The Shrewsbury and Telford Hospital NHS Trust

Board of Directors' Meeting
7 January 2021

Agenda No.	011/21			
Report	Infection Prevention and Control Report			
Executive Lead	Hayley Flavell, Director of Nursing			
	Link to strategic pillar:		**Link to CQC domain:**	
	Our patients and community		Safe	√
	Our people		Effective	√
	Our service delivery	√	Caring	√
	Our partners		Responsive	√
	Our governance	√	Well Led	√
	Report recommendations:		**Link to BAF / risk:**	
	For assurance	√	561, 1771	
	For decision / approval		**Link to risk register:**	
	For review / discussion	√		
	For noting			
	For information			
Executive summary:	This report provides an overview of the Infection Prevention and Control key metrics including hospital acquired infections for November 2020. Key points to note by exception are: • There were 2 post 48 hour CDiff cases in November 2020; the Trust remains below the trajectory YTD and is set to achieve the target of no more than 43 cases in 2020/21 • The MRSA screening of emergency admissions has been achieved for the last 4 months • There were 5 MSSA bacteraemia cases, however only 2 were considered to be device related, RCAs are being carried out for these cases • During the second wave of the Covid-19 pandemic to date there have been: - A total of 22 outbreaks - 198 patients and 117 staff have been affected - 9 outbreaks remain ongoing A summary of the actions completed from action plan developed following the Covid-19 assurance visits is included. With 21 of the 39 actions having been completed. The IPC BAF has been updated and is included in this report. 53 of the 63 items are RAG rated as Green, actions and mitigations are in place for the remaining 10 amber items			
Appendices	Appendix 1: IPC BAF (Updated December 2020)			

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 November 2020. An update in relation to Covid-19, the recent outbreaks and actions in relation to these is provided. It also outlines any recent 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.

