The Shrewsbury and Telford Hospital NHS Trust

Public Board of Directors Meeting
April 2021

Agenda item	081/21			
Report	Report from the Director of Infection Prevention & Control (DIPC)			
Executive Lead	Director of Nursing/Director of DIPC			
√ *tick only those applicable*	**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	√
√ *tick / input only those applicable, usually only one*	**Report recommendations:**		**Link to BAF / risk:**	
	For assurance	√	BAF1, BAF4	
	For decision / approval		**Link to risk register:**	
	For review / discussion		970, 1083, 1930, 2027, 2065	
	For noting			
	For information			
	For consent			
Presented to:	Infection Control Operational Group Infection Control Assurance Committee			
Dependent upon (if applicable)**:**	☐ ☐			

Executive summary:	This report provides an overview of the Infection Prevention and Control key metrics including hospital acquired infections for February 2021. Key points to note by exception are: • The Trust remains below the trajectory YTD and is set to achieve the target of no more than 43 cases of Clostridium Difficile (CDI) in 2020/21 • The Trust remains on target to achieve the 20% reduction set for E.Coli bacteraemias in 2020/21 • The planned target of no more than 24 cases of MSSA bacteraemia in 2020/21 is unlikely to be achieved with 24 cases reported YTD • There are 14 open Covid-19 outbreaks across the Trust at the time of this report , involving 153 patients and 70 staff • To date, 30 Covid-19 outbreaks have closed • There was 1 MRSA bacteraemia in January on ward 33, the investigation has been undertaken and learning actions identified • A period of increased incidence of pseudomonas infection reported on the ITU at the Princess Royal Hospital. • An outbreak of Vancomycin Resistant Enterococcus involving 2 patients was reported on Ward 28 Renal. An IPC BAF was issued by NHSE/I in 2020; the Trust was previously RAG rated green for 53 items and amber for 10 items. An updated IPC BAF was issued by NHSE/I in February 2021 with an additional 46 items added. A gap analysis against the updated BAF has been completed and the Trust is RAG rated as green for 96 actions and amber for the remaining items included in the BAF with actions being implemented to address these items.
Appendices	IPC BAF: March 2021

1.0 INTRODUCTION

This paper provides a report on the monthly performance against the 2020/21 objectives for Infection Prevention and Control. An update on hospital acquired infections: Methicillin-Resistant Staphylococcus aureus (MRSA) Clostridium Difficile (CDI), Methicillin-Sensitive Staphylococcus (MSSA) Escherichia Coli (E.Coli), Klebsiella and Pseudomonas Aeruginosa bacteraemia for January 2021 is provided. An update in relation to Covid-19, the recent outbreaks, actions and the learning in relation to these is provided. Details of other reported potential Health Care Acquired Infection (HCAI) outbreaks in February 2021 are included. The report also outlines any recent IPC initiatives and relevant infection prevention incidents. The updated IPC BAF is also included.

2.0 KEY QUALITY MEASURES PERFORMANCE

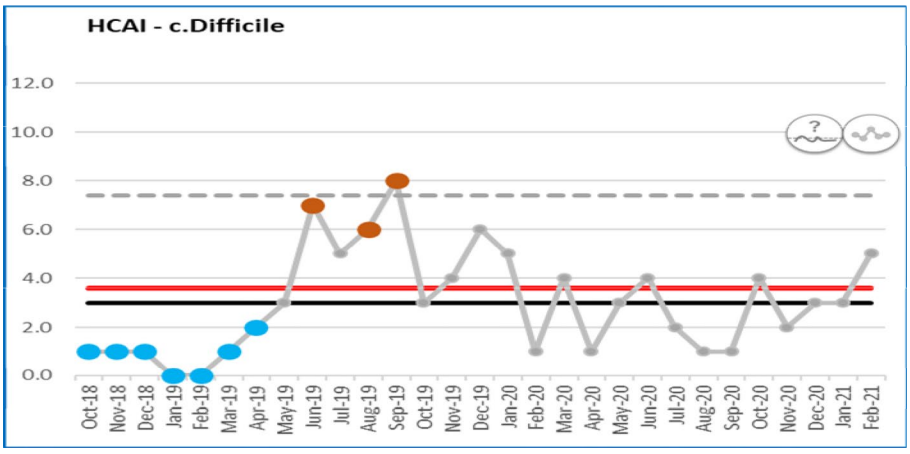
2.1 MRSA Bacteraemia

The target for MRSA bacteraemia remains 0 cases for 2020/21. There were no post 48 MRSA bacteraemia reported in the Trust in February 2021.The post infection review for the MRSA bacteraemia in January 2021 has been completed and the sample was considered to be a contaminant, therefore has been attributed to the Trust. Learning from this includes inappropriate prescribing of flucloxacillin, skin prep should have been chloraprep sponge applicator.

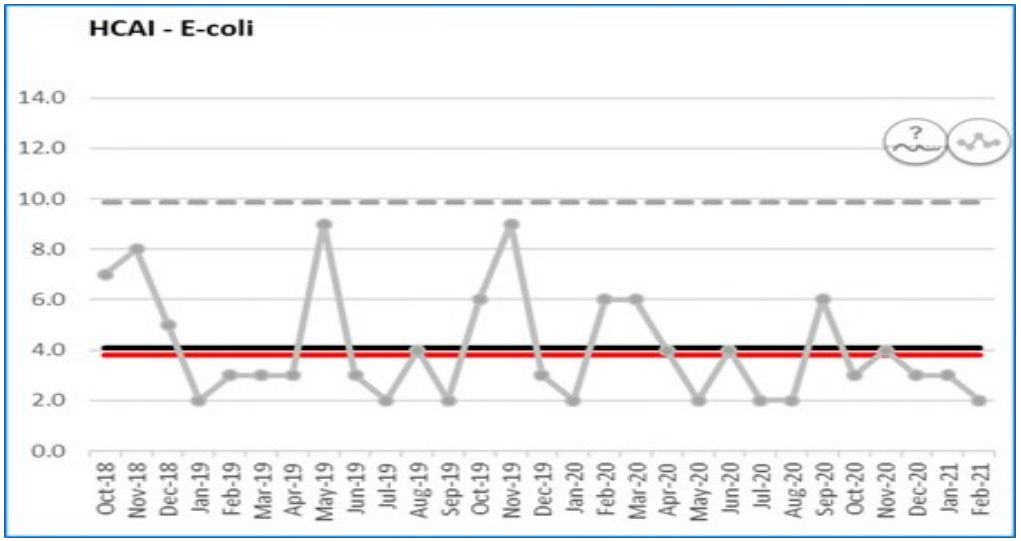
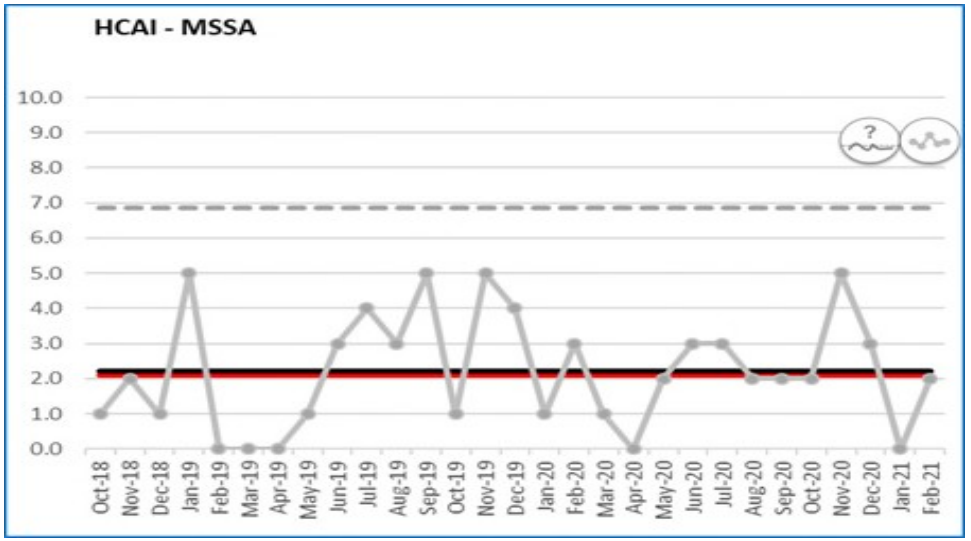
MRSA Bacteraemia	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sept 20	Oct 20	Nov 20	Dec 20	Jan 20	Feb 20	Annual Target
Number of Cases	0	0	0	0	0	0	0	0	0	1	0	0

