ward, the ward matron has been tasked with addressing this in conjunction with the IPC team

Vancomycin Resistant Enterococci (VRE)

There were 6 cases of VRE on Ward 23 in September 2020. An outbreak investigation was commenced, the samples were sent for typing; to date 4 typing results have been received and confirmed as different to each other and therefore not linked. The action plan from the investigation process will be signed off by the lead nurse for IPC and the ward matron.

Extended Spectrum beta-lactamase (ESBL)

There were 4 cases of ESBL on Ward 26 in September/October 2020. An outbreak investigation was commenced, the samples were sent for typing and we are awaiting results. This ward has been having increased input from the IPC team due to concerns about IPC standards on the ward; this was in place prior to the identification of the outbreak. All other patients on the ward were screened for ESBL where appropriate, there were no further cases identified. An outbreak meeting has been held and the IPC team, the ward matron and the Deputy Head of Nursing for scheduled care continue to be heavily involved on the ward.

2.9 COVID 19

The Trust has now started to see a rise in the number of Covid–19 positive patients being admitted to the Trust. An average of 15-20 positive patients are being cared for daily in our Trust. In October 2020, the Trust has seen a number of outbreaks on the medical wards at the Princess Royal Hospital Site; these involve both patient to patient and staff transmission. These outbreaks have occurred on Ward 15/16, Ward 9, CCU and Ward 7. Outbreak meetings have taken place chaired by the DIPC, attended by NHSI/E IPC Lead, CCG and PHE.

The initial findings in relation to lapses in care related to the appropriate and timely screening of patients both on admission and at 5 days, as well as some issues with PPE compliance. Actions taken to date include:

- All patients and staff have been screened on the wards.
- Ward level processes implemented to ensure compliance with screening
- Scoping implementation of day 13 screening in line with regional request
- Refining the daily SQL report in relation to swabbing
- Re-launch of the Covid-19 Dashboard
- Exec Walk abouts
- Heads of Nursing, matrons and ward manager IPC ward walks took place 19th

and 20th October 2020 to identify issues and challenge poor practice
- Invited NHSI/E and the CCG to visit and undertake an IPC Assurance visit on 28th October 2020

These outbreaks have been raised as a Serious Incident. A further detailed report of these outbreaks will be included

Hospital Onset (HO) COVID-19

Hospital Onset (HO) COVID-19 is defined as illness onset (or positive first specimen) 15 days or more after admission. Probable Hospital Onset COVID-19 is defined as an illness onset (or first positive specimen date) between 8-14 days after admission.

All cases reported in the Trust in September 2020 were pre 7 days of admission. At the time of writing this report there had been 14 patients who tested positive for COVID > 14 days after admission (Hospital Onset COVID) and 10 patients who tested cases of COVID positive 8-14 days after admission (Probable Hospital Onset COVID).

3.0 Serious Incidents (SI) related to Infection Prevention & Control

All MRSA and CDiff cases that result in death (Part 1 of the death certificate) are reported as Serious Incidents. Those deaths on Part 2 of the death certificate are patients considered to have died *with* MRSA or CDI rather than *of* it. No Infection Control Serious Incidents were reported for the period of August 2020.

One case for a patient who had CDiff reported on Part 1 of the death certificate was raised as an serious incident September 2020. An RCA had already been completed for this incident. The patient was an oncology patient, with a poor prognosis who had had extensive antibiotics as part of her treatment pathway, nil omissions identified

4.0 Infection Prevention and Control Initiatives

University Hospital North Midlands IPC Peer Review Visit

A supportive peer review was also undertaken by the Infection Prevention and Control Team from the University Hospital North Midlands on the 14th August 2020. This review took place at the request of the interim Chief Nurse and aimed to provide the interim Chief Nurse/DIPC with independent assurance and recommendations in relation to the following:

- Cohorting decisions
- 2m distancing and management of all Inpatient and out- patient areas
- Theatre usage and surgical pathways
- Cleanliness schedules
- Environmental /equipment cleanliness
- Estates situation and options
- Personal Protective Equipment use (PPE) use

The positive points noted during the visit included:

- Compliance with BBE across the Trust was noted to be very good
- The Trust IPC Committee appears well organised with good agenda and robust minutes
- Governance, structural groups, interagency working and response from senior team appear robust and in line with those established in other NHS Trusts
- Areas were noted to mostly be tidy
- Good personal relationships between IPC and Estates
- Regular meetings of the Trust Decontamination Group and Water Safety Group.