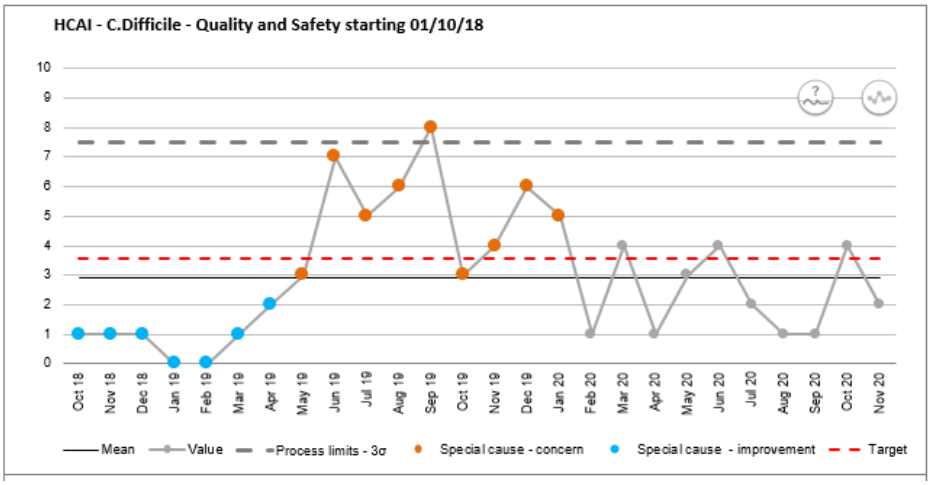
2.1 MRSA Bacteraemia

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

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

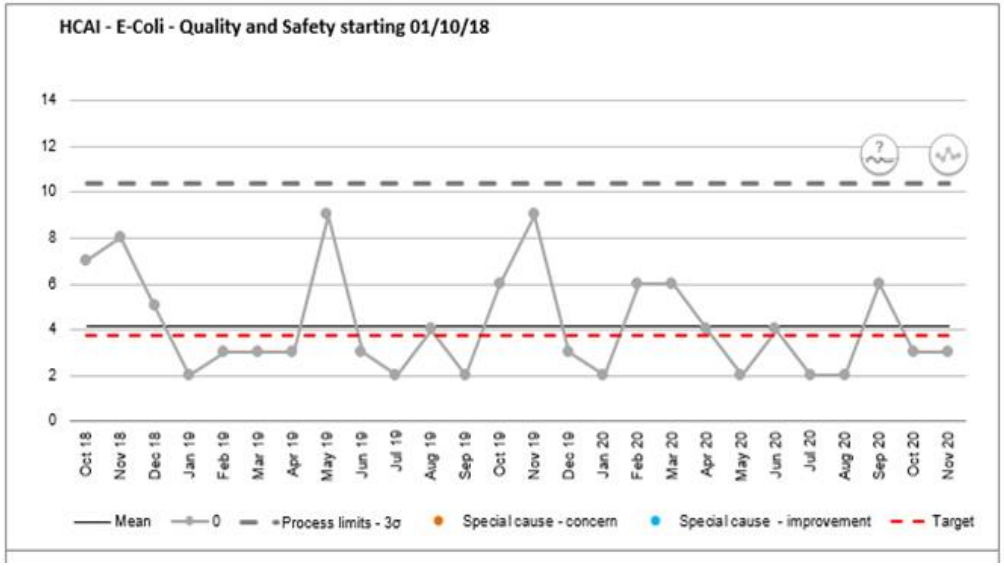
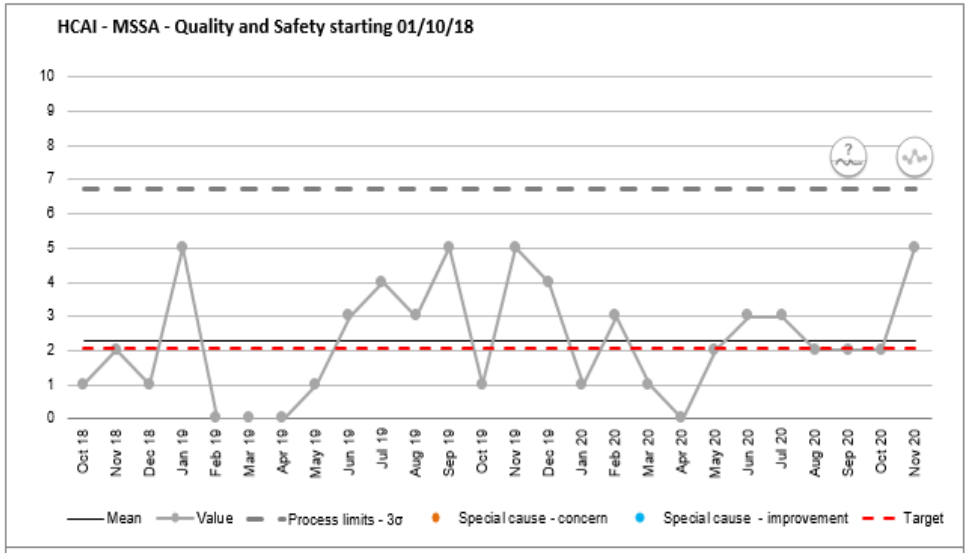
2.2 Clostridium Difficile

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 18 cases of CDiff against a target of 24 cases by month 8. The Trust remains below the trajectory YTD and on track for the target to be met. Total number of C-Diff cases reported per month is shown:

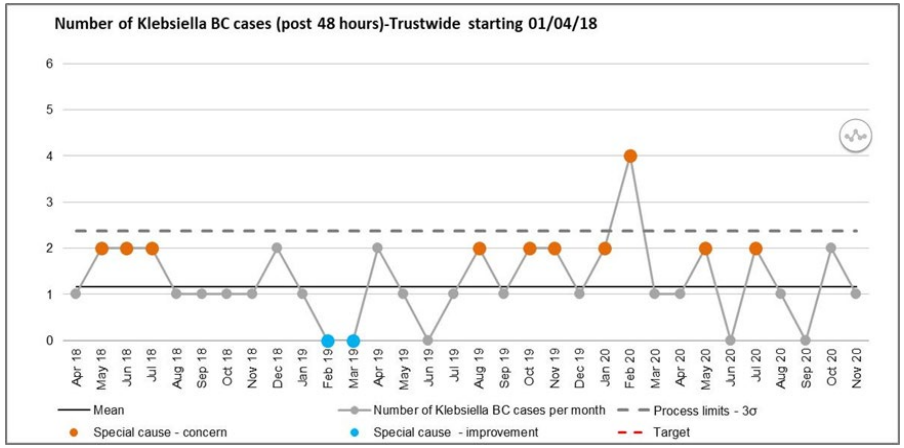


There were 2 cases of C difficile attributed to the Trust in November 2020; both were post 48 hour case. Ongoing themes from the previous RCAs include: use of laxatives and assumption that diarrhoea was caused by this, stool sample not collected in a timely manner, failure to commence a stool chart and inappropriate use of Tazocin.

