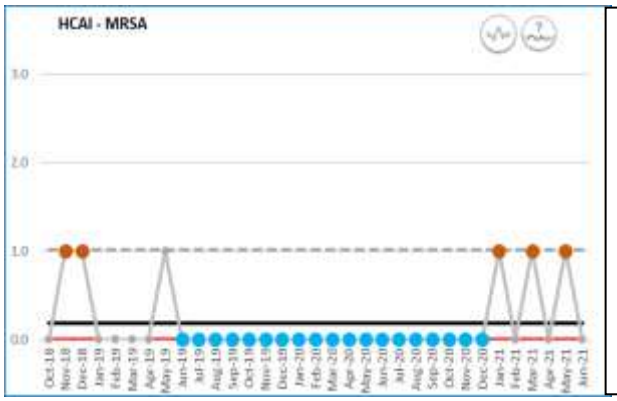
1.0 INTRODUCTION

This paper provides a report for Infection Prevention and Control for Quarter 1 (April to June 2021) against the 2021/2022 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 April to June 2021 is provided. An update in relation to Covid-19 is also provided. 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 was 1 case in Q1 2020/21



This was determined to be a contaminant.
Lessons learnt:

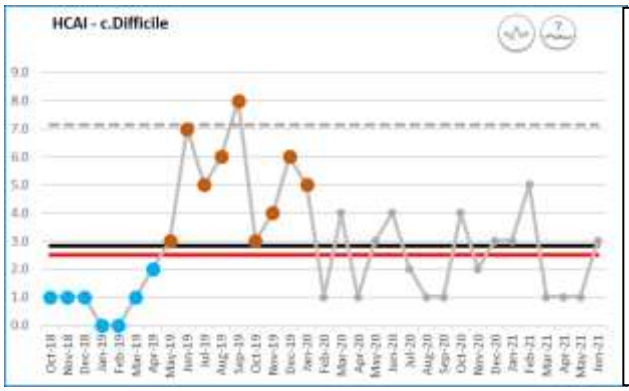
- Doctor who undertook the blood cultures recognised that they didn't complete the pre-cannulation cleaning for long enough.

Actions include:

- Training for junior doctors about blood cultures including procedure and correct labelling

2.2 Clostridium Difficile

There has been no target agreed for 2021/22, until this has been defined the Trust is working to no more than 43 cases as per previous years. Total number of C-Diff cases reported per month is shown:

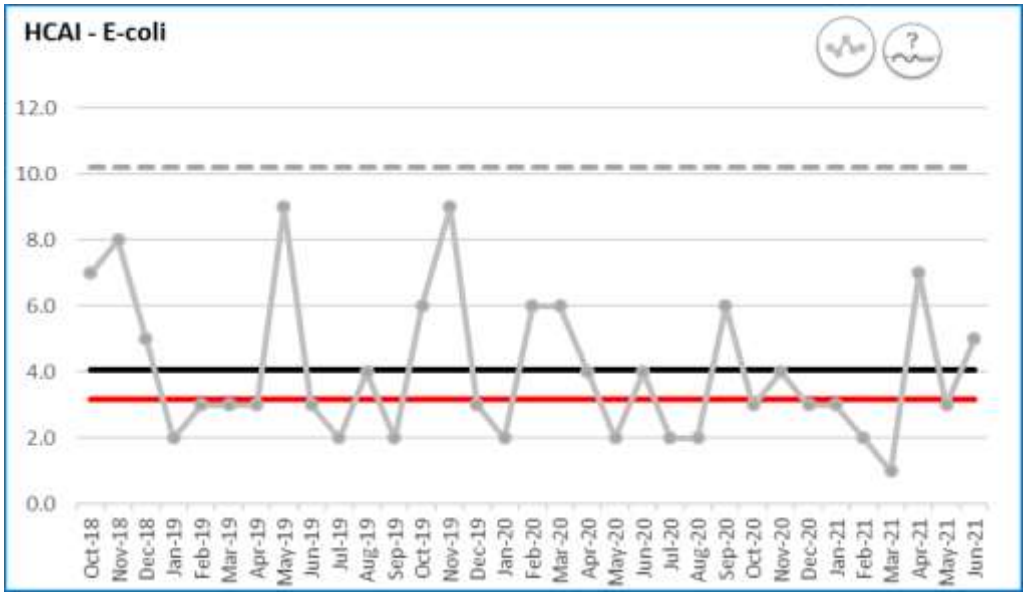
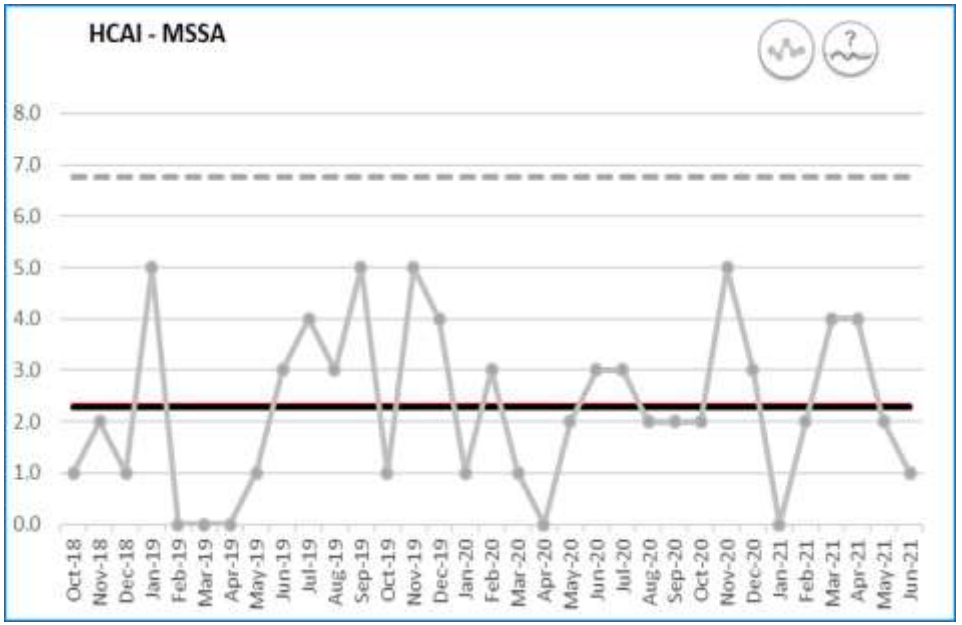


There have been 5 cases of C.Diff attributed to the Trust in Quarter 1 (April to June 2021). Three cases were post 48 hours of admission and two patient cases had been inpatients in the last 28 days prior to the positive sample. Whilst the number of cases in June 2021 was above the Trust monthly target overall for Quarter 1 the Trust remains below target with 5 cases against a target for Q1 of no more than 7 cases.

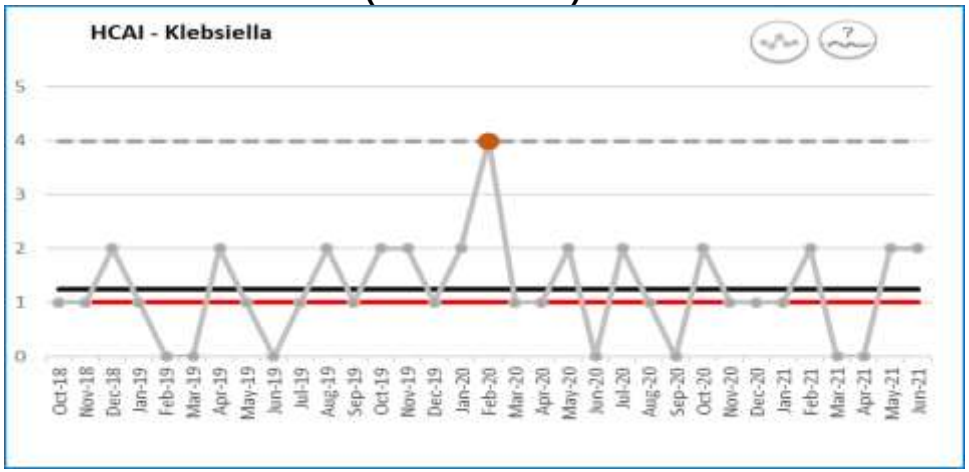
Root cause analysis investigations are undertaken on all C.Diff cases. Common themes identified continue to be:

- Timeliness of obtaining stool sample
- Ability to isolate immediately due to side-room availability
- Antimicrobial prescribing remain the consistent themes.

