The Shrewsbury and Telford Hospital NHS Trust

Board of Directors' Meeting
8 December 2020

Agenda Item	202/20			
Report	Infection Prevention and Control Report			
Executive Lead	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 October 2020. Key points to note by exception are: • There were 4 cases of post 48 hour CDiff case in October 2020, whilst this is above the monthly target the Trust remains below the trajectory YTD • In October 2020, 96% of cases were screened, which was above the 95% national target for the 3rd month. • 65% of front line staff have now been vaccinated as part of the annual Flu campaign At the time of this report there had been a total of thirteen outbreaks reported for the period between October and November 2020. 10 of these involved patients and staff on the wards at both the Princess Royal Hospital and Royal Shrewsbury Hospital and 3 outbreaks relating to staff outbreak. These outbreaks have been managed through outbreak meetings chaired by the Director of Nursing (DIPC) attended by Care Group, PHE, CCH and NHSI/E. A summary of the feedback received from the recent NHSI/E and CCG assurance visits as part of the Covid outbreaks is included and are being actioned.			
Appendices	Appendix 1: IPC BAF			

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 October 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.

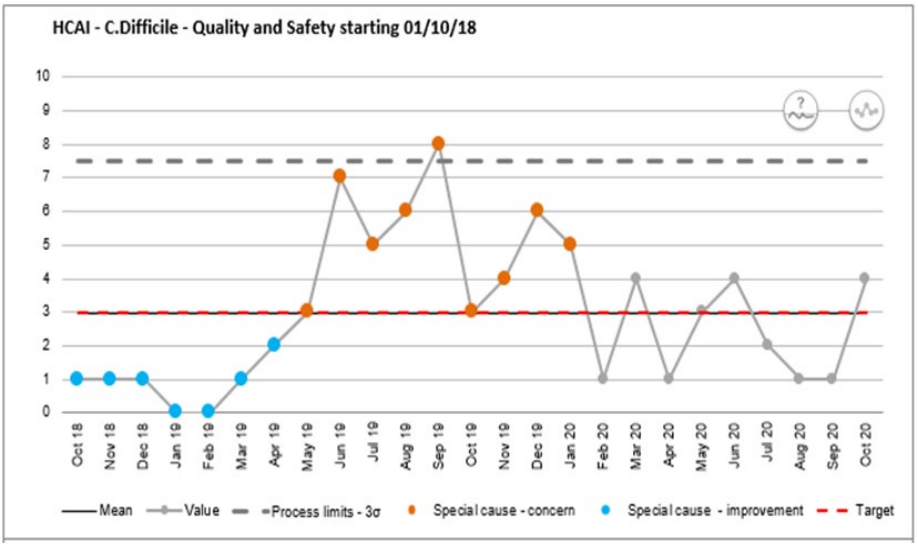
2.1 MRSA Bacteraemia

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

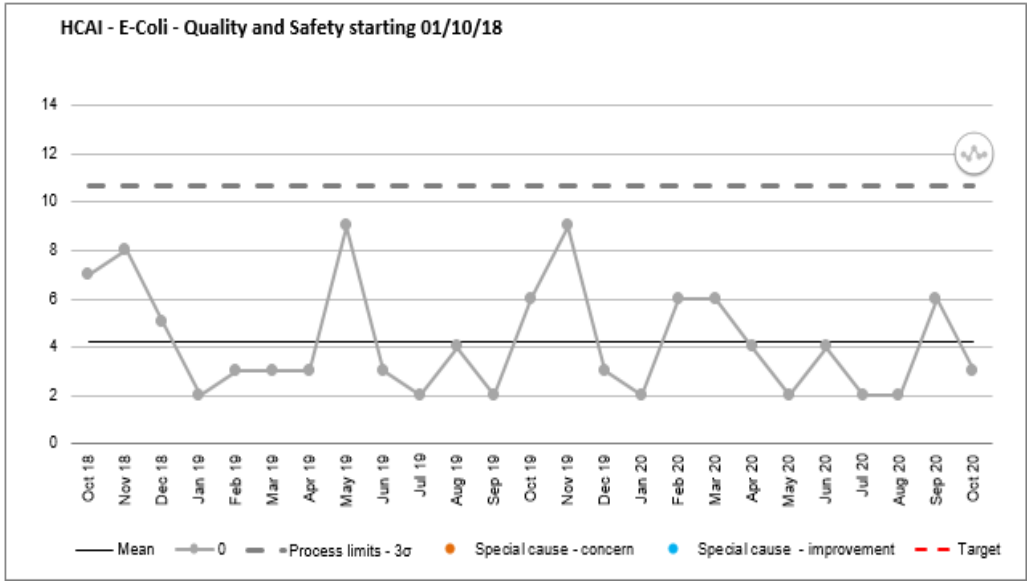
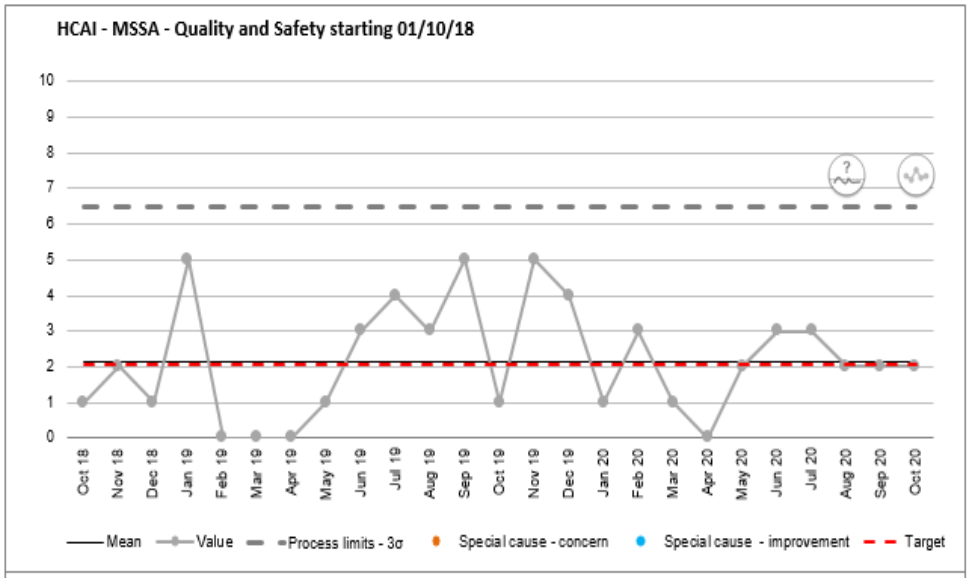
MRSA Bacteraemia	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sept 20	Oct 20	Annual Target
Number of Cases	0	0	0	0	0	0	0	0