The timeliness of isolating patients has been supported by the use of the redi-rooms. Anti-microbial stewardship is reported through to IPC Committee, this need discussing at Care Group Performance Reviews to ensure prescribing of antibiotics is addressed.

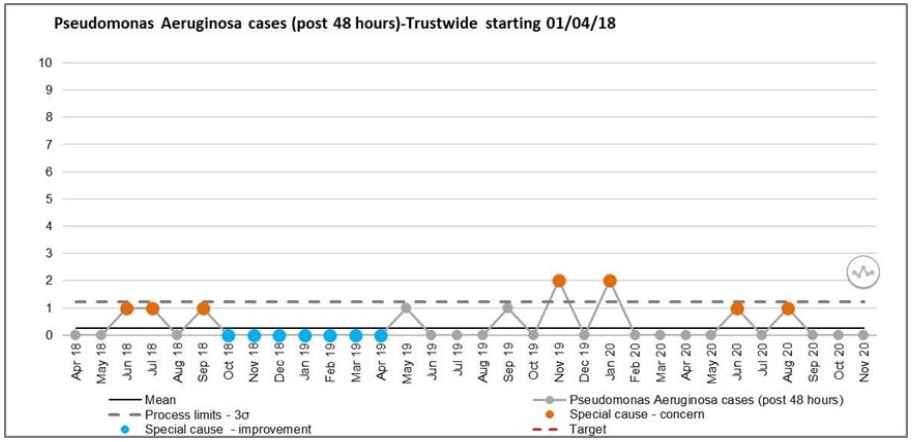
2.3 E.Coli Bacteraemia	2.4 MSSA Bacteraemia
The Number of E.Coli cases are shown:  	The number of MSSA cases are shown: 
There were 4 cases of post 48 Ecoli Bacteraemia in November 2020. None of the cases this month were considered to be device or intervention related. The sources were considered to be: biliary, abdominal neutropenic sepsis, intra-abdominal pancreatitis, and abdominal. In total YTD there have been 28 cases against a target by month 8 of 29 cases As of October 2020, if any cases are identified as being due to a device or intervention such as a CAUTI (Catheter Associated Urinary Tract Infection) or stent then RCA will be completed to ensure any lessons learnt and actions are put in place. In order to improve the management of catheter care across the Trust a Catheter Care Group has been set up and a new catheter care plan being developed.	There were 5 cases of post 48 hour MSSA bacteraemia in November 2020. Two were considered to be device/intervention related (Central Line and tracheostomy), two the source was unknown and one was due to a groin abscess. YTD there have been 19 cases against a target by month 8 of 16 cases. In line with the decision made by the DIPC that all cases will now have an RCA completed, these RCA investigations are currently being undertaken to identify if they are device or intervention related.

2.5 Klebsiella Bacteraemia (Post 48 Hours)



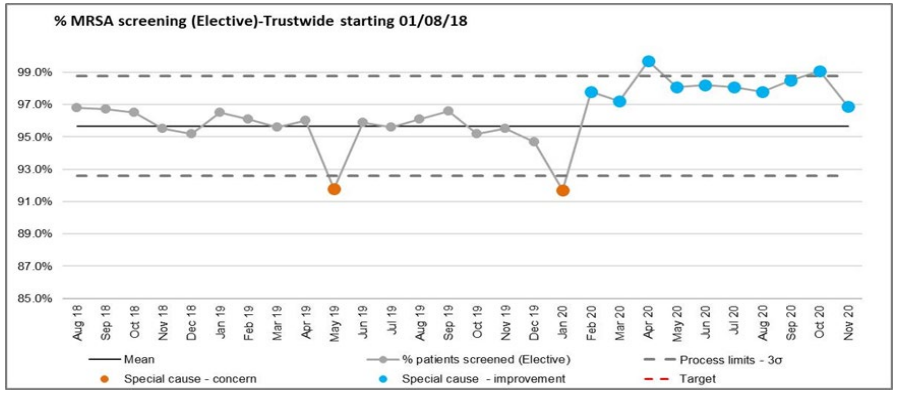
There was one case of post 48 hour Klebsiella Bacteraemia in November 2020. The source was considered to be a Lower Respiratory Tract Infection