The following key points were identified as requiring addressing during the review:

- Lack of isolation facilities
- Loss of bed capacity due to social distancing
- Environmental damage due to age of building
- Hand wash sink provision
- Social distancing issues around nurses stations
- Clutter in a small number of areas due to limited storage areas
- Lack of IPC involvement with some Estates services such as Legionella Control, Ventilation and Decontamination. However, this was improving through closer working with IPC and Estates

An action plan was developed by the IPC team following the visit. The IPC team are working with the Care Group Heads of Nursing, Estates and Facilities on the delivery of these actions which include:

- Address environmental/estates issues identified on the visit
- IPC Ops Group to be set up which can help drive and monitor some of the IPC improvements
- Establish process for annual mattress audits
- Ensuring nursing cleaning schedules completed and signed off twice daily
- Re-inforce social distancing across the organisation
- Ensure consistent nursing attendance at Decontamination Group, already in place for Water Safety Group

The action plan will be monitored via the monthly IPC Operational meeting chaired by the Deputy Director of Nursing.

IPC Initiatives

The majority of the IPC work during September 2020 has continued to be focused on the Covid-19 pandemic, preparations for the increasing numbers of patients in the hospital with the infection, the recent outbreaks of both Covid-19 and other infections and the restoration and recovery work which is ongoing.

The Infection Prevention and Control Team continue to undertake quality assurance audits. The team have also continued to contribute to the exemplar ward review assessment, these have continued to take place in the Emergency Departments and

adult inpatient wards in September and October 2020.

The seasonal Flu campaign is underway. The IPC team support this and undertake the Flu vaccination clinics. To date, 2148 front line staff (29%) have been vaccinated.

5.0 IPC Board Assurance Framework

NHSE/I issued an Infection Prevention and Control Board Assurance Framework in May 2020 for Trusts to use to asses themselves with regards to best practice and use as a tool to monitor actions required to ensure continuous improvement.

The IPC BAF has 10 Sections with 63 key lines of Inquiry. The IPC BAF is monitored monthly via the IPC Committee chaired by the DIPC/DoN. The Trust is now RAG rated as Green for 53 of these measures and amber for the remaining 10 measures.

There are ongoing actions being undertaken in relation to the remaining amber measures, these include full recruitment to the cleaning team, ensuring full compliance with PPE training, screening of all patients on admission and care in an isolation area which is challenging for the Trust due to the limited side rooms available so positive patients are cohorted on identified wards. Other actions include ensuring all staff “at risk” have had a risk assessment completed and the reduction of the movement of staff between areas which is also challenging as sometimes staff are required to move to maintain patient safety across all clinical areas. The IPC BAF is included in Appendix 1.

The CQC reviewed our IPC BAF in August 2020 with no concerns raised.

The BAF is reviewed monthly through the IPC Assurance Committee.

6.0 Recommendation

The Board of Directors are asked to take assurance from the report.

Appendix 1

Infection Prevention and Control Board Assurance Framework

RAG Key:

Action Complete	Action in Progress	Action off Track

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

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
	Systems and processes are in place to ensure:				
1.1	Infection risk is assessed at the front door and this is documented in patient notes	The Emergency department have a SOP for admissions, which covers a process to risk assess all patients as they arrive in ED. Navigator flow chart for PRH (00D).docx Update Managment of potentional Covid p Navigator flow chart for RSH.docx 24-RSH-ED Management of poter			Green
1.2	Patients with possible or confirmed COVID-19 are not moved unless this is essential to their care or reduces the risk of	All patients are screened on admission to the Trust as per national guidance – patients that are	It has been identified that the trust has a lack of	If no side rooms are available then positive patients	Amber

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
	transmission	identified as high risk of COVID cohorted on designated wards. Patients who are confirmed as positive are isolated in side rooms. See link for policy at bottom of document	side rooms that will be addressed by the Hospital Transformation Plan	are cohorted in a bay.	
1.3	Compliance with the national guidance around discharge or transfer of COVID-19 positive patients	All patients who are either positive or contacts of a positive patient are told they should complete self-isolation until 14 days from the first positive test. Patients that are going to Nursing Homes are screened prior to discharge as per national guidance. (See page 18 of SaTH COVID policy). Patient discharge information leaflet has been developed by corporate nursing.  COVID-19 Discharge Information Leaflet V There is a clinical pathway for patients discharged to Care Homes. Attached below:			Green

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
		UPDATED Pathway discharged patients F Covid 19 clinical pathway final 27.4.2(			
1.4	Patients and staff are protected with PPE, as per the PHE National Guidance	**STAFF** Staff have been trained to follow PHE guidance on PPE usage and have had donning and doffing training, there are posters in all clinical areas, and advice readily available on the Trust intranet. The compliance is recorded by corporate education: X:\StaffComplianceReports\Statutory & Mandatory Training Report\Covid-19 Report - May20 - Includes PPE & Hand Hygiene for HCA's & Nurses.xlsx The government has announced that from 15.06.2020 all staff whether clinical or non-clinical must wear a facemask while at work. **PATIENTS** When patients are transferred within the hospital or in other care settings			Green