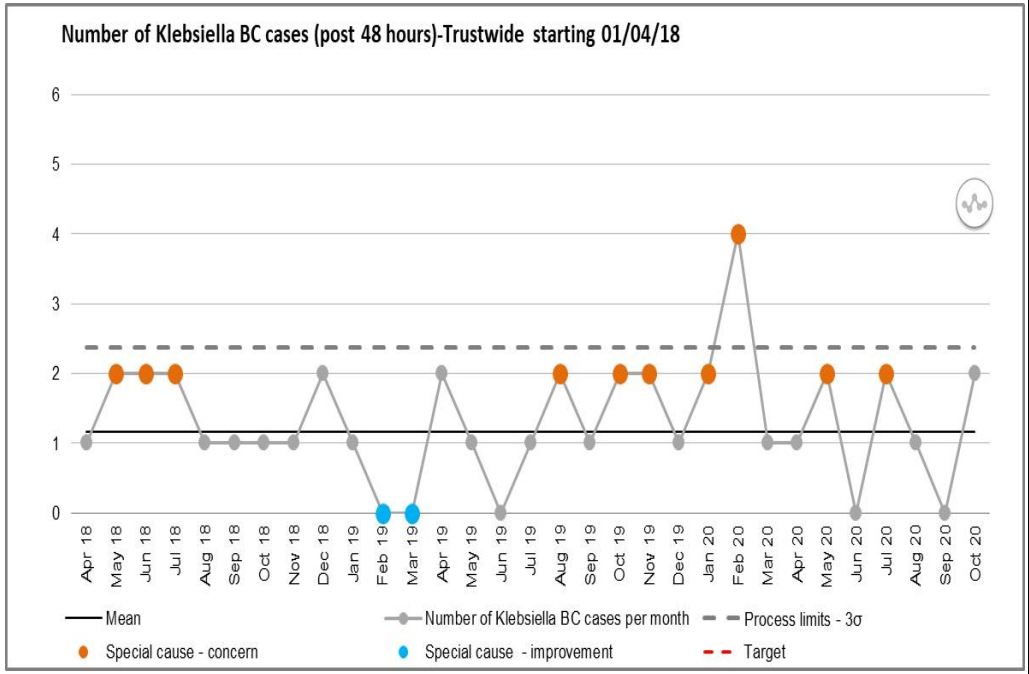
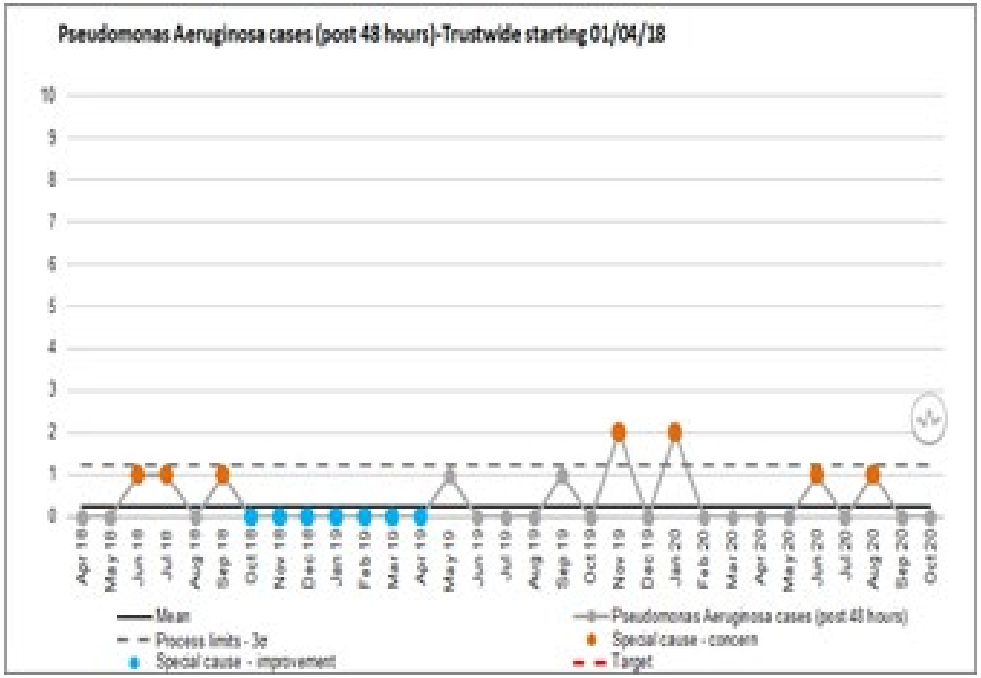
2.2 Clostridium Difficile

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 16 cases of CDiff; although the target for the month was exceeded the Trust remains below the trajectory YTD. Total number of C-Diff cases reported per month is shown:

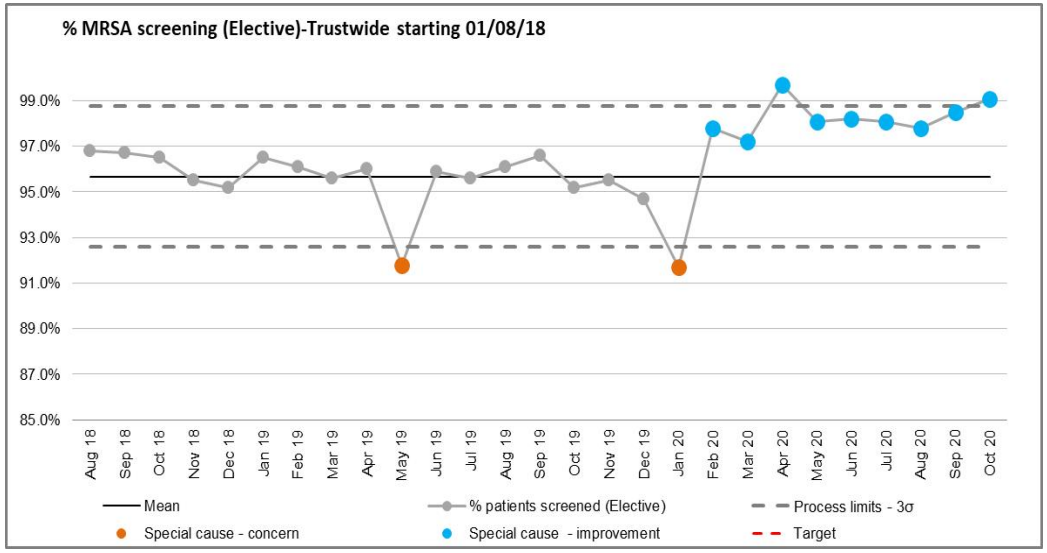
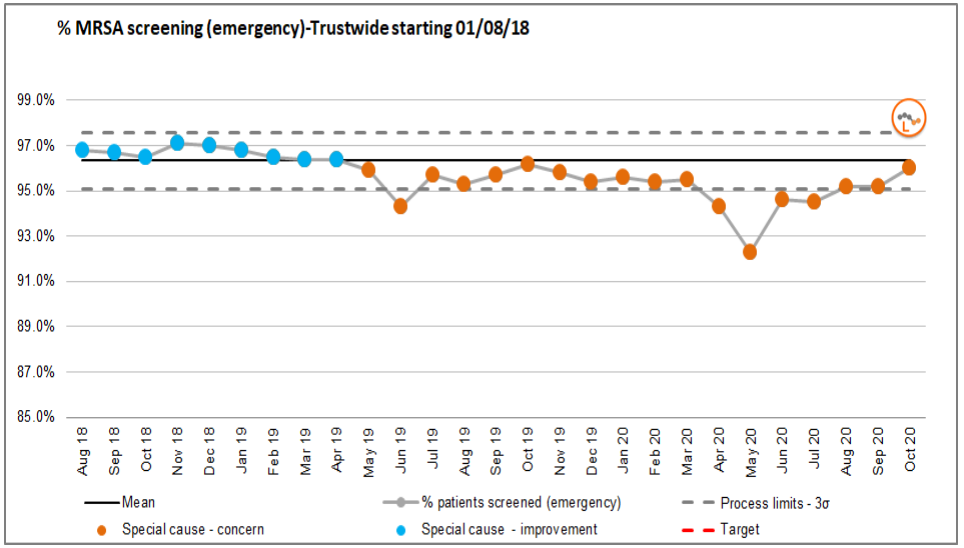


There were 4 cases of C difficile attributed to the Trust in October 2020. Two were Post 48 hour case. Ongoing themes from the RCAs continue to be promptly obtaining stool samples, timely isolation in a side room and antibiotic prescribing. The new redirooms now available at both hospital sites will help in relation to enabling the Trust to be able to provide additional side-room isolation capacity.

2.3 E.Coli Bacteraemia	**2.4 MSSA Bacteraemia**
The Number of E.Coli cases are shown: 	
There were 3 cases of post 48 Ecoli Bacteraemia in October 2020. None of these cases were considered to be device or intervention related; in all 3 cases the source was considered to be a urinary tract infection. Any infection considered to be a CAUTI (catheter associated urinary tract infection) will now have an RCA completed to ensure lessons are learnt and actions put in place to address this.	All hospital attributed (> 2 days from admission) are reviewed by the consultant microbiologist. There were two cases of Post 48 hours MSSA Bacteraemia in October 2020. Neither were considered to be device related; the source of investigation in one case was considered to be cellulitis and the other cases were considered to be soft tissue/skin. However, in line with the decision that all cases will now have an RCA completed, these RCA investigations are currently being undertaken.

2.5 Klebsiella Bacteraemia (Post 48 Hours)	2.6 Pseudomonas Aeruginosa Bacteraemia (Post 48 Hours)
	
There were 2 cases of Post 48 hour Klebsiella Bacteraemia in October 2020. In one case the source was unknown and in the 2nd cases the source was considered to be biliary, therefore not device related.	There were no cases of post 48 hour Pseudomonas in October 2020.