2.6 Pseudomonas Aeruginosa Bacteraemia (Post 48 Hours)



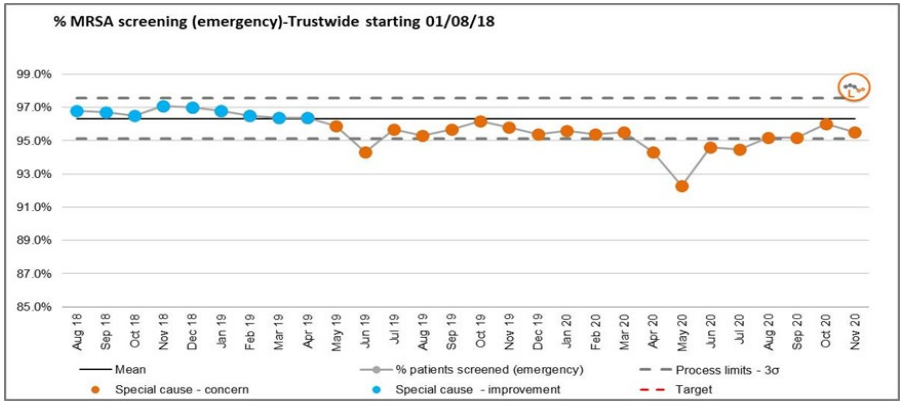
There were no cases of post 48 hour Pseudomonas Bacteraemia in November 2020. The last case reported was in August 2020.

2.7 MRSA Elective Screening



MRSA Elective screening in November 2020 was 96.9%. MSRA elective screening has been consistently above the 95% national target throughout 2020/21 YTD.

2.8 MRSA Emergency Screening



The MRSA emergency screening compliance for November was 95.5%; this is above the national target, having been achieved for the last 4 months. YTD performance is still below 95% due to the previous non-compliance.

3.0 Periods of Increased Incidence

There have been one periods of increased incidence reported in November 2020. This relates to 3 cases of Vancomycin-resistant Enterococcus (VRE) on Ward 23 Oncology; one case is not related to the other 2 cases which have been sent for typing.

4.0 COVID 19

In relation to COVID 19, the criteria for an outbreak are defined as:

"Two or more test-confirmed or clinically suspected cases of COVID-19 among individuals (for example patients, health care workers, other hospital staff and regular visitors, for example volunteers and chaplains) associated with a specific setting (for example bay, ward or shared space), where at least one case (if a patient) has been identified as having illness onset after 8 days of admission to hospital". (Public Health England, August 2020).

Since October 2020, during the second wave of the Covid-19 pandemic, the Trust has seen a number of outbreaks involving both patients and staff across both the PRH and RSH site. A summary of the outbreaks including the number of patients and staff involved and the current status in relation to whether these are ongoing or closed is provided, this is up to and including the 21st December 2020.

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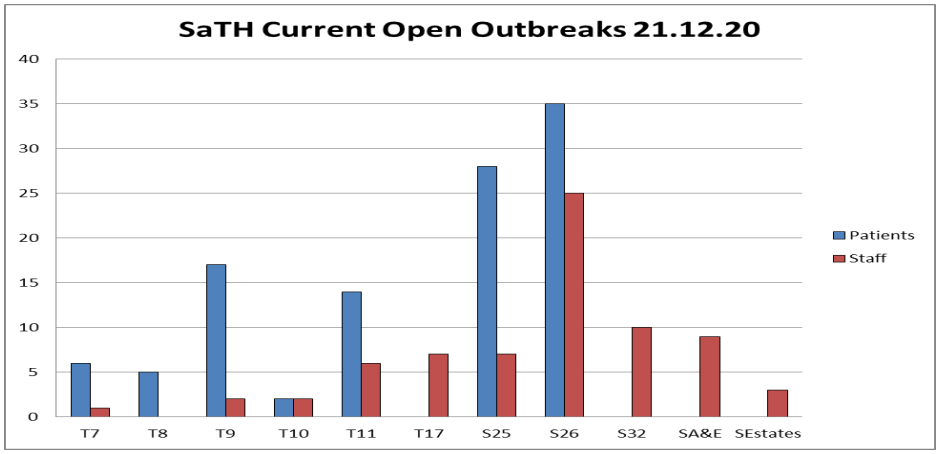
Site	Ward	Number of Patients Involved	Number of Staff Involved	Outbreak Status
RSH	Ward 25	28	7	OPEN
RSH	Ward 26	35	25	OPEN
RSH	Ward 32	0	10	OPEN
RSH	A&E	0	9	OPEN
RSH	Estates	0	3	OPEN
PRH	Ward 7	6	1	OPEN
PRH	Ward 8	5	0	OPEN
PRH	Ward 9	17	2	OPEN
PRH	Ward 11	14	6	OPEN
RSH	Ward 27	17	12	OUTBREAK CLOSED 08.12.2020
PRH	Ward 4	5	4	OUTBREAK CLOSED 08.12.2020
RSH	Ward 22F / SS	5	4	OUTBREAK CLOSED 04.12.2020
RSH	Ward 24	23	8	OUTBREAK CLOSED 04.12.2020
RSH	Ward 26	2	0	OUTBREAK CLOSED 03.12.2020
RSH	Ward 28	7	1	OUTBREAK CLOSED 04.12.2020
RSH	Research Team	0	2	OUTBREAK CLOSED 26.11.2020
PRH	Ward 6	8	2	OUTBREAK CLOSED 04.11.2020
PRH	Ward 7	10	0	OUTBREAK CLOSED 04.12.2020
PRH	Ward 9	5	2	OUTBREAK CLOSED 01.11.2020
PRH	Ward 15	11	12	OUTBREAK CLOSED 12.11.2020
PRH	Maternity Scanning	0	5	OUTBREAK CLOSED 04.12.2020
PRH	Porters	0	2	OUTBREAK CLOSED 04.12.2020