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
		then they wear a face mask (see section 9.8 of SaTH COVID Policy – Policy link at the bottom of the document)			
1.5	National IPC Guidance is regularly checked for updates and any changes are effectively communicated to staff in a timely way	The National IPC guidance is checked daily and the IPC team receive the daily Gov.uk guidance. • It is also discussed on the Trust COVID call held once per week per week (from July 2020) chaired by the COO/MD. • All changes for escalation throughout the Trust are also reported through to the Covid 19 Incident Control Room which is in place 7 days a week 8-8pm coordinated by a Strategic commander. • There is a daily message sent out to staff from a member of the executive team, which communicates any changes. • The IPC team are visiting the clinical areas in the Trust daily.			Green

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
1.6	Changes to Guidance are brought to the attention of Boards and any risks and mitigating actions are highlighted	• The Chief Nurse/DIPC is present and updates the Executive Team at the weekly Executive Team meeting. • Review of Guidance, changes to this and risks and mitigations in relation to these are discussed at IPCC and reported to the Quality and Safety Assurance Committee. • The Trust Board is updated via the Quality and Safety Assurance Committee meeting chaired by a Non-Executive Director; the Quality Governance Paper is presented monthly to the committee and includes an update on Infection Prevention and Control. The Medical Director also provides a monthly update on COVID to the Committee. • A Highlight report from the Quality and Safety Committee is presented at the Trust Board by the Non-Executive Director. • Weekly updates are provided to the Covid committee of any significant issues, with further • IPC BAF presented to trust Board In June 2020; Next Update due for September Board			Green
1.7	Risks are reflected in risk registers and the Board Assurance Framework where	Risks relating to COVID have been placed on the Trust Risk Register.			Amber

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
	appropriate	The Trust has a COVID risk 1771 on the BAF. BAF risk 1771 was reviewed by the Trust Board on 28.05.2020 – minutes to be added as evidence following ratification at Trust Board in July 2020 There is a risk on the Corporate Nursing Risk Register No 1855 relating to the provision of 7 day working for the IPC team Risk Register No 826, relates to the provision of cleaning 7 days a week and the delivery of additional cleaning services in-relation to extended hours of working.		Business case being developed for substantive 7 day service provision Recruitment to substantive cleaning posts in progress, temporary staff being utilised to mitigate gaps until full recruitment has taken place	
1.8	Robust IPC risk assessment processes and practices are in place for non COVID-19 infections and pathogens	This is normal practice in the Trust. There are policies in place for non-COVID infections that are in date. http://intranet.sath.nhs.uk/infection_control/Infection_control_policies_and			Green

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
		_related_information.asp			
2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections					
Systems and processes are in place to ensure:					
2.1	Designated teams with appropriate training are assigned to care for and treat patients in COVID-19 isolation or cohort areas	The Trust has designated areas for COVID patients, and training has taken place for all staff on PPE usage and Hand Hygiene. This has also been done for areas which are not identified as specific COVID wards. X:\StaffComplianceReports\Statutory & Mandatory Training Report\Covid-19 Report - May20 - Includes PPE & Hand Hygiene for HCA's & Nurses.xlsx			Green
2.2	Designated cleaning teams with appropriate training in required techniques and use of PPE, are assigned to COVID-19 isolation or cohort areas.	• All Cleanliness technicians are trained to complete all levels of cleaning required to all risk category wards. • All staff that are able to wear an FFP3 mask can now do so. • Training of the use of PPE has been cascaded to all staff from the Cleanliness Supervisors and Cleanliness Managers on each site.	Agency cleaning staff are also being used alongside substantive members of staff under full recruitment for the extended 24/7 cleaning service has taken place.	Both cleaning contractors used (Brite Start/Vortex) have a site (estates) and a local departmental induction carried out by the cleanliness supervisor and or	Amber

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
		• Staff are assigned to their own wards and departments, therefore current COVID-19 isolation and cohort areas have their own Cleanliness Technician for the duration of their 6 hour shifts, with additional support on each cohort ward of 3 hours. • Evening Cleaning on all wards has been implemented as from May 2020 and this consists of all touch points, floors, toilets and bathrooms, replenishment and the emptying of waste bags. • A&E on both sites are now covered for cleaning 24/7	Further review of staffing being undertaken to ensure the level of cleaning and support in place across the Trust to reduce nosocomial transmission	cleanliness manager (site respective) and are trained to SaTH Cleanliness team standards. For the first 2 weeks they buddy substantive staff. Facilities hold all RAMS for cleaning contractors we use and follow the management of contractor policy HS21. External Peer Review undertaken in August 2020. Report from visit awaited	
2.3	Decontamination and terminal decontamination of isolation rooms or cohort areas is carried out in line with PHE and other national guidance	The Trust uses Tristel to decontaminate areas as per guidelines. The Trust also additionally use HPV cleaning when able to access areas			Green