2.7 MRSA Screening

MRSA Elective Screening	MRSA Non-Elective Screening
	
MRSA Elective screening was above the 95% in October 2020 with a compliance of 99.1%. Elective MRSA screening continues to show special cause improvement, and has been above 97% since February 2020.	In October 96% of cases were screened, which was above the 95% national target for the 3nd consecutive month. Overall YTD performance now sits at 95%.

3.0 Periods of Increased Incidence

There have been no cases of increased incidence in October 2020.

4.0 COVID 19

The Trust is now seeing increasing numbers of COVID 19 positive patients admitted with and acquiring the disease during their hospital stay. As of 16th November 2020, there were 72 patients (39 at PRH and 33 at RSH) who were positive for the disease and 7 positive patients across the 2 sites were being cared for in the Critical Care Units, as well as a number of patients receiving non-invasive ventilation) (CPAP and NIV) on the COVID respiratory Wards.

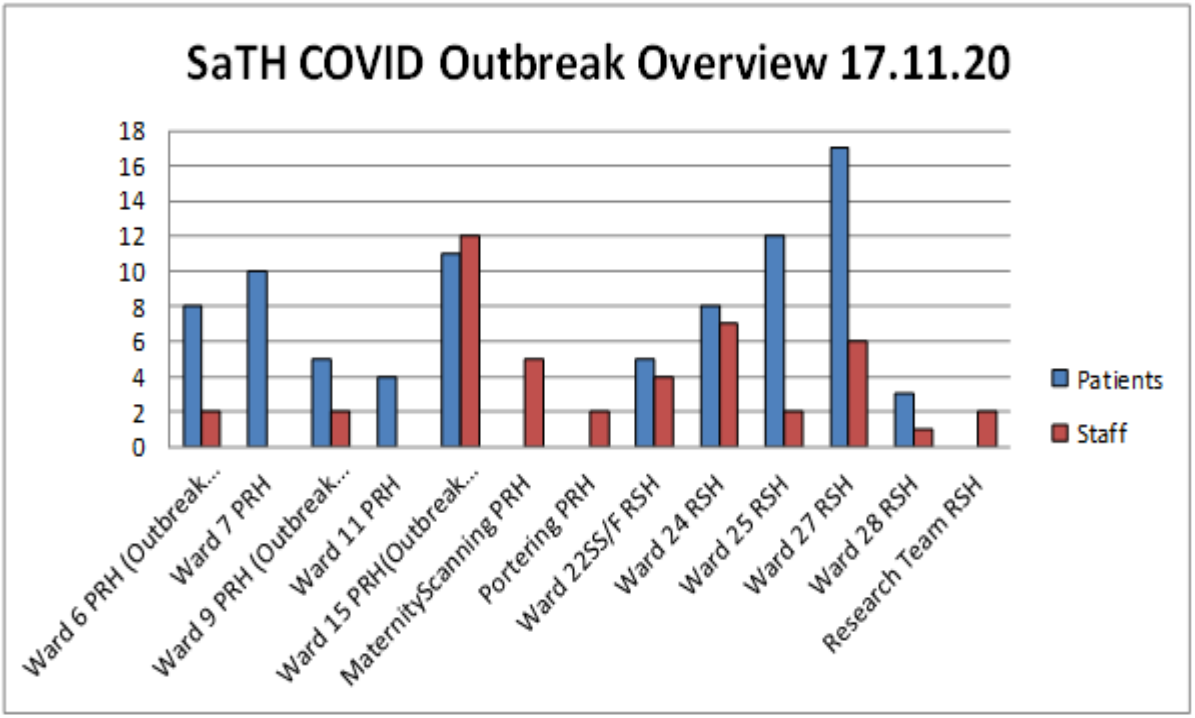
COVID-19 Outbreaks

During October and November 2020 the Trust has seen a number of outbreaks relating to COVID 19 at both hospital sites. In relation to COVID 19, the criteria for an outbreak is defined as:

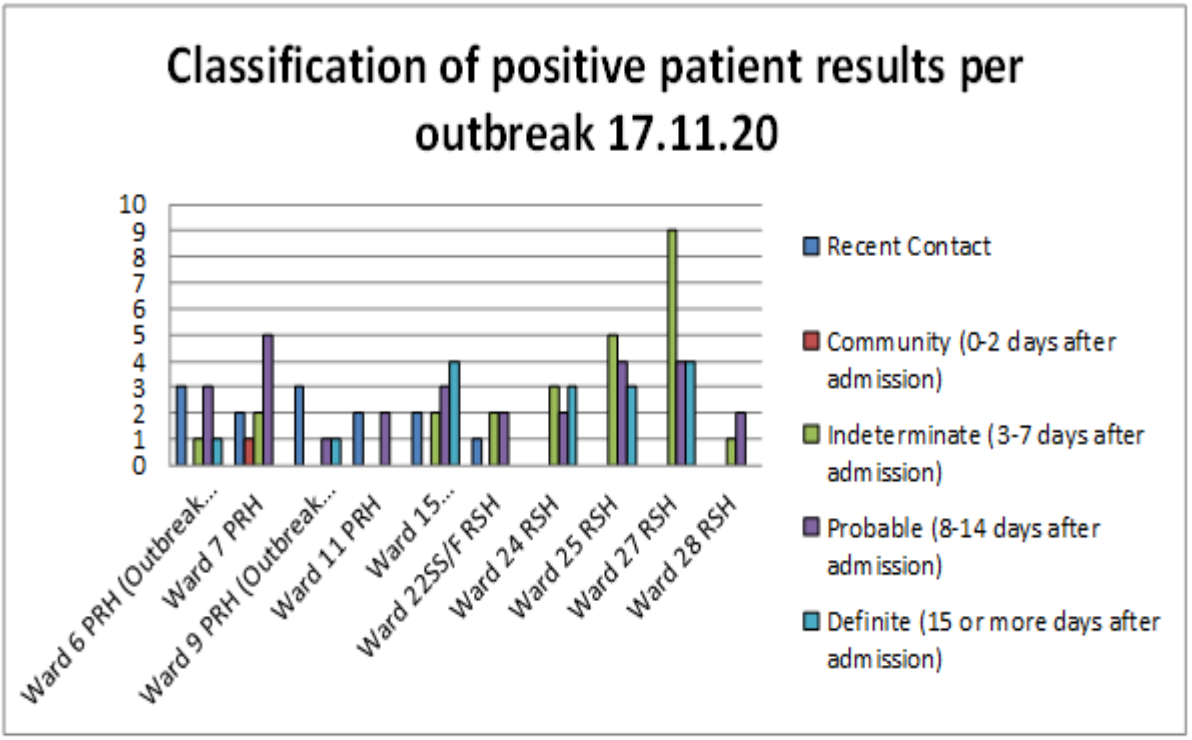
"Two or more test-confirmed or clinically suspected cases of COVID-19 among individuals (for example patients, health care workers, other hospital staff and regular visitors, for example volunteers and chaplains) associated with a specific setting (for example bay, ward or shared space), where at least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

Initially in October 2020, the first outbreak was declared for Ward 15/16, Stroke Unit. Further outbreaks were subsequently reported for Ward 6, 7, 9 at the Princess Royal Hospital. A subsequent outbreak was declared for Ward 27 at the Royal Shrewsbury Hospital on the 28th October 2020. Further outbreaks in November 2020 at the Royal Shrewsbury Hospital have included Ward 24, 22SS and Frailty, Ward 25 and Ward 28 (on the medical side of the ward), and Ward 11 at the Princess Royal Hospital.

Details of all outbreaks by ward shown below:



The outbreaks on the wards related to both patient and staff cases. Three outbreaks for ward 6, 9 and the Stroke unit have now been closed. Three outbreaks related to staff to staff only which include sonography staff in maternity, porters and research team, however, in only one of these 3 staff outbreaks was there a breach in social distancing.



Patients are swabbed for COVID 19 as part of their admission and at day 5 post admission, as well as being swabbed prior to discharge. 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. To date 25 cases from the outbreaks have been classified as indeterminate, 28 as probable and 16 as definite in relation to whether they acquired COVID 19 during our care. These definitions are under regular review by the Public Health England.