2.2 Clostridium Difficile

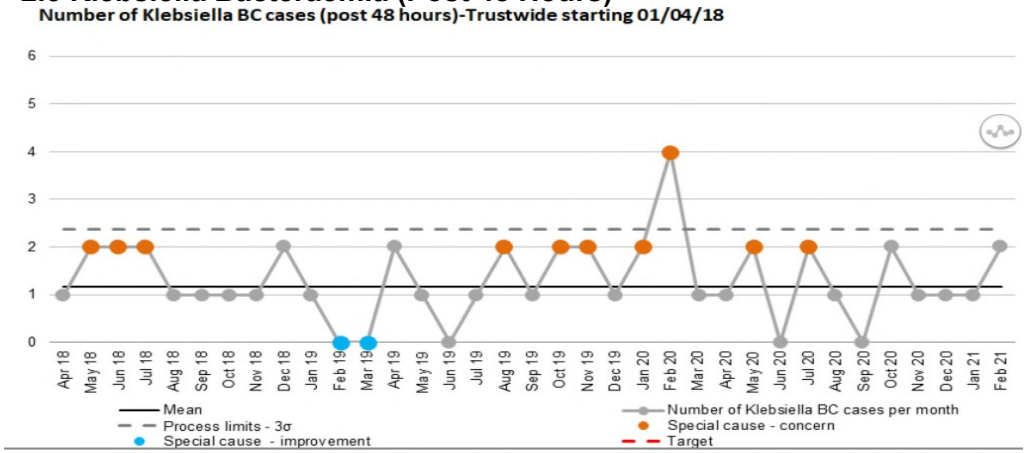
The target agreed with the CCG for this year is no more than 43 cases (same target as the previous year). Total number of C-Diff cases reported per month is shown:



There were 5 cases of C difficile attributed to the Trust in February 2021, 3 cases were post 48 hours of admission, and two had an inpatient stay in the last 28 days prior to the positive sample. Whilst this was above the Trust target of no more than 3 cases, cases remain below the target as year to date there have been 28 cases of CDiff against a target of 33 cases by month 11. The Trust remains below the trajectory YTD and on track for the target to be met.
Timeliness of obtaining stool sample, ability to isolate immediately due to side-room availability and antimicrobial prescribing remain the consistent themes. These have been discussed at the IPC Operational Committee for the Divisions to address and anti-microbial prescribing to be discussed at Medical Leadership Team meeting chaired by Medical Director.

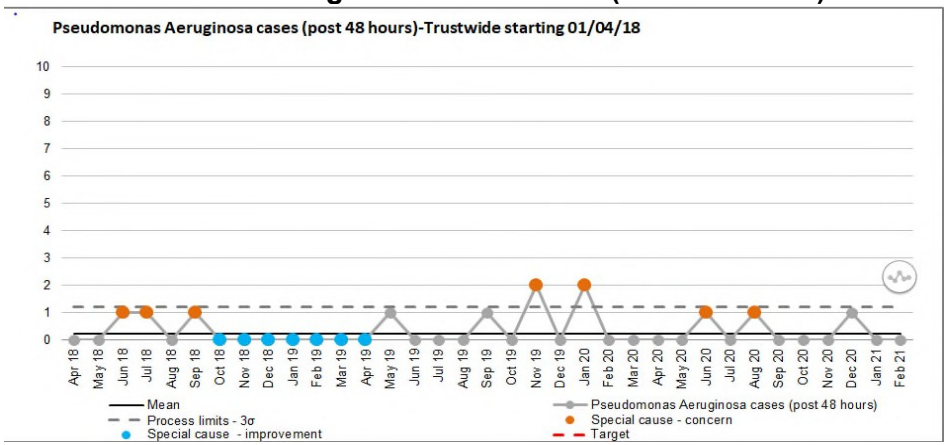
2.3 E.Coli Bacteraemia *The Number of E.Coli cases are shown:*  	***2.4 MSSA Bacteraemia*** *The number of MSSA cases are shown:* 
There were 2 cases of post 48 hour E.Coli Bacteraemia in February 2021. In both of these cases the source was considered to be a CAUTI therefore they were both device related and RCAs are currently being undertaken There have been 35 cases YTD against a target by month 11 of 41 cases. The target for 2020/2021 is no more than 44 cases; the Trust is on trajectory to achieve this target. Learning from RCAs undertaken to date include obtaining catheter, urine samples and blood cultures in a timely manner. A new catheter care plan has been implemented across the Trust. Catheter care is audited as part of the Matrons monthly Nursing Quality metrics and discussed at the monthly Nursing Metrics meeting in relation to any actions required	There were 2 cases of MSSA bacteraemia in February 2021. YTD there have been 24 cases against a target by month 11 of 22 cases. The target for 2020/2021 is for a 20% reduction in cases with no more than 24 cases, this target is unlikely to be achieved. Outcomes from RCAs undertaken for cases to date have showed that blood cultures and intravenous antibiotics prescribed according to Trust Policy. Improvements included ensuring the name of the staff member who has taken the blood culture to be recorded on the blood culture request forms.

2.5 Klebsiella Bacteraemia (Post 48 Hours)



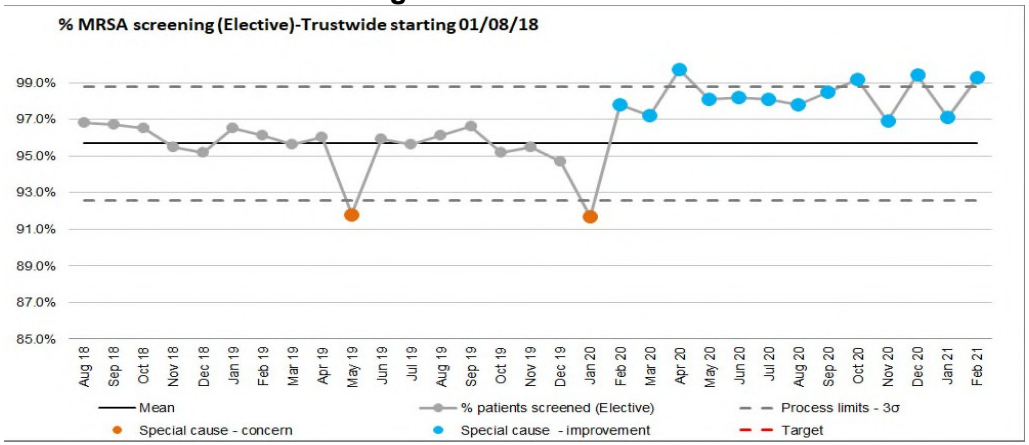
There were two cases of post 48 hour Klebsiella Bacteraemia in February 2021. These cases are being reviewed to determine if they were considered to be device or intervention related.