Actions include reminding staff of importance of obtaining stool sample, use of Redi-rooms and antimicrobial prescribing escalated to Divisional Governance.

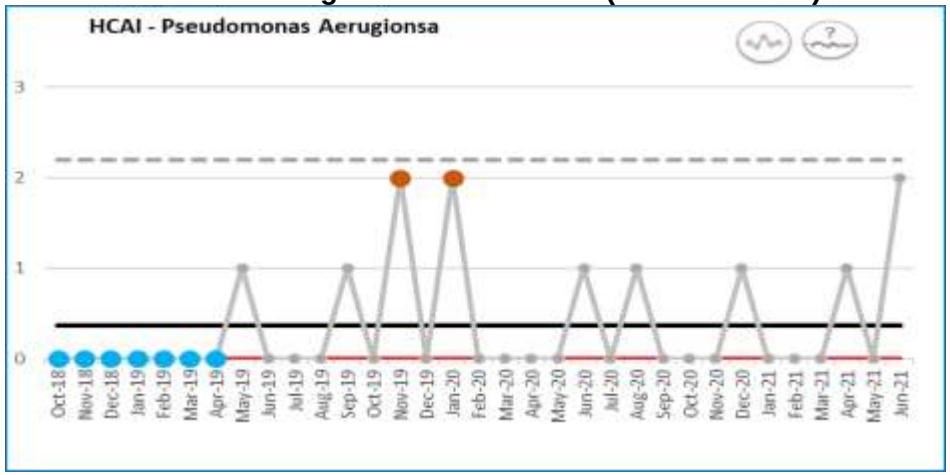
2.3 E.Coli Bacteraemia	**2.4 MSSA Bacteraemia**
The Number of E.Coli cases are shown: 	The number of MSSA cases are shown: 
The target for 2021/2022 is no more than 38 cases. There have been 15 cases of post 48 hour E.Coli bacteraemia in Quarter 1 (April to June 2021). This is higher than the trajectory of no more than 10 cases by the end of Q1. All cases which are deemed to be device related or in which the source cannot be identified have an RCA completed. In the majority of cases the source of the infection was not considered to be related to a device, however in 2 cases the source was considered to be a catheter associated urinary tract infection (CAUTI), 2 further cases in June are being evaluated to identify the source.	The target for 2021/2022 is no more than 28 cases There have been 7 cases of post 48 hour MSSA bacteraemia in Quarter 1 (April to June 2021). This is on trajectory of no more than 7 cases by the end of Q1. All cases deemed to be device related have an RCA completed. Of the 7 cases reported in Q1, there was one cases where the source could not be determined and therefore an RCA was completed.

2.5 Klebsiella Bacteraemia (Post 48 Hours)



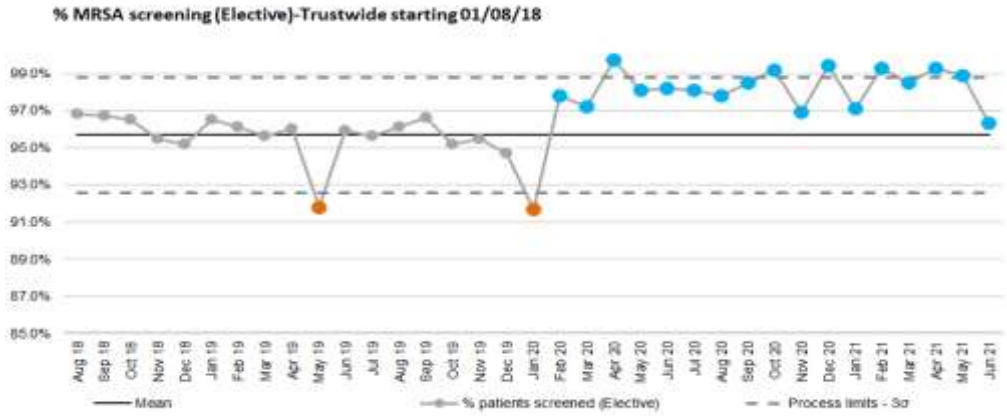
The target for 2021/2022 is no more than 12 cases. There were 4 cases of post 48 hour Klebsiella Bacteraemia in Q1 2021/2022. One case was deemed to be device related due to a catheter associated urinary tract infection.