To date there have been 22 outbreaks reported from October 2020 to the 21st December 2020. Of these, 13 outbreaks are now closed. A total of 198 patients and 117 staff have been

included in these outbreaks.

Covid-19 Update December 2020

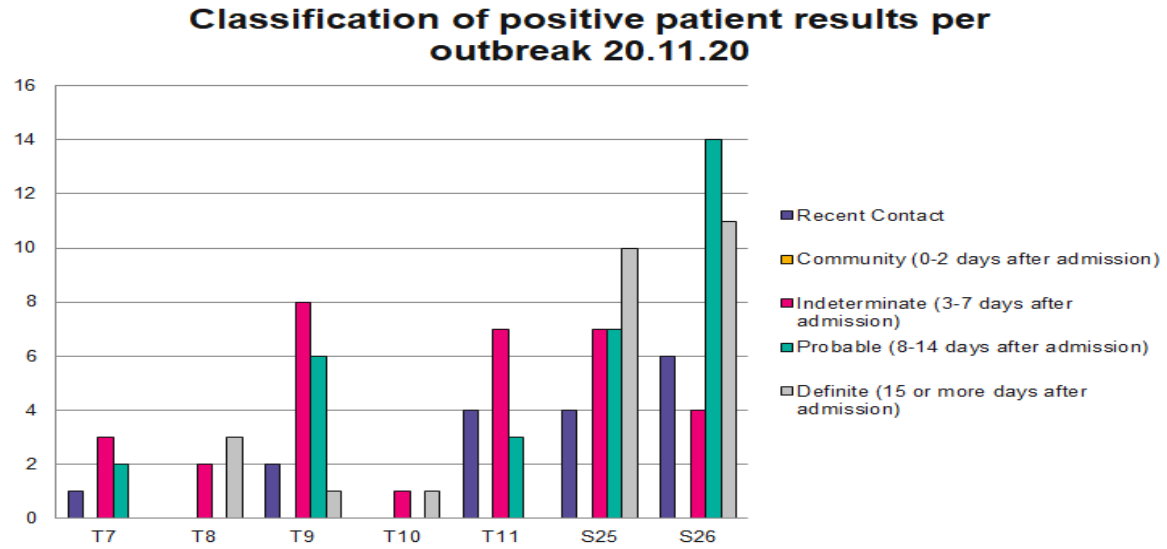
The current Covid-19 outbreaks which are still open or have been reported in December 2020 are shown.



Three outbreaks involved staff only. The remaining 6 outbreaks involve both patients and staff, with the two largest outbreaks in December 2020 having been on Ward 25 and Ward 26 and are ongoing. The outbreak on Ward 26 has seen the largest number of cases with 35 patients and 25 staff affected.

Previously patients were swabbed for COVID 19 as part of their admission and at day 5 post admission, as well as being swabbed prior to discharge. From December 2020, patients are now also swabbed on Day 3 post admission.

Definitions in relation to 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 and indeterminate as 3-7 days. For the outbreaks reported in December 2020 the duration of time from admission to a patient being screened as positive is shown:



For December 2020, 32 (30%) of cases from the outbreaks have been classified as probable hospital acquired (detected at day 8-14 following admission) and 26 (25%) of cases have been classified as definite (detected at day 15 or more following admission). This means there has been a significant number of cases acquired through hospital transmission.