2.6 Pseudomonas Aeruginosa Bacteraemia (Post 48 Hours)



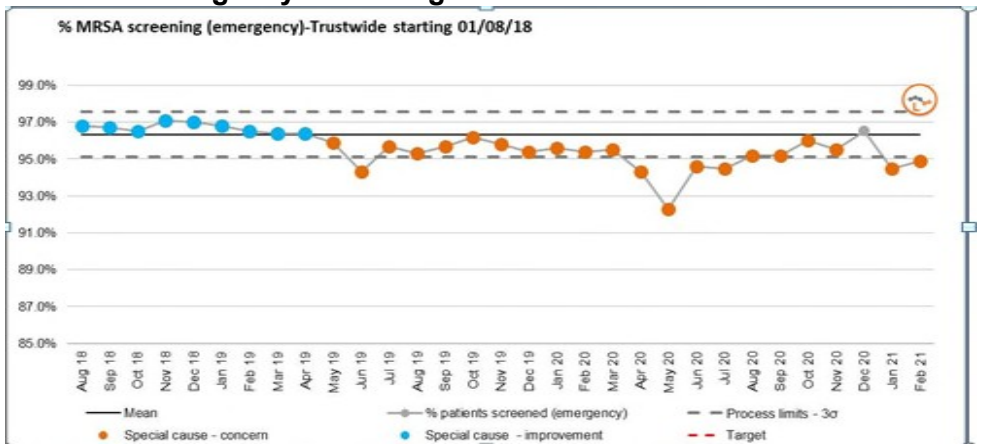
No cases of post 48 hour Pseudomonas Bacteraemia were reported February 2021

2.7 MRSA Elective Screening



MRSA Elective screening in February 2021 was 99.4%; YTD performance is 98.4%.

2.8 MRSA Emergency Screening



The MRSA emergency screening compliance for February 2021 was 94.9%, this remains below 95% target and YTD is 94.8%.

Root Cause Analysis Infections for MSSA and E.Coli Bacteraemia

All MSSA and E.Coli post 48 hour bacteraemia are reviewed by the microbiology team, those deemed to be device related or where the source of infection cannot be determined are expected to have an RCA completed. There have been some delays in the completion of these RCAs due to the availability of the clinical teams in order to complete the documentation and attend meetings as a result of the pressures caused by the Covid-19 pandemic. There are currently 10 RCAs which have not yet been finalised, 3 RCAs are awaiting a meeting date, 5 have meeting dates for the RCAs schedules to take place and 2 RCAs have been completed but are awaiting presentation at governance meetings. These outstanding RCAs need to be completed by the end of March 2021.

3.0 PERIODS OF INCREASED INCIDENCE/OUTBREAKS

Period of Increased Incidence

Six cases of pseudomonas infection were reported for the ITU at the Princess Royal Hospital, an initial outbreak meeting was called and actions agreed. The 6 cases were sent for typing and all came back as different meaning this was not an outbreak. Actions agreed as part of the review meeting included:

- Ensure that all staff are aware that waste water and IV fluids should not be drained into the hand wash basins on the unit but should be taken to the sluice
- Estates to undertake water testing on the outlets in the ITU side of the unit Estates to review if there are any POU filters on any outlet
- Daily IPC visits to Unit and Weekly audits

Outbreak

Two positive cases of Vancomycin Resistant Enterococcus were reported on Ward 28 Renal, only one case could be sent for typing, so as the typing for both cases would not be able to be matched this was agreed as an outbreak. Issues which required actioning include:

- Improvement and monitoring of the standard of cleanliness on the ward
- Ensuring all staff have had aseptic non-touch technique (ANTT) training.

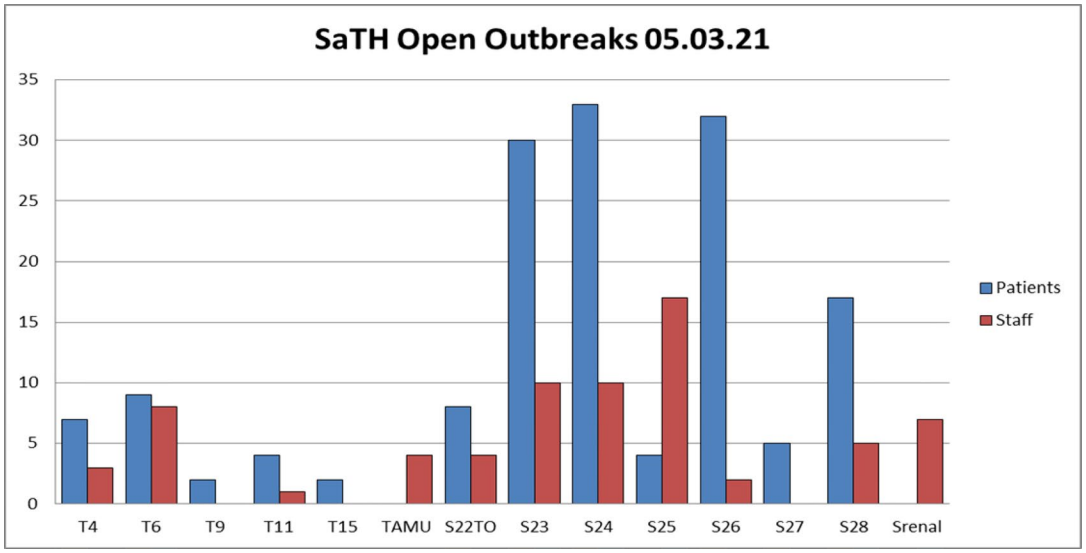
4.0 COVID 19

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).

Current Open Outbreak Summary (Second Wave)

Throughout February 2021 the Trust has continued to have a number of Covid-19 outbreaks. A summary of the outbreaks including the number of patients and staff involved and the current status of the Covid-19 outbreaks open as of the 5th March 2021 are shown:



The number of new outbreaks and outbreaks which have remained open in February 2021 has reduced with 14 outbreaks open as of the 5th March compared to 17 outbreaks at the end of January 2021. A majority of these outbreaks included both patients and staff. However, 2 outbreaks related to staff only; these were on the Renal Unit at The Royal Shrewsbury Hospital and on the AMU at the Princess Royal Hospital (PRH). The outbreaks on ward 9 and ward 15 at PRH involved patients only.

Princess Royal Hospital					Royal Shrewsbury Hospital				
Date of Outbreak	**Ward**	**No Patients**	**No Staff**	**Total**	**Date of Outbreak**	**Ward**	**No Patients**	**No Staff**	**Total**
11.01.2021	6	9	8	17	21.01.2021	26	32	2	34
21.01.2021	4	7	3	10	25.01.2021	28	17	5	22
05.02.2021	AMU	0	4	4	26.01.2021	24	33	10	43
24.02.2021	11	4	0	4	01.02.2021	23	30	10	40
24.02.2021	9	2	0	2	03.02.2021	22TO	8	4	12
24.02.2021	15	2	0	2	03.02.2021	25	4	17	21
Total PRH		24	15	39	08.02.2021	Renal	0	7	7
					24.02.2021	27	5	0	5
							129	55	184

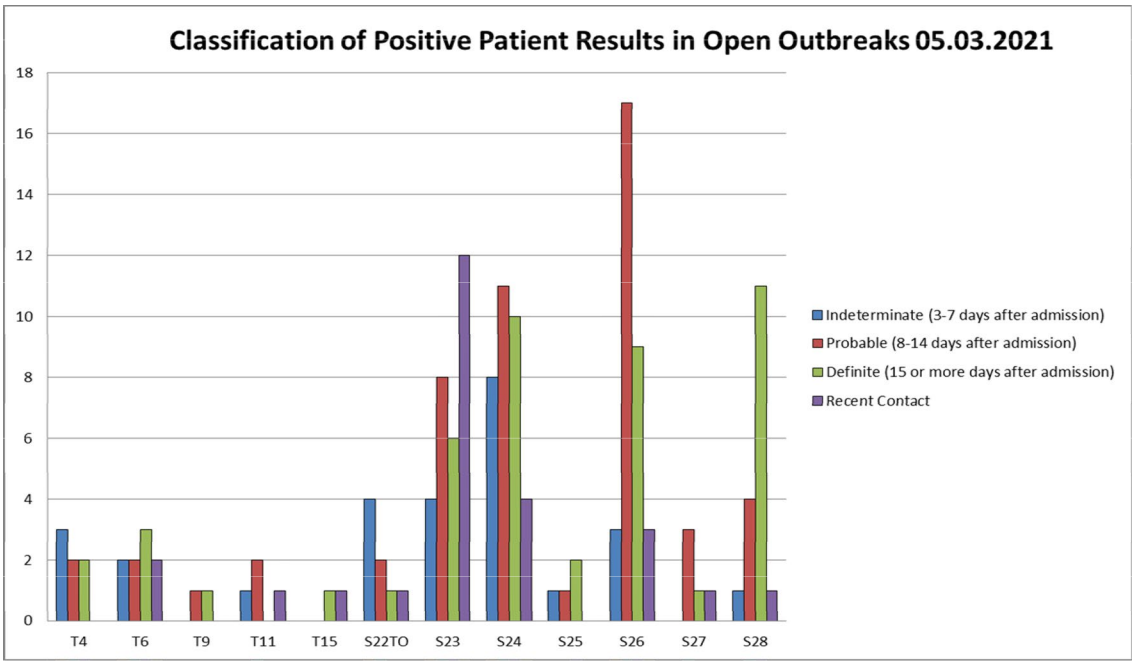
In total 153 patients and 70 staff were involved in these outbreaks. The largest number of outbreaks have occurred on the Royal Shrewsbury Hospital Site, with the biggest outbreaks occurring on ward 23 and ward 24.