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
		and Facilities keep an account of areas which have been HPV cleaned. Facilities have compiled a proactive/reactive dashboard on HPV/UV cleaning which is kept on shared drive. Z:\Facilities\Cleanliness Decontamination Dashboard			
2.4	Increased frequency (at least twice daily), of cleaning in areas that have higher environmental contamination rates as set out in the PHE and other national guidance	Cleaning service is accessible across the Trust as noted above & cleaning frequency has increased to twice daily as from May 2020. Ward Staff are also cleaning lockers, tables and contact points twice daily (as per PHE guidance) and cleaning records are completed.			Green
2.5	Attention to the cleaning of toilets/bathrooms, as COVID-19 has frequently been found to contaminate surfaces in these areas	Facilities undertake a full bathroom clean twice daily & touch points are cleaned three times daily.			Green
2.6	Cleaning is carried out with neutral detergent, a chlorine based disinfectant in the form of a solution at a minimum strength of 1,000ppm available chlorine, as per national guidance. If an alternative disinfectant is used, the local infection prevention and control team (IPCT) should	Environmental cleaning is carried out with detergent/chlorine mix (Tristel Fuse). Contingency plan to use detergent clean followed by sodium hypochlorite (Milton) 1,000ppm in case of Tristel Fuse shortage			Green

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
	be consulted on this to ensure that this is effective against enveloped viruses.				
2.7	Manufacturers' guidance and recommended product 'contact time' must be followed for all cleaning/ disinfectant solutions/ products	Facilities SOP follows recommended contact time of 5 minutes.			Green
2.8	'frequently touched' surfaces, e.g. door/toilet handles, patient call bells, over-bed tables and bed rails, should be decontaminated at least twice daily and when known to be contaminated with secretions, excretions or body fluids as per national guidance	Facilities confirm that toilet door handles cleaned 3 x daily, Heads of Nursing confirmed that call bells/over bed tables & bed rails cleaned twice daily by housekeepers.			Green
2.9	Electronic equipment, e.g. mobile phones, desk phones, tablets, desktops and keyboards should be cleaned at least twice daily as per national guidance	Heads of Nursing confirm that all electronic equipment is cleaned twice daily. This is reviewed by the IPC team on their ward visits.			Green
2.10	Rooms/areas where PPE is removed must be decontaminated, timed to coincide with periods immediately after PPE removal by groups of staff (at least twice daily) as per national guidance	Facilities decontaminate these areas twice daily.			Green
2.11	Linen from possible and confirmed COVID-19 patients is managed in line with PHE and other national guidance and the appropriate precautions are taken	Linen is handled as per Trust Policy/National guidance. http://intranet/Facilities_Department/Policies_and_Procedures.asp			Green
2.12	Single use items are used where	Single use items are used as per		If this cannot be	Green

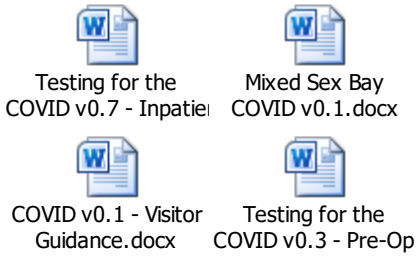
Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
	possible and according to Single Use Policy	policy.		followed then reuse should follow PHE guidelines: https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control/managing-shortages-in-personal-protective-equipment-ppe	
2.13	Reusable equipment is appropriately decontaminated in line with local and PHE and other national policy	Power Air Purified Respirator units with helmet head-tops are decontaminated according below SOP.  Hood Usage and Decontamination SOP A process for decontaminating reusable tight-fitting Respiratory Protective Equipment (half mask or full face respirators with P3 filters)			Green

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
		V2 - Usage and Decontamination of F The Trust is not currently re-using any FFP3 respirators beyond a single task or session. Re-useable (communal) non-invasive equipment is decontaminated: • Between each patient and after patient use • After blood and body fluid contamination • At regular intervals as part of equipment cleaning http://intranet.sath.nhs.uk/document_library/viewPDFDocument.asp?DocumentID=10065 If required the Trust have a plan and SOP (attached below) for reusable (washable) surgical gown but this has not been required as yet.			