Outbreak meetings have taken place twice weekly throughout October, November, and December as the outbreaks have been managed; some wards have been closed to manage these outbreaks. Outbreak meetings are chaired by the Director of Infection Prevention and Control/Director of Nursing and are attended by key staff across the Trust, CCG, PHE and NHSI/E IPC leads.

In order to manage the second wave of the Covid-19 pandemic in relation to high risk (red) and amber pathways, to ensure the safe management of patients requiring cohorting or patients who are contacts of positive patients, a Standard Operating Procedure for mixed sex accommodation and the mixing of contacts for when the hospital is under significant bed capacity pressures has been developed. This is only to be enacted with the agreement of the Director of Infection Prevention and Control in hours or the Executive on –call out of hours. When this occurs the expectation is that staff will complete a datix so that this can be closely monitored.

Lessons Learnt from the most recent Outbreaks:

The main learning and actions from the most recent outbreaks includes:

- Ensuring we continue to have robust systems in place for in admission, Day 3 and Day 5 swabbing
- Ensuring that cleaning is undertaken twice daily and more frequently in relation to touch points
- That bathroom facilities for positive patients and contacts are clearly segregated on the wards
- That IPC policies and procedures including the correct use of PPE is followed
- Training in relation to IPC and PPE has been completed by all staff including nurses and medical staff in the clinical areas
- That the importance of social distancing both in the clinical and non-clinical environments is maintained
- Correct procedures for the storage of staff hoods during a shift and decontamination of these is followed

Measures in Place to monitor this include:

- Daily IPC visits to outbreak areas
- Proactive / reactive staff & patient screening
- Enhanced cleaning in place, with SOP outlining accountability for sign off
- PPE use & practices reviewed and audited
- Audits of hand hygiene and re-enforcing good hand hygiene
- Encouraging patients to wear masks when in the Bays as well as practices already in place for when patients leave the bays to go to bathrooms/off ward
- Challenging poor behaviours / practice immediately
- Daily review of cases
- Monitoring of patient swabbing on admission, Day 3 & Day 5, and the development of a COVID-19 Dashboard which includes this
- Redi-rooms 6 per site to increase the availability of side room capacity
- Plastic protective curtains for use in AMUs and wards for patients to try to limit the number of contacts for patients.

University Hospital North Midlands, CCG & NHSE/I Assurance Visits

An action plan was developed following the assurance visits undertaken at the Trust in relation

to its management of the Covid-19 pandemic as well as a wider review of infection prevention and control measures/practices at the Trust. University Hospital North Midlands NHS Trust carried out a supportive peer visit in August 2020. Visits were also undertaken by NHSI/E Assistant Director of IPC and the IPC Lead Nurse from Shropshire and Telford CCG following a series of Covid-19 outbreaks at the Trust affecting both patients and staff during the second wave of the pandemic. These visits took place in October 2020 and November 2020. A further visit to Ward 26 following the recent outbreak on the ward was undertaken by the CCG IPC Lead on the 18th December 2020.

The feedback and areas for improvement from these visits were incorporated into an overarching action plan. The action plan consists of actions to be undertaken by nursing, estates and facilities. Of the 39 actions, 21 are completed, 13 are in progress and 5 actions have not yet commenced. This action plan is monitored through the IPC Operational Group and reported through to the IPC Committee monthly.

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

The previous Covid-19 outbreaks at the PRH and RSH in October and November 2020 were raised as a serious incident. The recent outbreak on ward 26 has also been raised as a serious incident in December 2020.

6.0 IPC Initiatives

The IPC team have continued to support the ongoing work in relation to COVID-19, ensuring that swabbing is being undertaken as per national guidance, supporting the outbreak meetings and national reporting of outbreak information. They have developed the SOP for managing mixed sex accommodation breaches due to COVID-19 and the management of contacts when the hospital sites have capacity issues. The IPC team continue to monitor all outbreaks ensuring that IPC policy and practice is adhered to, including the quality of cleanliness.

The completion of RCAs for MSSA and E.Coli bacteraemia has also commenced and is co-ordinated by the IPC team.

7.0 IPC Board Assurance Framework

In May 2020 NHSE/I issued an Infection Prevention and Control Board Assurance Framework (IPC BAF) for all acute Trusts to use to assess themselves with regards to best practice and use as a tool to monitor actions required to ensure continuous improvement. The Infection Prevention and Control Board Assurance Framework (IPC BAF) has 10 Sections with 63 key lines of Inquiry The Trust completed its self-assessment and this was reported through to Board in May 2020.