It is hoped that if no further cases are reported by 24th March 2021 all outbreaks will be closed with the exception of Ward 23 Oncology which will remain open

Classification of Positive Patient Results per Outbreak

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 and open as of the 3rd February 2021, the duration of time from admission to a patient being screened as positive is shown:



This shows that 31% of cases were classified as definite hospital acquired, 35% of cases were probably hospital acquired, 17% cases were indeterminate, and 17% of cases were recent contacts of positive patients.

Outbreak meetings continue to take place twice weekly and 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.

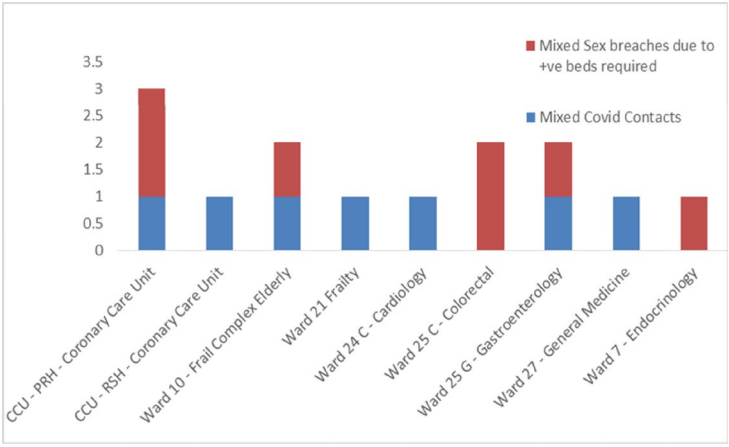
Closed Outbreak Summary (Second Wave)

From October 2020 the Trust has reported a number of Covid-19 outbreaks across both hospital sites which at the time of this report had closed. There were a total of 30 outbreaks. A total of 9 outbreaks involved staff only. Two outbreaks on Ward 7 and Ward 22SS involved patients only. The remaining 19 outbreaks involved both patients and wards with the largest outbreaks being on Ward 9, 26 and 11.

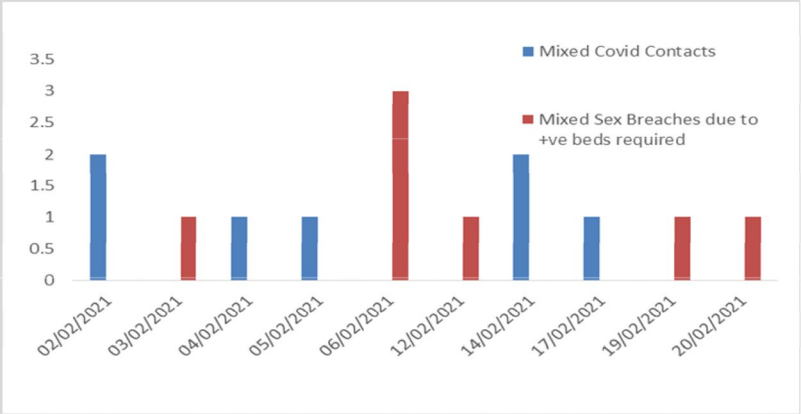
PRH					RSH				
Date of Outbreak	**Ward**	**No Patients**	**No Staff**	**Total**	**Date of Outbreak**	**Ward**	**No Patients**	**No Staff**	**Total**
15.10.2020	9	5	2	7	29.10.2020	27	17	10	27
15.10.2020	15/16	11	11	22	08.11.2020	Research	0	2	2
15.10.2020	6	8	2	10	11.11.2020	24	20	7	27
15.10.2020	7	10	0	10	13.11.2020	22SS/F	5	4	9
13.11.2020	Mat	0	5	5	14.11.2020	25	23	7	30
14.11.2020	Porters	0	2	2	18.11.2020	28	2	2	4
14.11.2020	11	26	10	36	19.11.2020	26	37	27	64
26.11.2020	4	5	2	7	21.11.2020	ED	0	9	9
10.12.2020	9	50	5	55	30.11.2020	32	0	10	10
14.12.2020	10	2	2	4	10.12.2020	Estates	0	3	3
14.12.2020	17	0	9	9	18.12.2020	25	7	6	13
16.12.2020	7	23	3	26	23.12.2020	35	0	3	3
16.12.2020	8	5	2	7	21.01.2021	35	3	2	5
07.01.2021	19	0	9	9	03.02.2021	21	7	1	8
12.01.2021	10	9	5	14	03.02.2021	22SS	4	0	4
Total		**154**	**69**	**223**	**Total**		**125**	**93**	**218**

Mixed Sex Accommodation Breaches and Covid Mixed Contacts

To ensure the provision of cohorting and the safe management of patients requiring cohorting or patients who are contacts of positive patients there is, on occasion the need to mix sexes in the Ward Bays and mix contacts, this has to be authorised by the Director of Infection Prevention and Control in hours or the Executive on –call out of hours and reported as a Datix. In February 2021 there were 14 incidents reported as shown below:



There were 7 MSA breaches due to the need to mix Covid-19 contacts and 7 due to the need to cohort positive patients.



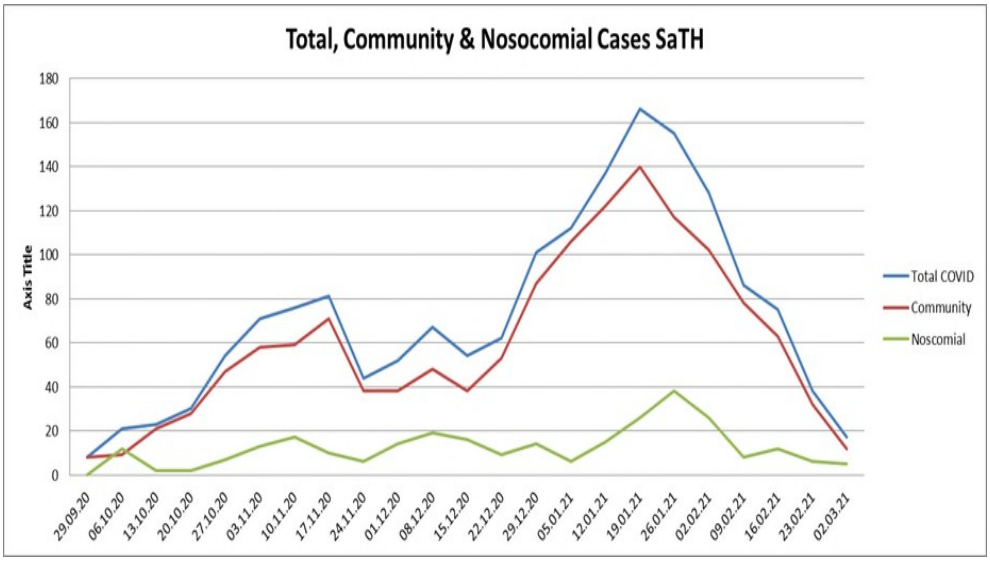
Covid-19 Outbreak Assurance Visits

A number of assurance visits have taken place in relation to Covid-19 and the ongoing outbreaks. The University Hospital North Midlands NHS Trust undertook a supportive peer visit in August 2020 and assurance visits by NHSE/I and the CCG following the Covid-19 Outbreaks in October, November and December 2020. All improvement actions have been completed or commenced and have been included in the overarching action plan from all the assurance meetings and is monitored through the IPC Operational Group.