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
		launderable gowns Standard Operating F The Trust is using single use eyewear/visors and not reusable – however guidance is available on how to decontaminate if there is a procurement issue. https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control/managing-shortages-in-personal-protective-equipment-ppe			
2.14	Review and ensure good ventilation in admission and waiting areas to minimise opportunistic airborne transmission	• Increased air-changes via mechanical ventilation to ensure air dilution. • Areas have been encouraged to open windows where possible • Non circulating portable air conditioning units may be considered			Green
3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance					
Systems and process are in place to ensure:					
3.1	Arrangements around anti-microbial stewardship are maintained	• Antibiotic Policy in place.	Pharmacy are unable to see every inpatient chart every	Pharmacy seeks to prioritise undertaking a full	Amber

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
		• Antibiotic prescriptions are reviewed by a pharmacist wherever possible. • eScript pharmacy program used to record antibiotic prescriptions, data entered by pharmacy staff and occasionally doctors when undertaking discharge summaries. • Prescriptions are screened to ensure compliance with Trust Antibiotic Policy and Stewardship, including choice, course length, and review periods. • Overall antibiotic usage is lower than average see Fingertips Portal. High usage of WHO access group antibiotics due to longstanding antibiotic policy decisions which are reviewed regularly.	day, currently due to COVID 19 & the absence of Electronic Prescribing and Medicines Administration system. No ability to monitor prospectively antibiotic prescriptions from Accident and Emergency or Outpatient clinics at present.	Medicines Reconciliation as soon as possible after admission and to see all patients at discharge. See Trust board sign off for Wave 3 of NHSE/I funding for EPMA system. This is a 2-3 year plan. Business case due for submission on 15th September 2020	
3.2	Mandatory reporting requirements are adhered to and boards continue to maintain oversight	IPC continue to report organisms, such as MSSA, Ecoli, Pseudomonas, Klebseilla and MRSA to PHE. This information also goes to the Quality and Safety Assurance Committee monthly chaired by a Non-Executive Director.			Green

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
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					
Systems and process are in place to ensure:					
4.1	Implementation of national guidance on visiting patients in a care setting	The Trust adopted the national guidance on suspending visiting. http://intranet.sath.nhs.uk/Library_Intranet/documents/Coronavirus/Visiting_Suspended.pdf The Trust is reviewing the newly issued guidance on 06.06.20 to enable adoption.  C0524 Visiting healthcare inpatient s The trust has adopted the guidance on compassionate visiting for end of life care. http://intranet.sath.nhs.uk/Library_Intranet/documents/Coronavirus/EndofLife/eol care visiting guidelines.pdf	New National Guidance for visiting issued on 06.06.20 not yet implemented in line with the rest of STP	Individual visiting requests are being reviewed and actioned in line with national guidance. End of life Care visiting line with national guidance Visiting restrictions have been revised in Maternity, Neonatal unit, paediatrics and Gynaecology. Planned pilots to increase visiting in some wards in scheduled care and unscheduled being developed for September	Amber

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
				2020	
4.2	Areas in which suspected or confirmed COVID-19 patients are where possible being treated in areas clearly marked with appropriate signage and have restricted access	The Trust has adopted a traffic light system for areas. http://intranet.sath.nhs.uk/Library_Intranet/documents/Coronavirus/PPE/TrafficLight_Main.pdf			Green
4.3	Information and guidance on COVID-19 is available on all Trust websites with easy read versions	The Trust has a designated COVID 19 page on the intranet where all information is easily accessible. http://intranet.sath.nhs.uk/coronavirus/default.asp Easy read versions available: 			Green
4.4	Infection status is communicated to the receiving organisation or department when a possible or confirmed COVID-19 patient needs to be moved	• All infection status information is included in any transfer information including COVID status.			Green

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
		• The Trust is trialing use of a COVID sticker in the patients' notes. • Lead Nurse SC has requested approval for costing of stickers before this can be rolled out Trust wide. • Use of these stickers will be monitored via the IPC Quality Walks			
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					
Systems and process are in place to ensure:					
5.1	Front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed COVID-19 symptoms and to segregate them from non COVID-19 cases, to minimise the risk of cross-infection as per national guidance	See Section 1: Emergency Department SOP (1.1).			Green
5.2	Mask usage is emphasised for suspected individuals	Surgical facemasks are used by all staff in clinical areas as all patients are treated as potentially positive. Patients are encouraged to wear surgical facemasks when in transport or in hospital corridor areas.			Green

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
5.3	Ideally segregation should be with separate spaces, but there is potential to use screens, e.g. to protect reception staff	Screens have been purchased for outpatient administration areas where unable to maintain social distancing.			Green

5.4	For patients with new-onset symptoms, it is important to achieve isolation and instigation of contact tracing as soon as possible	• Patient is isolated or cohorted appropriately
		• Contact tracing is commenced upon positive result
		  ○ This is done by IPC team who look back 48 hours following a positive result of bay contacts via the SQL
		  ○
					Green