2.6 Pseudomonas Aeruginosa Bacteraemia (Post 48 Hours)



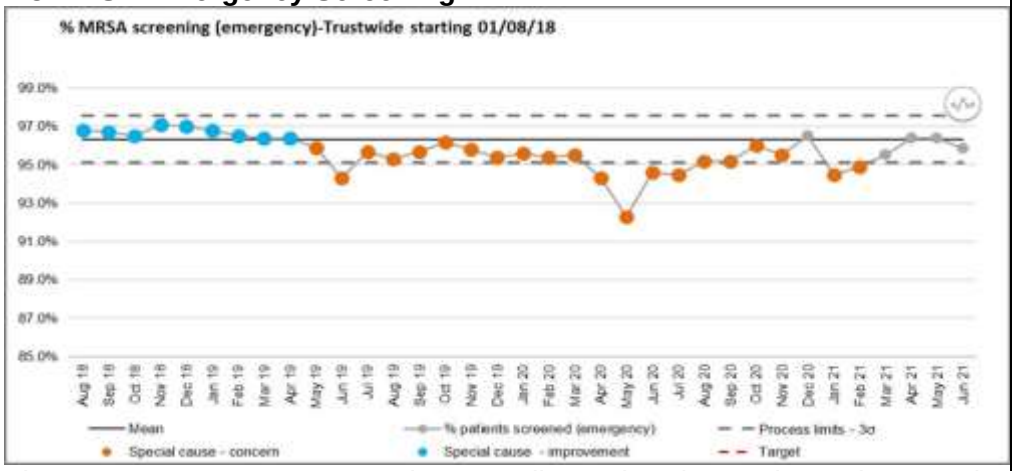
There were 3 cases of Pseudomonas Aeruginosa in Q1 of 2021/2022. One case was deemed to be device related due to a catheter associated urinary tract infection and one case was query device related.

2.7 MRSA Elective Screening



MRSA Elective screening compliance has been above the 95% target throughput Q1. YTD performance is 98.2%

2.8 MRSA Emergency Screening



The MRSA emergency screening compliance has been above the 95% in Q1 of 2021/22. YTD is performance is 96.23%.

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 a Root Cause Analysis (RCA) completed. Three cases were deemed to be device related or source undetermined requiring an RCA in Quarter 1 of 2020/2021.

Learning from completed RCAs include:

- Documentation relating to insertion of catheters
- Samples not taken in a timely manner
- Documentation in relation to blood cultures
- Consistent recording of Visible Infusion Phlebitis (VIP) scores

Actions implemented in relation to improvements include:

- Reminder to staff about correct labelling of blood cultures
- Monitoring of VIP scores daily by ward managers and compliance monitored at monthly Nursing metrics meetings
- Catheter insertion and care plan introduced, the use of this documentation is monitored via the monthly matron Nursing Quality Metrics audits.