A majority of the actions have been completed. Outstanding actions relate to Estates and facilities work. A meeting has been held with Estates, Facilities and IPC to progress these and fortnightly meetings have been put in place to monitor these actions.

Analysis of Covid-19 Nosocomial Infections

The IPC Team has completed an analysis of nosocomial Covid-19 cases. Nosocomial cases are those deemed to have been acquired at Day 8 or above following admission to hospital.



The most recent data is up to and including week of 2nd March 2021. The analysis shows that the nosocomial hospital infections are declining and follow a similar pattern seen for overall cases in the community however cases are not reducing as quickly in the hospital as they are in the community. .

For the most recent week 2nd -8th March 2021, there were 5 patient cases identified where the infection was detected greater than 8 days after admission, therefore were nosocomial. Of these 5 cases, 1 had previously been identified as a contact of a positive case. This is a decrease from 6 cases in the previous week. The nosocomial cases account for 29.4% of all new positive cases seen in the Trust in that week compared to 15.8% in the previous week.

Ongoing actions being undertaken include:

- Wards are being Tristell cleaned twice daily.
- When outbreaks are identified , if required cohorting plans are put into place
- Any non-compliance with PPE is addressed at the time
- Staff informed not to be congregating in areas.
- Patients advised to wear masks at all times

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, a summary of the finding and recommendations where previously reported.

The outbreak on ward 26 in December 2021 was also raised as a serious incident and the report is being finalised. No further serious incidents relating to Infection Prevention and Control were reported in January 2021.

6.0 IPC INITIATIVES

Quality Ward Walks continue to be undertaken by the IPC team. Compliance scores range from 75-100% across the clinical areas reviewed. Issues are escalated at the time of the Quality Ward Walks and areas of non-compliance highlighted to the ward manager/matron.

Quality Ward Walks with the Deputy Director of Nursing, Divisional Directors of Nursing and IPC Team are planned to take place across both hospital sites in April 2021.

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. This Infection Prevention and Control Board Assurance Framework (IPC BAF) had 10 Sections with 63 key lines of Inquiry. The IPC BAF was reviewed monthly and the Trust was RAG rated Green for 53 of the 63 key lines of enquiry and amber for the remaining elements. An updated version of the IPC BAF was issues by NHSE/I on the 16th February 2021; this updated BAF had an additional 46 key lines of enquiry. A gap analysis has been carried out by the IPC team and the Trust is RAG rated green for 96 items and amber for the remaining 13 items. The gap analysis is outlined below and a copy of the fully updated BAF is included in Appendix 1.

Section	RAG Rated Green	RAG Rated Amber	Amber Key Line of Enquiry
Section1: Systems and Processes	17	2	There are pathways in place which support minimal or avoid patient bed/ward transfers for duration of admission unless clinically imperative
			Monitor of staff compliance with wearing appropriate PPE when in the clinical areas. Consider implementing the role of PPE

			guardians/champions
Section 2: Provide and Maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections	15	2	Designated cleaning teams with appropriate training in required techniques and use of PPE, are assigned to COVID-19 isolation or cohort areas
			Monitor adherence environmental decontamination with actions in place to mitigate any identified risk
Section 3	1	1	Ensure appropriate anti-microbial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance
Section 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	5	0	
Section 5: Ensure prompt identification of people who have or at risk of developing an infection so that they can	13	1	To ensure 2 metre social and physical distancing in all patient care areas
Section 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	12	2	All staff (clinical and non-clinical) have appropriate PPE training, in line with latest PHE and other guidance, to ensure their personal safety and work environment is safe
			All staff providing patient care and working within the clinical environment are trained in the selection and use of PPE appropriate for the clinical situation and on how to safely Don and Doff
Section 7: Provide or secure adequate isolation facilities	5	0	
Section 8: Secure adequate access to laboratory support as appropriate	11	1	That sites with high nosocomial rates should consider testing COVID negative patients daily
Section 9: Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections	4	0	
Section 10: Have a system in place to manage the occupational health needs and obligations of staff in relation to infection	13	4	Staff in 'at-risk' groups are identified and managed appropriately including ensuring their physical and psychological wellbeing is supported
			A documented record of this discussion should be available for the staff member and held centrally within the organisation, as part of employment record including Occupational health
			Following consideration of reasonable adjustments e.g. respiratory hoods, personal re-usable FFP3, staff who are unable to pass a fit test for an FFP

			respirator are redeployed using the nationally agreed algorithm and a record kept in staff members personal record and Occupational health service record
			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

Actions are being implemented to increase compliance with many of the key lines of enquiry currently rated as amber. Actions include a business case to secure permanent funding for the cleanliness team, ensuring improved compliance with PPE training and social distancing measure in the clinical areas.

8.0 RISKS AND ACTIONS

The Risk register is updated monthly. There are 10 risks on the risk register. One new risk was recorded in March following a MHRA alert relating to the sterility of intravenous consumables supplied by Becton Dickinson UK. This risk has been acknowledged as very low nationally; the Trust has completed a QIA and risk assessment in relation this product and its continued use in view of the low risk associated.

3 risks are RAG rated Red prior to risk controls which reduces the risks to Amber following these controls being in place. These risks are:

- **Risk 1844**: Risk of poor monitoring of IPC outbreaks including COVID19 due to lack of electronic surveillance system
- **Risk 1749**: There is a risk associated with the isolation of patients who have airborne infections due to the lack of negative pressure isolation rooms in the Trust
- **Risk 1456**: There is a risk of Healthcare associated infection due to the lack of isolation facilities which may lead to delays when a patient needs to be isolated

9.0 CONCLUSION

This IPC report has provided a summary of the performance in relation to the key performance indicators for IPC for February 2021. Overall performance in relation to many of the IPC KPIs remains positive, which the improvement targets for C.Diff and E.Coli set to be achieved for 2020/21. There has been one MRSA bacteraemia in January which the investigation concluded was a contaminant. The current Covid-19 outbreaks, nosocomial infections and mitigating actions have been outlined.

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
3.1	23.02.2021	Janette Pritchard, Kara Blackwell	Full Review and update
3.2	09.03.2021	Janette Pritchard	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.			Green
1.2	there are pathways in place which support minimal or avoid patient bed/ward transfers for duration of admission unless clinically imperative	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.	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.	Amber

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
		See link for policy at bottom of document		Where possible any one 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	
1.3	that on occasions when it is necessary to cohort COVID or non-COVID patients, reliable application of IPC measures are implemented and that any vacated areas are cleaned as per guidance.	• Any patients who are tested positive are isolated in side rooms. • Suspected cases are cohorted as appropriate in high and low risk bays. • WM will sign off domestic cleaning schedule and WM/Matron monitor and ward environmental cleaning and sign off of completion		If positive patients cannot be isolated in a side room, then they will be cohorted in a bay of positive patients	Green
1.4	monitoring of IPC practices, ensuring resources are in place to enable compliance with IPC practice • staff adherence to hand hygiene?	The IPC Team perform regular Quality Ward Walks on all wards in the Trust. If a ward has been identified as an outbreak ward, then a weekly enhanced			Green