5.5	Patients with suspected COVID-19 are tested promptly	• All patients are tested for COVID when the decision to admit has been made. • High risk cases are transferred to the identified COVID wards. • Low risk patients are screened and moved if positive swab result obtained with the bay they vacate then becoming a contact Bay • Any inpatients that develop new symptoms are tested immediately. http://intranet.sath.nhs.uk/document_library/viewPDFDocument.asp?DocumentID=10065			Green

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
		• 5 day rescreen for any negative cases has been introduced			
5.6	Patients that test negative but display or go on to develop symptoms of COVID-19 are segregated and promptly re-tested and contacts traced	The Trust policy advises actions to take when this happens. Please refer to Section 9.1 of COVID policy (link at bottom of document).			Green
5.7	Patients that attend for routine appointments who display symptoms of COVID-19 are managed appropriately	Where possible routine appointments are being carried out over the telephone, when a patient must attend in person, information regarding COVID symptoms are included in their appointment letter. Posters are displayed in OPD's, advising patients who are symptomatic not to enter the buildings.			Green
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					
Systems and process are in place to ensure:					

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
6.1	All staff (clinical and non- clinical) have appropriate training, in line with latest PHE and other guidance, to ensure their personal safety and working environment is safe	All staff should have received training on hand hygiene, PPE usage relevant to their roles. Further training is provided as required. X:\StaffComplianceReports\Statutory & Mandatory Training Report\Covid-19 Report - 03Apr20 - includes Hand Hygiene, PPE Video & MaskFit.xls	There are some members of staff who have not accessed this training or have not recorded their compliance. The Heads of Nursing report that the specific COVID data provided by corporate education does not match the monthly mandatory training report.	Ward managers, Matrons are to ensure that staff have completed the required training. All managers have been contacted by the IPC team to ensure their staff have completed the training and that the details of staff who have completed training has been provided to the education department to ensure records are correct Corporate Education Department Manager is reviewing data for accuracy and to	Amber

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
				feedback to Care Groups in relation to compliance. Local records being held by departments of staff trained	
6.2	All staff providing patient care are trained in the selection and use of PPE appropriate for the clinical situation and on how to safely don and doff it	All staff should have been trained in the use of and donning and doffing of PPE. There are posters available for this and all staff should have access to the Trust intranet which also has this information accessible. http://intranet.sath.nhs.uk/coronaviruses/ppevideos.asp On 28 May all departments completed a PPE audit.	As above	As above Donning and doffing training has been provided by IPC Team	Amber
6.3	A record of staff training is maintained	Any training that staff attend is recorded by the Trust Corporate Education team, and this information	The Heads of Nursing report that the specific COVID	Corporate Education Department	Amber

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
		is reported to all Ward Managers (link as above)	data provided by corporate education does not match the monthly mandatory training report due to delays in local training data being provided to Education Department for updating centrally.	Manager to review and scrutinise data for accuracy. Local records being held by departmetns of staff trained	
6.4	Appropriate arrangements are in place that any reuse of PPE in line with the CAS alert is properly monitored and managed	Any CAS alerts which the Trust receives would be fed through the Trust COVID incident control room and be communicated to relevant staff across the Trust. This is monitored by Ward Managers on a daily basis, and is included within the IPC QWW audits and on 28 May all departments I completed a PPE audit			Green
6.5	Any incidents relating to the re-use of PPE are monitored and appropriate action taken	At present the only PPE in the Trust that is reusable is the Hoods and any incidents regarding this would be raised to the Trust COVID incident room, and Health and Safety.			Green
6.6	Adherence to PHE national guidance on the use of PPE is regularly audited	The IPC team visit clinical areas every day which includes monitoring			Green

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
		PPE use. The IPC QWW have been re-launched with a new format which will also monitor PPE usage. Any non-compliance is addressed at the time. On 28 May all departments completed a PPE audit.			
6.7	Staff regularly undertake hand hygiene and observe standard infection control precautions	Bi monthly hand hygiene audits are undertaken on all wards & departments X:\HighImpactInterventions IPC Team undertake Quality Ward Walks which includes standard IPC precautions Y:\InfectionControl\Quality Walks\April 20- March 21\Quality Walks by year May 20 - March 21.xls IPC Nurses visit wards daily & observe practice & educate			Green
6.8	Hand dryers in toilets are associated with greater risk of droplet spread than paper towels. Hands should be dried with soft, absorbent, disposable paper towels from a dispenser which is located closed to the sink but beyond	Hand dryers have been removed and replaced with paper towel dispensers			Green