The CQC reviewed our IPC BAF in August 2020 with no concerns raised. The IPC BAF is reviewed monthly at the IPC Operational Group and reported through to the IPC Assurance Committee chaired by the Director of Infection Prevention and Control/Director of Nursing for ongoing monitoring.

The IPC BAF has been fully reviewed in December 2020. Of the 63 key lines of enquiry in the IPC BAF, the Trust continues to assess itself as RAG rated Green for 53 of these measures and amber for the remaining 10 measures. The policies and procedures included in the IPC BAF have been reviewed and updated. Following recent outbreaks and discussions with NHSE/I a new Standard Operating Procedure for the Management of Contacts has been developed. This is included in the evidence for the key line of enquiry outlined in 1.2. "*Patients with possible or confirmed COVID-19 are not moved unless this is essential to their care or reduces the risk of transmission"* as mitigation in relation to this measure.

There remain 10 key lines of enquiry which are amber. There are ongoing actions in relation

to these which include:

- Ongoing recruitment to the cleaning team
- Compliance with PPE training, this is monitored through the Care Group reporting at the IPC Operational Group
- Use of cohorting of positive patients on identified cohort wards
- Temporary Rapid Response Team and some contractor support is helping to address the gaps in service.(this needs reviewing in March 2021)
- Ensuring all staff at risk have had a risk assessment completed
- Restriction of the movement of staff to work in other clinical areas whenever possible. This is challenging as sometimes staff are required to move to maintain patient safety across all clinical areas.

8.0 Risks and Actions

The Infection Prevention and Control Risk Register has been presented at the IPC Committee In December 2020. The risk register consists of 13 risks relating to aspects of IPC across the Trust. The residual risk scores are currently being reviewed with the IPC team based on the current actions in place to mitigate these. There are 2 risks, which the committee agreed would be removed from the IPC risk register:

- Risk 1500-IPC standards in the Emergency Departments and Acute Medical Units
- Risk 1540- Use of portable fans in the clinical areas.

9.0 Conclusion

This IPC report has provided a summary of the performance in relation to the key performance indicators for IPC. The report demonstrates that our performance in relation to these KPIs is good, with the Trust remaining under-trajectory for C.Diff cases YTD and set to achieve the target of no more than 43 cases in 2020/21. There have been no MRSA bacteraemia in the month or for 18 months. There is a sustained improvement in relation to MRSA screening of emergency admissions, with the target having been achieved for the last 4 months.

The challenges associated with Covid-19 have continued with a number of outbreaks reported since the last update provided to Board with several recent outbreaks involving a large number of both patients and staff.

Director of Nursing
December 2020

Appendix 1:

Infection Prevention and Control Board Assurance Framework

RAG Key	Action Complete	Action in Progress	Action off Track

Version Number	Date Reviewed	Reviewed by	Change made
2.0	14.12.20	Janette Pritchard, Kara Blackwell	Full Review and update

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. RSH - ED Management of Poter Navigator flow chart for PRH Navigator flow chart for RSH Update management of Potential COVID Pa			Green

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
1.2	Patients with possible or confirmed COVID-19 are not moved unless this is essential to their care or reduces the risk of transmission	All patients are screened on admission to the Trust as per national guidance – patients that are 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	It has been identified that the trust has a lack of side rooms that will be addressed by the Hospital Transformation Plan	Patients who have been identified as positive COVID 19 will only be moved if they are being transferred to one of the COVID high risk wards. 6 Redi-Rooms available for use at each site which increases side room capacity for isolation Where possible anyone identified as a contact of a COVID positive case will also not be moved, with the exception of when the hospital is full and there is no admitting capacity. An SOP has been created to guide executives on the least risk options.	Amber

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
				SOP for Managing Contacts when the h	
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.			Green

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
		 COVID-19 Discharge Information Leaflet V There is a clinical pathway for patients discharged to Care Homes. Attached below:  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\PPE Report - Oct20.xlsx The government has announced that from 15.06.2020 all staff whether clinical or non-clinical must wear a facemask while at work. Masks are now worn in all clinical areas and office spaces throughout the Trust			Green

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
		PATIENTS When patients are transferred within the hospital or in other care settings then they wear a face mask (see section 9.8 of SaTH COVID Policy – Policy link at the bottom of the document) Patients are also advised to wear masks when in their bed and must wear a mask when leaving their bed space to go to the bathroom or leaving the ward.			
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.			Green

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
		• The IPC team are visiting the clinical areas in the Trust daily.			
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 monthly as an appendices in the IPC report			Green