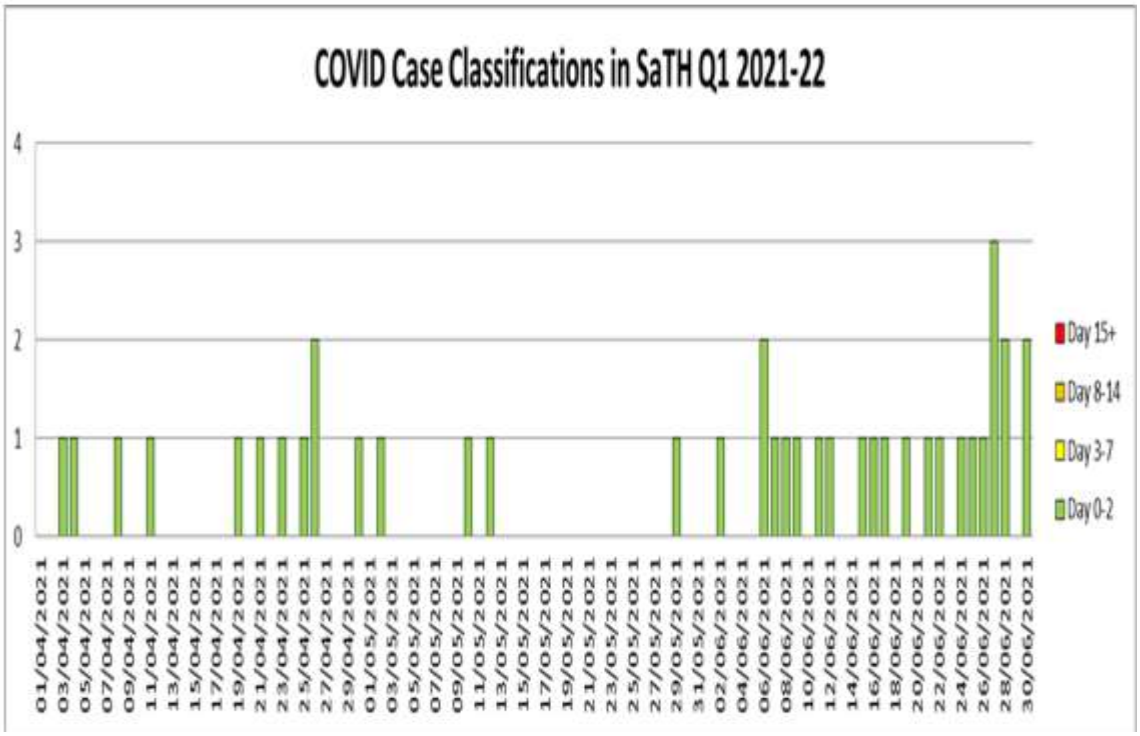
3.0 PERIODS OF INCREASED INCIDENCE/OUTBREAKS

The periods of increased incidence are shown for Quarter 1 2021/2022. Typing confirmed that these cases although linked in time and place were not the same so these were not classified as outbreaks.

	Ward	Infective Organism	Typing	Learning
April 2021	Ward 25	2 cases ESBL	Typing confirmed not the same therefore not an outbreak. .	In case 1 and 2 Missed opportunity in both cases for obtaining MSU/CSU on admission Case 2 Missed opportunity in one patient to obtain a stool sample, poor catheter care
June 2021	Ward 21	2 cases C.Diff	Typing confirmed not the same	Lapses in environmental cleanliness, staff hand hygiene
	ITU RSH	2 cases VRE	Typing confirmed not the same	

4.0 COVID 19 UPDATE

The number of Covid-19 cases in the Trust in Quarter 1 (April to June 2021) has remained very low, with a small increase in cases in the last 3 weeks of June 2021. The graph below shows that the patients cared for with Covid-19 in Quarter 1 were all diagnosed as positive shortly after admission, i.e. they were admitted with the illness. As cases increase again in the community it is expected that the number of patients admitted with Covid-19 will start to increase.



The last nosocomial Covid-19 case in the Trust was in March 2021. Ongoing actions to reduce any transmission in the hospital remain in place and include:

- Ongoing patient screening on admission, Day 3, Day 5 and Day 15
- Plastic curtains around bed spaces
- Ensuring PPE compliance and social distancing by all staff
- Encouraging patients to wear face masks at all times but particularly when mobilising to the bathroom
- Robust cleaning of the ward environment with Tristell twice daily

5.0 SERIOUS INCIDENTS (SI) RELATED TO INFECTION PREVENTION & CONTROL

There was one IPC serious incident reported in Quarter 1 of 2021/2022.