Outbreak meetings have taken place throughout the week during October and November, these are attended by key staff across the organisation, CCG, PHE and NHSI/E IPC leads. The Outbreak meetings are chaired by the Director of Nursing.

Lessons Learnt

The main learning from the outbreaks to date is summarised below:

- On admission and Day 5 screens missed in some areas
- Patients are being moved before screening result is known
- Positive patients are generating large numbers of ‘contacts’
- Not enough isolation facilities / cohort areas in the Trust
- Some issues identified with deep cleaning of areas and sign off of this

Measures in Place

As part of the outbreak meeting a full action plan has been developed. Key actions implemented include:

- Daily IPC visits

- Proactive / reactive staff & patient screening
- Enhanced cleaning in place, with SOP outlining accountability for sign off
- PPE use & practices reviewed
- 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 Day 0 & Day 5 screens; systems and processes reviewed and reinforced at ward level to ensure this is consistently achieved
- Redi-rooms 6 per site to increase the availability of side room capacity
- Plastic protective curtains for use in AMUs and wards for patients with a view to try to limit the number of contacts for patients in large bays in AMU.

5.0 NHSI/E and CCG COVID Assurance Visits

As part of the management of the COVID-19 outbreaks there have been 2 assurance visits which have taken place. The first was attended by the IPC Assistant Director from NHSI/E and the CCG Lead for IPC at the Princess Royal Site following the initial outbreaks in October 2020. The 2nd assurance visit to the Royal Shrewsbury Hospital took place on the 17th November 2020 attended by the CCG Lead for IPC.

There was good engagement from the Care Group teams, Estates and Facilities as part of these visits. The verbal feedback provided as part of these visits was very positive. Written feedback provided by the CCG Lead for IPC stated it was evident that the senior nursing leadership and the staff were working together to implement the actions required to deliver an effective response to the Covid-19 outbreaks currently being experienced in the Trust.

Some of the Areas of good practice observed included:

- Staff BBE & wearing surgical masks
- Overall good hand hygiene practices
- Overall correct use of PPE
- Physical temporary barrier erected to stop staff moving directly between wards 15 & 16 as part of the management of the Covid-19 outbreak in that area
- All wards clean, tidy and clutter free
- Cleaning checklists completed
- Systems observed on all wards for monitoring patient Covid-19 testing in line with national guidance, this included discrete flagging of Covid-19 positive and contact patients on PSAG boards
- Staff awareness of social distancing whilst moving around the hospital
- Processes in place on all wards for staff safety briefings and care huddles
- Ward Managers and Matrons had a clear understanding of Covid-19 risk pathways and the control measures required to prevent transmission, including the recent adoption of ‘bubble nursing’

Some areas for improvement included:

- Estates issues in majority of areas on both sites, these had been escalated to Estates who were addressing
- Breaches in integrity of trolley mattresses covers on day surgery unit and some chair cushions in other areas
- Commode seat damage on ward 16. This was only 6 months old and may be as result of chlorine use

- Review of office risk assessments at PRH site to ensure social distancing of 2m, some offices were small for the number of staff
- Review of housekeeping hours to ensure sufficient cover and parity across ward bed bases – ward 25 advised they had insufficient hours and less than on other wards of similar size
- Awaiting doors to be fitted to bay 1 on ward 28. A temporary solution is currently in place using heavyweight plastic sheeting with zip closures.
- Encouraging/reminding patients to wear face masks

The feedback and areas for improvement from these two visits will be incorporated into the action plan developed following the IPC Peer Review Visit undertaken by University Hospital North Midlands in August 2020. This will be monitored through the IPC Operational Group and reported through to the IPC Committee.

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

The recent COVID 19 outbreaks have been raised as a serious incident and the investigation is currently in progress

7.0 IPC Initiatives

The focus of the majority of the IPC work during October 2020 has continued to be COVID 19 and managing the increased outbreaks. Alongside this has been supporting the introduction of the redirooms.

The Infection Prevention and Control Team continue to undertake quality assurance audits and contribute to the Exemplar baseline audits which have continued.

The seasonal Flu campaign is underway. The IPC team support this and undertake the Flu vaccination clinics. To date, over 3000 staff (65%) of front line staff have been vaccinated.