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
1.7	Risks are reflected in risk registers and the Board Assurance Framework where appropriate	Risks relating to COVID have been placed on the Trust Risk Register. The Trust has a COVID risk 1771 on the BAF. BAF risk 1771 was reviewed by the Trust Board on 28.05.2020			Amber
		There is a risk on the Corporate Nursing Risk Register No 1855 relating to the provision of 7 day working for the IPC team		Business case being developed for substantive 7 day service provision Following discussion with the new DoN, business case for 7 day service currently not being progressed as mitigating actions include: -Consultant microbiology oncall 24/7 for advice -Weekly cohorting meeting Friday	
		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.	Pre business case submitted outlining service gaps and cost to address them.	Use of Contractor hours including a Rapid Response Team funded from Covid monies	
1.8	Robust IPC risk assessment processes	This is normal practice in the Trust.			Green

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
	and practices are in place for non COVID-19 infections and pathogens	There are policies in place for non-COVID infections that are in date. http://intranet.sath.nhs.uk/infection_control/Infection_control_policies_and_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	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	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. Business case for	Temporary Rapid Response Team and some contractor support is helping to address the gaps in service. This situation will need to be reviewed in March 2021	Amber

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
		and Cleanliness Managers on each site. • 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	additional funding has been submitted, and is awaiting approval.	External Peer Review undertaken in August 2020.  Supportive Peer Review Feedback Aug	
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 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			Green

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
		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 be consulted on this to ensure that this is effective against enveloped viruses.	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
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	Facilities confirm that toilet door handles cleaned 3 x daily, Heads of Nursing confirmed that call bells/over bed tables & bed rails cleaned twice			Green

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
	secretions, excretions or body fluids as per national guidance	daily by housekeepers.			
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 possible and according to Single Use Policy	Single use items are used as per policy.		If this cannot be 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-	Green

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
				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)  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			Green

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
		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.  Lauderable Gowns SOP The Trust is using single use eyewear/visors and not reusable.			
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	• Antibiotic Policy in place.	Antibiotic policy in	Pharmacy seeks to prioritise	Amber

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
	stewardship are maintained	• 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.	place. Pharmacy medicines management service review antibiotic prescriptions. EScript program still in use and antibiotics are entered and recorded when seen by pharmacy staff and doctors undertaking discharge summaries. All reviewed antibiotic prescriptions are checked against the antibiotic policy, where not in line they are queried with the medical team, course lengths and route are also queried. SaTH continues to be below the England average for antibiotic usage and we monitor usage on a quarterly basis.	undertaking a full 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 submitted 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			Green

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
		and Safety Assurance Committee monthly chaired by a Non-Executive Director.			
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. 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.	Amber
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/coronavirus/p			Green

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
		pevideos.asp			
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: Testing for the COVID v0.7 - Inpatie Mixed Sex Bay COVID v0.1.docx COVID v0.1 - Visitor Guidance.docx Testing for the COVID v0.3 - Pre-Op			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. • 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.			Green

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
		• 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
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

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
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/coronavirus/ipc.asp • 5 day rescreen for any negative cases has been introduced			Green
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

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
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:					
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\PPE Report - Oct20.xlsx	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 feedback to Care	Amber

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
				Groups in relation to compliance. Local records being held by departments of staff trained, Care Group Leads ensuring managers send this information to Corporate Education	
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/coronavirus/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 is reported to all Ward Managers (link as above)	The Heads of Nursing report that the specific COVID data provided by corporate education does not match the monthly mandatory training report due to delays	Corporate Education Department Manager to review and scrutinise data for accuracy. Local records being held by departments	Amber

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
			in local training data being provided to Education Department for updating centrally.	of staff trained, Care Group Leads ensuring managers send this information to Corporate Education	
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 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.			Green
6.7	Staff regularly undertake hand hygiene and observe standard infection control	Bi monthly hand hygiene audits are undertaken on all wards & departments			Green

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
	precautions	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			
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 the risk of splash contamination, as per national guidance	Hand dryers have been removed and replaced with paper towel dispensers			Green
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

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
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					
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:					

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
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
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			Green

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
		Wards, AMU's and Phlebotomy at both sites. For roll out plan see below:  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. • It is also discussed on the Trust COVID Daily Call chaired by the COO/MD.			Green

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
		• 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 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.			Green

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
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) • 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	**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
		• 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.			
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			Green

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
		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. 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,	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	Amber

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
		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 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		Workforce assurance 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 our local drive through testing sites and test results are processed on site at our lab.			Green

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
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/coronavirus/ipc.asp