Serious Incident Related to IPC- Transrectal (TRUS) Prostate Biopsy Service

On the 20th April 2021, the Infection Prevention and Control team were asked to assist in a review of the Transrectal (TRUS) prostate biopsy service following an increase in the number of patients readmitted with sepsis. The TRUS biopsy service was paused to enable an investigation. In total 14 patients were identified who had been readmitted with sepsis like episodes following the procedures , within a period of 4-5 months prior to the 20th April. It was identified that 3 Serratia blood cultures typed the same indicating that cross infection has occurred.

The TRUS biopsy service recommenced on 21/05/2021 following the IPC investigation and review of the service . Prior to the re-commencement of the service, the IPC team gave advice on the room and equipment layout to encourage safe practice. It was identified by the service that correct hand hygiene, PPE and decontamination processes added time to each procedure, therefore IPC suggested that an additional person should be allocated to the clinic to ensure adequate decontamination of the equipment and environment between patients. All staff involved also had to provide evidence that IPC mandatory training, hand hygiene training, PPE training and Tristell 3 step training (decontamination of probe) had been completed. The IPC nurses were present for this list to observe practice and have continued to review the clinic regularly with unannounced visits to observe practice.

A Standard Operating Procedure (SOP) was rewritten and the Urology Clinical Nurse Specialist team instigated a surveillance programme to follow up patients post-procedure to identify any issues in a timely manner. The investigation has been presented at NIQAM, RALIG and at the Urology Clinical Governance meeting to highlight the issues identified and share lessons. The Trust decontamination lead has reviewed the decontamination policy and has instigated an audit of decontaminated on intra-cavity medical devices decontaminated outside of a central decontamination unit. An external review from University Hospitals Birmingham NHS Trust has also been commissioned by the Director of Infection Prevention and Control and is to take place at the beginning of July 2021.

6.0 IPC INITIATIVES

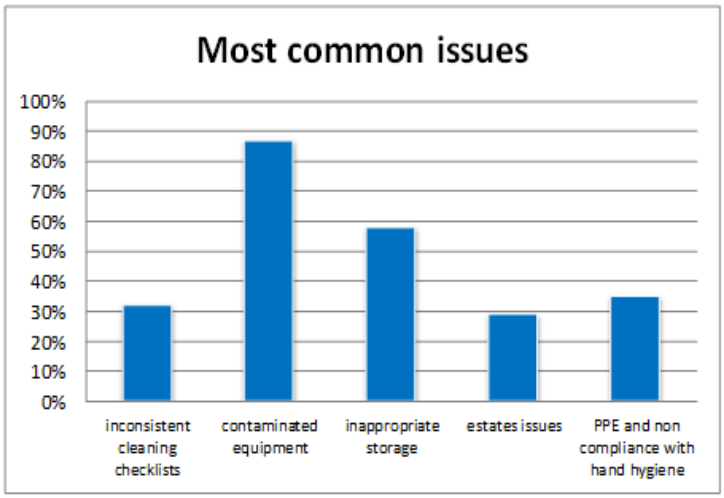
Quality Ward Walks continue to be undertaken by the IPC team. Compliance scores range from 75-100% across the clinical areas reviewed. During Quarter 1 the Infection Prevention and Control Team completed 71 Quality Ward Walks (QWW) across the clinical areas at both hospital sites. The results of the QWW showed:

- 51% of the clinical areas audited achieved a score of >90%
- 32% of the clinical areas achieved scores of 81-90%
- 17% of the clinical areas achieved scores of <80%

The issues identified during the visits are escalated to the Ward Managers at the time of the audit and communicated to the Matrons and Divisional Heads of Nursing. There is an action plan created and the Ward Managers have to complete this within a week. If the score is between 80% to 90% the area is re-audited within a month, if the score is below 80% the area is re-audited within a week.