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
	• staff social distancing across the workplace • staff adherence to wearing fluid resistant surgical facemasks (FRSM) in: a) clinical b) non-clinical setting	Quality Ward walk will be completed. This observes adherence to Hand Hygiene, social distancing and adherence to wearing surgical facemasks in both clinical and non-clinical settings.			
1.5	monitoring of staff compliance with wearing appropriate PPE, within the clinical setting consider implementing the role of PPE guardians/safety champions to embed and encourage best practice	The Ward Managers and Matrons are responsible for monitoring compliance with support from the IPC Team. Heads of Nursing have suggested that IPC link nurses for all areas have it added to responsibilities and quick guide produced for them on actions they can take to support good practice	The IPC Team are to produce a quick guide for Link Nurses on actions they can take to support good practice		Amber
1.6	implementation of twice weekly lateral flow antigen testing for NHS patient facing staff, which include organisational systems in place to monitor results and staff test and trace	From day one of phase one of testing in November 2020: Webform for staff/Bank/agency/contractors/students to report on internet site ; Process for a PCR swab test referral via the Absence Line when testing reveals positive result.			Green
1.7	additional targeted testing of all NHS staff, if your trust has a high nosocomial rate, as recommended by your local and regional infection prevention and control/Public Health team.	Due to high background infection rates and outbreaks within the Trust additional targeted testing is taking place within the Trust and will be reviewed as levels decrease.	No guidance published on what a 'high nosocomial rate' is		Green

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
1.8	training in IPC standard infection control and transmission-based precautions are provided to all 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			Green
1.9	IPC measures in relation to COVID-19 should be included in all staff Induction and mandatory training	All staff are asked to complete Infection Prevention Training at Induction – Level 1 for Non-Clinical – Level 2 for Clinical. Clinical Staff Complete Refresh this Annually			Green
1.10	all staff (clinical and non-clinical) are trained in putting on and removing PPE; know what PPE they should wear for each setting and context; and have access to the PPE that protects them for the appropriate setting and context as per national guidance	Clinical staff have been trained to follow PHE guidance on PPE usage and have had donning and doffing training, there are posters in all areas, and advice readily available on the Trust intranet. The compliance is recorded by corporate education see above There is a mask etiquette poster at all mask stations in the Trust which provide guidance on how to don and doff a mask for non-clinical staff and visitors.			Green
1.11	there are visual reminders displayed communicating the importance of wearing				Green

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
	face masks, compliance with hand hygiene and maintaining physical distance both in and out of the workplace				
1.12	national IPC national guidance is regularly checked for updates and any changes are effectively communicated to staff in a timely way	The National IPC guidance is checked daily and the IPC team receive the daily Gov.uk guidance. • It is also discussed on the Trust COVID call held once per week per week (from July 2020) chaired by the COO/MD. • All changes for escalation throughout the Trust are also reported through to the Covid 19 Incident Control Room which is in place 7 days a week 8-8pm coordinated by a Strategic commander. • There is a daily message sent out to staff from a member of the executive team, which communicates any changes. The IPC team are visiting the clinical areas in the Trust daily.			Green
1.13	changes to national guidance are brought to the attention of boards and any risks and mitigating actions are highlighted	See 1.12			Green
1.14	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.		Business case being developed for substantive 7 day service provision Following discussion	Green

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
		BAF risk 1771 was reviewed by the Trust Board on 28.05.2020 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.	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 Use of Contractor hours including a Rapid Response Team funded from Covid monies	
1.15	robust IPC risk assessment processes and practices are in place for non COVID-19 infections and pathogens	This is normal practice in the Trust. There are policies in place for non-COVID infections that are in date. http://intranet.sath.nhs.uk/infection_control/Infection_control_policies_and_related_information.asp			Green
1.16	that Trust Chief Executive, the Medical Director or the Chief Nurse approves and personally signs off, all daily data submissions via the daily nosocomial sitrep. This will ensure the correct and accurate measurement and testing of	"nosocomial" sitrep is signed off by either CE/MD/DoN			Green

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
	patient protocols are activated in a timely manner.				
1.17	This Board Assurance Framework is reviewed, and evidence of assessments are made available and discussed at Trust board	BAF is reviewed at IPCOG & IPCAC X:\CorporateMeetings\CURRENT\IPCC\2021\March 2021\Paper 01 - IPCOG Minutes 11 Feb 2021.docx			Green
1.18	ensure Trust Board has oversight of ongoing outbreaks and action plans	Deputy Director of Nursing attends Trust Board meeting monthly and presents an overview of current outbreaks			Green
1.19	there are check and challenge opportunities by the executive/senior leadership teams in both clinical and non-clinical areas	Regular Confirm and Challenge meetings for Divisions are held which are attended by a member of the executive team			Green
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			Green

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
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. • 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	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 additional funding has been submitted, and is awaiting approval. Reduced capability for cleaning from 10pm – 6am Nursing teams under pressure balancing patient care and cleaning the environment	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 External Peer Review undertaken in August 2020. Additional funding requested for more cover during these hours Review of nursing cleaning duties to see if domestic staff can complete on their behalf	Amber
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			Green

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
		Facilities keep an account of areas which have been HPV cleaned. Facilities have compiled a proactive/reactive dashboard on HPV/UV cleaning which is kept on shared drive. Z:\Facilities\Cleanliness Decontamination Dashboard			
2.4	Assurance processes are in place for monitoring and sign off terminal cleans as part of outbreak management	Terminal cleans are signed off by the Ward Manager and Cleanliness Technician on the Ward cleaning checklist once complete and the Cleanliness team also maintain their own terminal clean records			Green
2.5	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
2.6	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

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
2.7	Manufacturers' guidance and recommended product 'contact time' must be followed for all cleaning/ disinfectant solutions/ products	Facilities SOP follows recommended contact time of 5 minutes.			Green
2.8	'frequently touched' surfaces, e.g. door/toilet handles, patient call bells, over-bed tables and bed rails, should be decontaminated at least twice daily and when known to be contaminated with secretions, excretions or body fluids as per national guidance	Facilities confirm that toilet door handles cleaned 3 x daily, Heads of Nursing confirmed that call bells/over bed tables & bed rails cleaned twice daily by housekeepers.			Green
2.9	Electronic equipment, e.g. mobile phones, desk phones, tablets, desktops and keyboards should be cleaned at least twice daily as per national guidance	Heads of Nursing confirm that all electronic equipment is cleaned twice daily. This is reviewed by the IPC team on their ward visits.			Green
2.10	Rooms/areas where PPE is removed must be decontaminated, timed to coincide with periods immediately after PPE removal by groups of staff (at least twice daily) as per national guidance	Facilities decontaminate these areas twice daily.			Green
2.11	Linen from possible and confirmed COVID-19 patients is managed in line with PHE and other national guidance and the appropriate precautions are taken	Linen is handled as per Trust Policy/National guidance. http://intranet/Facilities_Department/Policies_and_Procedures.asp			Green
2.12	Single use items are used where 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:	Green

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
				https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control/managing-shortages-in-personal-protective-equipment-ppe	
2.13	Reusable equipment is appropriately decontaminated in line with local and PHE and other national policy	Power Air Purified Respirator units with helmet head-tops are decontaminated according below SOP. A process for decontaminating reusable tight-fitting Respiratory Protective Equipment (half mask or full face respirators with P3 filters) 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		New versions of reusable respirator document https://intranet.sath.nhs.uk/coronavirus/ppevideos.asp	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. The Trust is using single use eyewear/visors and not reusable.			
2.14	ensure cleaning standards and frequencies are monitored in non-clinical areas with actions in place to resolve issues in maintaining a clean environment	The C4C monitoring programme includes the auditing of non-clinical areas			Green
2.15	ensure the dilution of air with good ventilation e.g. open windows, in admission and waiting areas to assist the dilution of air	• 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 • Matrons were emailed in October with PHE paper & requested implementation : Simple summary of ventilation actions to mitigate the risk of COVID-19, 1 October 2020 https://www.gov.uk/government/publicat			Green

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
		ions/emg-simple-summary-of-ventilation-actions-to-mitigate-the-risk-of-covid-19-1-october-2020			
2.16	monitor adherence environmental decontamination with actions in place to mitigate any identified risk	C4C monitoring audits and Cleanliness team inspections identify environmental decontamination risks and actions are taken to mitigate as necessary	Currently there is no environmental swabbing taking place post HPV or UV cleans	Assurance is provided by Inivos on the efficacy of these cleans	Amber
2.17	monitor adherence to the decontamination of shared equipment with actions in place to mitigate any identified risk	QWW provide evidence of equipment decontamination Ward have local records/cleaning schedules			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 antimicrobial stewardship is 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,	Antibiotic policy in 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	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.	Amber