8.0 IPC Board Assurance Framework

The Infection Prevention and Control Board Assurance Framework 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 remains RAG rated as Green for 53 of these measures and amber for the remaining 10 measures (Appendix 1). A detailed review and update of the IPC BAF is being undertaken in November 2020 and will be reported through to Board as part of the IPC report in December 2020.

9.0 Risks and Actions

The Trust faces ongoing challenges in relation to the management of the COVID pandemic particularly given its Estate issue, lack of isolation facilities and demands around bed capacity. The Trust will continue to manage this pandemic in line with all relevant NHS Guidance and our IPC Policy. Risks and mitigations are also managed through the IPC BAF and via regular updating of the COVID Policy based on the most recent evidence base and national guidance.

The ongoing actions in relation to the Trust response to the pandemic are outlined in the report.

Conclusion

This IPC report has provided a summary on out 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 under trajectory for CDiff cases and an improved position in relation to

MRSA screening of emergency admissions. The challenges associated with Covid, the current position in relation to the outbreaks, lessons learnt and action in place have been outlined alongside the assurance provided from the recent visits from NHSI/E and CCG

Director of Nursing
November 2020

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 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	It has been identified that the trust has a lack of side rooms that will be addressed by the Hospital	If no side rooms are available then positive patients are cohorted in a bay. 3xRedi-rooms now	Amber

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
		positive are isolated in side rooms. See link for policy at bottom of document	Transformation Plan	available at both sites which will enable the greater availability of sider room capacity	
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:  UPDATED Pathway discharged patients F  Covid 19 clinical pathway final 27.4.2(			Green
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			Green

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

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

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; the IPC BAF is included in the monthly IPC Board report as an Appendices.			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 – 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 Following discussion with the new DoN, business case for 7 day service currently not being progressed as mitigating actions include: -Consultant microbiology on call 24/7 for advice -Weekly cohorting meeting Friday Recruitment to substantive cleaning posts, temporary staff being utilised to mitigate any gaps	Amber
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.			Green

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
		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	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 cleanliness manager (site respective) and	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	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 and Assurance Visits Oct/Nov CCG/NHSI. Action plan in place.	
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.			Green

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
		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 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-	Facilities confirm that toilet door handles cleaned 3 x daily, Heads of			Green

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
	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	Nursing confirmed that call bells/over bed tables & bed rails cleaned twice 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-	Green

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

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

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
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. • 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	Pharmacy are unable to see every inpatient chart every 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	Pharmacy seeks to prioritise 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	Amber

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
		Portal. High usage of WHO access group antibiotics due to longstanding antibiotic policy decisions which are reviewed regularly.	present.	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
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.	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	Amber

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

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
		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			
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. • Use of these stickers will be monitored via the IPC Quality Walks			Green
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	See Section 1: Emergency Department SOP (1.1).			Green

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
	non COVID-19 cases, to minimise the risk of cross-infection as per national guidance				
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
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.			Green

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
		http://intranet.sath.nhs.uk/document_library/viewPDFDocument.asp?DocumentID=10065 • 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 feedback to Care Groups in relation to compliance.	Amber

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
				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	As above	As above Donning and doffing training has been	Amber

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
		intranet which also has this information accessible. http://intranet.sath.nhs.uk/coronavirus/ppevideos.asp On 28 May all departments completed a PPE audit.		provided by IPC Team	
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 in local training data being provided to Education Department for updating centrally.	Corporate Education Department Manager to review and scrutinise data for accuracy. Local records being held by departments of staff trained	Amber
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

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
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 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	Hand dryers have been removed and replaced with paper towel dispensers			Green

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
	dispenser which is located closed to the sink but beyond 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					
Systems and process are in place to ensure:					

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
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
8.2	Patient and staff COVID-19 testing is undertaken promptly and in line with PHE	Staff testing programme is in place for all symptomatic staff who contact the helpline in line with PHE and national			Green

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
	and other national guidance	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: 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			Green

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
		performed in the as per guidelines			
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. • 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.			Green

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

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
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 • Headspace - Free subscription • Trust Coaches	**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
		• 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 the risk of transmitting coronavirus			Green

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

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