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
	the risk of splash contamination, as per national guidance				
6.9	Guidance on hand hygiene, including drying, should be clearly displayed in all public toilet areas as well as staff areas	All toilets have posters with hand hygiene guidance			Green
6.10	Staff understand the requirements for uniform laundering where this is not provided on site	All staff change into their uniform at work Uniforms should be transported home in a disposable plastic bag, which can then be washed separately from other linen in a half load then iron or tumble dry for at least thirty minutes. http://intranet.sath.nhs.uk/document_library/viewPDFDocument.asp?DocumentID=10065			Green
6.11	All staff understand the symptoms of COVID-19 and take appropriate action in line with PHE and other national guidance, if they or a member of their household displays any of the symptoms	Staff are requested to phone the HR sickness absence line if they are displaying Covid 19 symptoms. Staff are advised by this single point of referral to self-isolate if they or their family members are symptomatic. HR will then refer member of staff for screening			Green
7. Provide or secure adequate isolation facilities					

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
Systems and process are in place to ensure:					
7.1	Patients with suspected or confirmed COVID-19 are isolated in appropriate facilities or designated areas where appropriate	• Any patients who are tested positive are isolated in side rooms. • Suspected cases are cohorted as appropriate in high and low risk bays.		If positive patients cannot be isolated in a side room, then they will be cohorted in a bay of positive patients	Green
7.2	Areas used to cohort patients with suspected or confirmed COVID-19 are compliant with the environmental requirements set out in the current PHE national guidance	The Trust follows national guidance (section 4.4.3).			Green
7.3	Patients with resistant/alert organisms are managed according to local IPC guidance, including ensuring appropriate patient placement	All patients with alert/resistant organisms are managed as per normal Trust policy.			Green
8. Secure adequate access to laboratory support as appropriate					
Systems and process are in place to ensure:					
8.1	Testing is undertaken by competent and trained individuals	• The laboratory at SaTH is UKAS accredited • All staff are HCPC registered • Quality assurance training and competence assessments are all in place.			Green

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
8.2	Patient and staff COVID-19 testing is undertaken promptly and in line with PHE and other national guidance	Staff testing programme is in place for all symptomatic staff who contact the helpline in line with PHE and national guidance STW STP FINAL COVID19 Testing Prot Patient testing is in place in accordance with National and PHE guidance for all admissions over 24hours, and for patients who are discharged to a care setting. Staff and Patient Testing Programme - Antibody testing has been launched in the Trust with a booking system in place. This is prioritised initially for staff working in ED, ITU, Respiratory Wards, AMU's and Phlebotomy at both sites. For roll out plan see below:			Green

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
		 Copy of Antibody testing 6 week plan v			
8.3	Screening for other potential infections takes place	All screening for other organisms usually monitored continue to be performed in the as per guidelines			Green
9.	**Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections**				
	Systems and process are in place to ensure:				
9.1	Staff are supported in adhering to all IPC policies, including those for other alert organisms	The IPC team monitor daily alerts and ensure staff follow the appropriate policy, this includes phone calls and daily ward visits which monitor this. This is also reported to Trust IPCC committee, via care group reports and IPC team QWW reports.			Green
9.2	Any changes to the PHE national guidance on PPE are quickly identified and effectively communicated to staff	The National IPC guidance is checked daily and the IPC team receive the daily Gov.uk guidance.			Green

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
		• It is also discussed on the Trust COVID Daily Call chaired by the COO/MD. • All changes for escalation throughout the Trust are also reported through to the Covid 19 Incident Control Room which is in place 7 days a week 8-8pm coordinated by a Strategic commander. • There is a daily message sent out to staff from a member of the executive team which communicates any changes. • The IPC team are visiting the clinical areas in the Trust daily.			
9.3	All clinical waste related to confirmed or suspected COVID-19 cases is handled, stored and managed in accordance with current national guidance	All clinical waste is disposed of as per national guidance. See section 10 of SaTH COVID Policy linked at bottom of document.			Green
9.4	PPE stock is appropriately stored and accessible to staff who require it	The stock of PPE is continually monitored, there is a procurement conference call daily, and the Trust send a daily PPE submission to the Regional West Midlands COVID. Procurement are available from 7.30am until 11pm Monday to Friday. Saturday and Sunday 7.30am until 1pm from 11.30pm-7.30am daily			Green

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
		there is a stores and procurement person on call to allow staff to contact if required. SaTH are also part of the LHRP PPE Task and Finish group.			
10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection					
Appropriate systems and process are in place to ensure:					
10.1	Staff in 'at-risk' groups are identified and managed appropriately including ensuring their physical and psychological wellbeing is supported	Staff are risk assessed by managers and appropriate mitigation taken including remote working / working away from high risk areas. Staff in at risk groups have been prioritised for remote working. A range of support activities have been put in place for staff during this time including: • Comprehensive FAQs for staff • Staff App – Regularly updated with guidance • Team Prevent – Managers Advice Line (Occupational Health)	**Risk Category Total % Assessed** BAME 55+ 100% White Over 60 55% Male 71% Health Risk 100% Pregnancy 100%	On-going work to complete the rest of the assessments	Amber