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

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
4.1	Implementation of national guidance on visiting patients in a care setting	The Trust adopted the national guidance on suspending visiting. The trust has adopted the guidance on compassionate visiting for end of life care. http://intranet.sath.nhs.uk/Library_Intranet/documents/Coronavirus/EndofLife/eolcare visiting guidelines.pdf		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.	Green
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/ppevideos.asp			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
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
4.5	There is clearly displayed and written information available to prompt patients' visitors and staff to comply with hands, face and space advice.	Posters have been produced & are displayed in patient environment			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	Screening and triaging of all patients as per IPC and NICE Guidance within all health and other care facilities must be undertaken to enable early recognition of COVID-19 cases**.**	See Section 1: Emergency Department SOP (1.1).			Green
5.2	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	See Section 1: Emergency Department SOP (1.1).			Green

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
	COVID-19 cases, to minimise the risk of cross-infection as per national guidance				
5.3	staff are aware of agreed template for triage questions to ask	The trIage/navigator form asks the 3 key questions related to covid to allow appropriate immediate identification of the appropriate pathway for that patient			Green
5.4	triage undertaken by clinical staff who are trained and competent in the clinical case definition and patient is allocated appropriate pathway as soon as possible	identified through Manchester triage initial Assessment, navigator and pit stop nurses are trained in Manchester triage ED also have Manchester triage train the trainer ED senior staff in both depts			Green
5.5	face coverings are used by all outpatients and visitors	Outpatients & visitors wear face coverings			Green
5.6	face masks are available for all patients and they are always advised to wear them	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.			Green
5.7	provide clear advice to patients on use of face masks to encourage use of surgical facemasks by all inpatients (particularly when moving around the ward) if this can	Following PHE guidance, all patients where possible should be wearing facemasks - SOP for this completed			Green

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
	be tolerated and does not compromise their clinical care				
5.8	monitoring of Inpatients compliance with wearing face masks particularly when moving around the ward (if clinically ok to do so)	Staff encourage patients to wear facemasks, it this cannot be tolerated or patients refuse this is documented in the patients noted			Green
5.9	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
5.10	to ensure 2 metre social & physical distancing in all patient care areas	Patient bedspaces don't allow 2 metre distancing at times	It has been identified that patients will not always be 2 metres apart	• Clear curtains are now at every bedspace • Patients encouraged to maintain social distance	Amber
5.11	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
5.12	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

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
5.13	there is evidence of compliance with routine patient testing protocols in line with Infection prevention and control and testing document: https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/11/key-actions-boards-and-systems-on-infection-prevention-control-testing-23-december-2020.pdf	Dashboard in place showing compliance with admission, Day 3 & Day 5 swabs. Discharge testing is completed by a newly dedicated 'Swab Squad' Offsite screening pathway in place for elective patient screening			Green
5.14	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:					
6.1	separation of patient pathways and staff flow to minimise contact between pathways. For example, this could include provision of separate entrances/exits (if available) or use of one-way entrance/exit systems, clear signage, and restricted access to communal areas	Patients are admitted on a low, medium and high risk pathway and staff cross over of these pathways is kept to a minimum			Green

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
6.2	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 Divisions in relation to compliance. Local records being	Amber

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
				held by departments of staff trained, DivisionalCare Leads ensuring managers send this information to Corporate Education	
6.3	all staff providing patient care and working within the clinical environment are trained in the selection and use of PPE appropriate for the clinical situation and on how to safely don and doff it. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/911313/PHE_quick_guide_to_donning_doffing_PPE_standard_health_and_social_care_settings.pdf	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
6.4	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, Divisional Leads ensuring managers send this information	Green

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
				to Corporate Education	
6.5	adherence to PHE national guidance on the use of PPE is regularly audited with actions in place to mitigate any identified risk	IPC Team undertake PPE audits as part of QWW for wards			Green
6.6	hygiene facilities (IPC measures) and messaging are available for all patients/individuals, staff and visitors to minimise COVID-19 transmission such as: • hand hygiene facilities including instructional posters • good respiratory hygiene measures • staff maintain physical distancing of 2 metres wherever possible in the workplace unless wearing PPE as part of direct care • staff maintain social distancing (2m+) when travelling to work (including avoiding car sharing) and remind staff to follow public health guidance outside of the workplace • frequent decontamination of equipment and environment in both clinical and non-clinical areas • clear visually displayed advice on	The Trust policy advises actions http://intranet.sath.nhs.uk/coronavirus/ppevideos.asp			Green

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
	use of face coverings and facemasks by patients/individuals, visitors and by staff in non-patient facing areas				
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	the use of hand air dryers should be avoided in all clinical areas. Hands should be dried with soft, absorbent, disposable paper towels from a dispenser which is located close to the 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			Green

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
		half load then iron or tumble dry for at least thirty minutes. http://intranet.sath.nhs.uk/document_library/viewPDFDocument.asp?DocumentID=10065			
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
6.12	a rapid and continued response through ongoing surveillance of rates of infection transmission within the local population and for hospital/organisation onset cases (staff and patients/individuals)	Every positive COVID result is reviewed daily and all cases are assigned a category based on PHE guidance. System wide groups monitor and discuss community situation with regards to prevalence and also have a dashboard that reflects the local data			Green
6.13	positive cases identified after admission who fit the criteria for investigation should trigger a case investigation. Two or more positive cases linked in time and place trigger an outbreak investigation and are reported.	All patients who are positive on day 8 or after will trigger an RCA X:\IPC\COVID-19\COVID_RCAS Two or more cases linked by time and place trigger an outbreak & are investigated. Meetings take place twice a week & are attended by NHSEI & PHE			Green

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
6.14	Robust policies and procedures are in place for the identification of and management of outbreaks of infection. This includes the documented recording of outbreak meetings.				Green
7. Provide or secure adequate isolation facilities					
Systems and process are in place to ensure:					
7.1	restricted access between pathways if possible, (depending on size of the facility, prevalence/incidence rate low/high) by other patients/individuals, visitors or staff	See 6.1			Green
7.2	areas/wards are clearly signposted, using physical barriers as appropriate to patients/individuals and staff understand the different risk areas	All wards have appropriate signage to differentiate pathways			Green
7.3	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
7.4	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
7.5	Patients with resistant/alert organisms are managed according to local IPC guidance, including ensuring appropriate patient	All patients with alert/resistant organisms are managed as per normal			Green

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
	placement	Trust policy.			
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 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 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. Antibody testing has been launched in the Trust with a booking system in place. This is prioritised initially for staff working in ED, ITU, Respiratory Wards, AMU's and Phlebotomy at both sites. For roll out plan see below:			Green

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
8.3	regular monitoring and reporting of the testing turnaround times with focus on the time taken from the patient to time result is available	Reported daily on PLACERS data return			Green
8.4	regular monitoring and reporting that identified cases have been tested and reported in line with the testing protocols (correctly recorded data)	Cases are reported electronically twice daily via SGSS and there is a daily sitrep (PLACERS) for all positive reported cases			Green
8.5	Screening for other potential infections takes place	All screening for other organisms usually monitored continue to be performed in the as per guidelines			Green
8.6	that all emergency patients are tested for COVID-19 on admission.	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			Green
8.7	that those inpatients who go on to develop symptoms of COVID-19 after admission are retested at the point symptoms arise.	Wards are aware of the requirement to swab for new onset of symptoms, and the request forms have the option to select new onset symptoms			Green
8.8	that those emergency admissions who test negative on admission are retested on day 3 of admission, and again between 5-7 days post admission.	SQL report set up to inform Ward Managers when days 3 & 5 COVID screens are due, and dashboard in place to show compliance by ward area			Green
8.9	that sites with high nosocomial rates should consider testing COVID negative patients daily.	This will be discussed and decided as relevant in conjunction with ongoing outbreaks – fluctuating lab capacity could make this difficult			Amber
8.10	that those being discharged to a care home	Discharge testing is completed by a			Green

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
	are being tested for COVID-19 48 hours prior to discharge (unless they have tested positive within the previous 90 days) and result is communicated to receiving organisation prior to discharge	newly dedicated 'Swab Squad'			
8.11	that those being discharged to a care facility within their 14 day isolation period should be discharged to a designated care setting, where they should complete their remaining isolation.	following PHE and regional guidance on discharging patients who have tested positive for Covid 19 to the community. All patients will be given appropriate advice when they are discharged. Many patients will no longer be infectious by this time. Patients who are being discharged to nursing homes are only discharged if they are no longer infectious unless the nursing home is able to isolate patients with Covid and has agreed to take the patient			Green
8.12	that all Elective patients are tested 3 days prior to admission and are asked to self-isolate from the day of their test until the day of admission.	All elective patients are tested 3 days prior to admission & are ask to comply with self isolation			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.			Green

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
		This is also reported to Trust IPCC committee, via Divisional reports and IPC team QWW reports.			
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. • There is a daily message sent out to staff from a member of the executive team which communicates any changes. • The IPC team are visiting the clinical areas in the Trust daily.			Green
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			Green

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
		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.			
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	**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
		• HR Advice and Support - Extended Hours Support for COVID-19 • SaTH Trained Listeners - Hotline Coaching hotline • A free wellbeing support helpline • Peer-to-Peer Listening • Coaching and listening ear support lines available • Redeployment Coaching Support • Wellbeing Hubs • Headspace - Free subscription • Trust Coaches • Freedom to Speak Up Guardians • Accommodation for Staff in Critical Service Roles Staff are being risk assessed taking into consideration the health, age, ethnicity and gender. The Trust is ensuring that all BAME staff have had a risk assessment by the end of June.			
10.2	that risk assessment(s) is (are) undertaken and documented for any staff members in an at risk or shielding groups, including Black, Asian and Minority Ethnic and pregnant staff	Risk assessment process in place with support also available via occupational health (as required). Documents available on intranet and SaTH app.			Green
10.3	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			Green

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
		quantitative (ambient particle counting) methods. During the course of the fit test staff are trained to don the respirator correctly, and to perform a fit check specific to the valved/ unvalved type of respirator they are fitted to. Reports on numbers fit-tested are submitted to the incident command room twice weekly, and a recent submission is attached for information. http://intranet.sath.nhs.uk/health/FFP3_Mask_Fit_Testing.asp Practice in the fit testing open sessions conforms to HSE guidance on reducing the risk of transmitting coronavirus during the fit test, and this information was also cascaded out to Divisional 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.			

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
10.4	staff who carry out fit test training are trained and competent to do so	The majority of RPE fit testers have been trained by a Fit to Fit accredited external trainer. A smaller number were trained in-house by a member of the H&S Team. A list of current, trained fit testers is maintained at https://intranet.sath.nhs.uk/health/FFP3_Mask_Fit_Testing.asp and this was last updated on 5 Feb 21. This includes dates of in-house refresher training and competency assessments.			Green
10.5	all staff required to wear an FFP respirator have been fit tested for the model being used and this should be repeated each time a different model is used	Fit tests are undertaken for every make and model of FFP3/ reusable respirator issued to staff. The H&S Team work closely with Procurement colleagues to coordinate fit testing provision with stock changeovers. A weekly report on fit testing outcomes is escalated to the Incident Command Centre.			Green
10.6	a record of the fit test and result is given to and kept by the trainee and centrally within the organisation	Records of fit tests are recorded on each staff member's ESR record, and a report on current fit test data by individual is produced by Corporate Education weekly and published at https://intranet.sath.nhs.uk/health/FFP3_Mask_Fit_Testing.asp. The original fit test records are scanned for H&S Team files, then returned to the employing ward department to be held on personal files (though there is currently an admin	A copy of the fit test record is not given to the staff member at the time of the fit test.	Staff are encouraged to access the fit testing report on the intranet to look up their own records.	Green

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
		backlog). Staff are not given a copy of the fit test record at the time of the fit test, but are encourage to make a note/ take a photograph of the FFP3 they fit to, and are informed that their name will be published on the intranet within a week for future reference.			
10.7	for those who fail a fit test, there is a record given to and held by trainee and centrally within the organisation of repeated testing on alternative respirators and hoods	Records of failed fit tests are managed in the same way as records of successful fit tests, as described above.			Green
10.8	for members of staff who fail to be adequately fit tested a discussion should be had, regarding re deployment opportunities and options commensurate with the staff members skills and experience and in line with nationally agreed algorithm	Staff who cannot wear an FFP3 in stock have access to loose-fitting RPE and, in Critical Care areas, reusable tight-fitting RPE. Staff who cannot wear any of the alternatives to FFP3s are assigned to suitable duties by their own line managers, with HR support.			Green
10.9	a documented record of this discussion should be available for the staff member and held centrally within the organisation, as part of employment record including Occupational health	Awaiting update from Workforce			Amber
10.10	following consideration of reasonable adjustments e.g. respiratory hoods, personal re-usable FFP3, staff who are unable to pass a fit test for an FFP respirator are redeployed using the nationally agreed algorithm and a record	Awaiting update from Workforce			Amber

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
	kept in staff members personal record and Occupational health service record				
10.11	boards have a system in place that demonstrates how, regarding fit testing, the organisation maintains staff safety and provides safe care across all care settings. This system should include a centrally held record of results which is regularly reviewed by the board	Results are published at https://intranet.sath.nhs.uk/health/FFP3_Mask_Fit_Testing.asp. A report on fit testing outcomes is presented monthly to the IPC Operational Group and the IPC Assurance Committee, and also to the quarterly Health, Safety, Security and Fire Committee.			Green
10.12	Consistency in staff allocation is maintained, with reductions in the movement of staff between different areas and the cross-over of care pathways between planned and elective care pathways and elective care pathways and urgent and emergency care pathways, as per national guidance	**USC** – due to the current vacancies and the staff sickness this can be challenging. This is kept to a minimum where possible. **SC** –there is some movement of staff to cover sickness/gaps in rosters, however this is kept to a minimum. The elective ward is protected. **Women's and Children's Services** – Paediatrics and Neonates allocate staff between Covid /Non Covid/symptomatic areas. Gynae – there are only 2 RN's on shift, so can be a challenge where joint RN input is required. Allocation of 1RN/1HCA where possible is the aim with the least interaction as possible.	There is still some movement of staff between areas to ensure safe provision of staffing due to gaps	Matrons are responsible for ensuring daily staffing plans are in place which mitigate the movement of staff between areas but maintain safety and that these are communicated to the Clinical Site Team out for out of hours. Monthly staffing report provided to Workforce assurance committee	Amber

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
		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			
10.13	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
10.14	health and care settings are COVID-19 secure workplaces as far as practical, that is, that any workplace risk(s) are mitigated maximally for everyone	Covid-secure guidance, including templates for risk assessments, was produced by the H&S Team and is published at https://intranet.sath.nhs.uk/coronavirus/waysofworking.asp. A list of completed and missing risk assessments is maintained at the same page, and updated frequently. Completed covid-secure risk assessments are published at the same page. Some physical inspections of covid-secure areas are undertaken by the H&S Team and reported via the Health, Safety, Security and Fire Committee.			Green
10.15	staff are aware of the need to wear facemask when moving through COVID-19	The need for facemasks is addressed in covid-secure guidance and risk			Green

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
	secure areas.	assessments described above. The Communications Team have produced standard posters published at https://intranet/coronavirus/briefings.asp , including ones addressing the use of surgical masks. Surgical mask stations are present at entrances to buildings and other key areas including the staff restaurants, the PRH Education Centre and SECC and these are equipped with surgical masks, hand gel, clinical waste bins and posters are displayed.			
10.16	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
10.17	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			Green

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

SaTH COVID Policy Link: http://intranet.sath.nhs.uk/coronavirus/ipc.asp