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
		• Employee Assistance Programme • HR Advice and Support - Extended Hours Support for COVID-19 • SaTH Trained Listeners - Hotline Coaching hotline • A free wellbeing support helpline • Peer-to-Peer Listening • Coaching and listening ear support lines available • Redeployment Coaching Support • Wellbeing Hubs • Headspace - Free subscription • Trust Coaches • Freedom to Speak Up Guardians • Accommodation for Staff in Critical Service Roles Staff are being risk assessed taking into consideration the health, age, ethnicity and gender. The Trust is ensuring that all BAME staff have had a risk assessment by the end of June.			

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
10.2	Staff required to wear FFP reusable respirators undergo training that is compliant with PHE national guidance and a record of this training is maintained	Staff are fit-tested to FFP3s and more recently FFP2s, in accordance with HSE guidance on tight-fitting RPE. The Trust uses both qualitative and quantitative (ambient particle counting) methods. During the course of the fit test staff are trained to don the respirator correctly, and to perform a fit check specific to the valved/ unvalved type of respirator they are fitted to. Reports on numbers fit-tested are submitted to the incident command room twice weekly, and a recent submission is attached for information. http://intranet.sath.nhs.uk/health/FFP3_Mask_Fit_Testing.asp Practice in the fit testing open sessions conforms to HSE guidance on reducing the risk of transmitting coronavirus during the fit test, and this information was also cascaded out to Care Group fit testers for local implementation on 25 March 2020 and 6 April 2020, via email.			Green

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
		The PHE videos covering donning and doffing of PPE, including FFP3s, have been promoted via the Trust intranet and via sessions held in the Education Centre lecture theatres. Training records relating to those videos are held on ESR, and a report is available on request from Tom George, Corporate Education.			
10.3	Consistency in staff allocation is maintained, with reductions in the movement of staff between different areas and the cross-over of care pathways between planned and elective care pathways and elective care pathways and urgent and emergency care pathways, as per national guidance	**USC** – due to the current vacancies and the staff sickness this can be challenging. This is kept to a minimum where possible. **SC** –there is some movement of staff to cover sickness/gaps in rosters, however this is kept to a minimum. The elective ward is protected. **Women's and Children's Services** – Paediatrics and Neonates allocate staff between Covid /Non Covid/symptomatic areas. Gynae – there are only 2 RN's on shift, so can be a challenge where joint RN input is required. Allocation of 1RN/1HCA where possible is the aim with the least interaction as	There is still some movement of staff between areas to ensure safe provision of staffing due to gaps	Matrons are responsible for ensuring daily staffing plans are in place which mitigate the movement of staff between areas but maintain safety and that these are communicated to the Clinical Site Team out for out of hours. Monthly staffing report provided to Workforce assurance	Amber

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
		possible. **Maternity** – this area is challenging as there are women on the planned and unplanned pathways in the same areas and staff will be caring both groups of patients. There is a dedicated team running the planned Caesarean Section list		committee	
10.4	All staff adhere to national guidance on social distancing (2 metres) wherever possible, particularly if not wearing a facemask and in non-clinical areas	Staff are expected to socially distance & wear facemasks in clinical areas. As from Monday 15th June in line with newly issued national guidance staff will be wearing facemasks in corridors and if not socially distanced in offices			Green
10.5	Consideration is given to staggering staff breaks to limit the density of healthcare workers in specific areas	Breaks are staggered on wards/departments. Staff are also encouraged to maintain the 2m social distancing.			Green
10.6	Staff absence and well-being are monitored and staff who are self-isolating are supported and able to access testing	The Trust had set up a 7 day a week sickness line for staff to call and registered their absence. This is monitored and reported daily. Staff that are required to isolate are automatically referred for testing at			Green

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
		our local drive through testing sites and test results are processed on site at our lab.			
10.7	Staff that test positive have adequate information and support to aid their recovery and return to work.	The feedback of results is provided via our system occupational health team. The information on results and advice is provided to staff via qualified occupational health professionals that can provide support and advice to aid recovery. Staff only return to work when fully fit and do so as part of the return to work process. This includes a return to work discussion with their manager and completion of return to work assessment. This details any known risks underlying health conditions any adjustments that need to be made and referral to occupational health if required.			Green

SaTH COVID Policy Link: http://intranet.sath.nhs.uk/document_library/viewPDFDocument.asp?DocumentID=10065