The most common issues identified during the QWW were:

- Contaminated equipment
- Inappropriate storage
- Non-compliance with PPE and hand hygiene
- Inconsistent cleaning checklists
- Estates issues.



7.0 PREPARATION FOR THE IPC NHSE/I REVIEW

Since May 2021 the Infection Prevention and Control Team have been preparing for the NHSE/I IPC Review. The Trust was previously reviewed by the Director of IPC for NHSE/I in November 2019 and given a IPC rating of Green. This was downgraded to Red following the publication of the CQC Report in April 2020 after some breaches in IPC were observed during the CQC inspection which took place in November 2019. The team have been supporting the Divisions and the improvements required which include:

- Visiting the wards every morning to support staff with IPC concerns and identifying relevant IPC issues. This includes advising on patient movement, PPE usage and escalation of estates concerns.
- Working with Estates in relation to improvements in the Bed store/mattress areas and weekly reviews of the areas
- Improvements in the Phlebotomy areas
- Working with Estates to address Waste disposal rooms issues and ensure improvements in this area
- Making improvement to mask stations, removing mask station tables, where possible and replacing them with face mask dispensers.
- Development of blood culture awareness poster
- Development and implementation of Pre NHSE/I Visit checklists
- Review of the Covid-19 Policy to include several changes based on the updated PHE guidelines issued on the 1st of June 2020.
- Weekly preparation meetings with Deputy Chief Nurse, Divisions, IPC, Estates and Facilities
- Providing weekly updates to the Nursing, Midwifery and AHP meetings and Senior Nurse meetings.

Two mock IPC reviews took place, an internal mock inspection co-ordinated by IPC and the Divisional Nursing Teams and an external mock inspection from an IPC lead from another acute Trust, this external mock inspection was very positive.

The visit took place across both hospital sites on the 20th July 2021 attended by the NHSE/I Director of IPC, Public Health England and The CCG. Ward 23 Oncology, Ward 24 and Ward 27 were visited at the Royal Shrewsbury Hospital site and the Emergency Department, Intensive Care and Ward 8 were visited at the Princess Royal Hospital. Overall the Trust was rated as Green for IPC as an outcome of the NHSE/I visit.

8.0 RISKS AND ACTIONS

The Risk register for IPC is held by the Director of Nursing as the Director for Infection Prevention and Control (DIPC) and is updated monthly.

There are 11 risks on the risk register which includes a new risk relating to decontamination of medical equipment which was added to the IPC Risk Register in June 2021. Of the 11 risks, 4 risks are RAG rated Red prior to risk controls. Following application of the risk controls and mitigation 3 risks are rated as Amber the decontamination risk remains.

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

A new risk was added to the IPC Risk Register in June 2021, having previously sat on the Estates Risk Register. This risk is related to decontamination:

- **Risk 2077**: Lack of assurance around the decontamination of medical devices.

  Actions taken in relation to this decontamination risk include Standard Operating Procedures for decontamination of probes, review of Decontamination Policy and Terms of Reference and staff training. An external review of decontamination is taking place at the beginning of July 2021.

9.0 IPC BOARD ASSURANCE FRAMEWORK

This Prevention and Control Board Assurance Framework (IPC BAF) was last updated by NHSE/I in February 2021 and consists of 10 domains and 109 key lines of enquiry (See Appendix 1). The Trust is RAG rated green for 100 of the key lines of enquiry and amber for the remaining 9 items which are outlined below.

Section	RAG Rated Green	RAG Rated Amber	Amber Key Line of Enquiry
Section1: Systems and Processes	18	1	There are pathways in place which support minimal or avoid patient bed/ward transfers for duration of admission unless clinically imperative
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	Arrangements around anti-microbial stewardship
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	**12**	**0**	
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	**15**	**2**	Staff in 'at-risk' groups are identified and managed appropriately including ensuring their physical and psychological wellbeing is supported
			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 have been 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.

A new IPC BAF was issued by NHSE/I on the 30th June 2021; the IPC team are currently completing a gap analysis of this new BAF and will be reviewing the RAG rating associated with the decontamination key lines of enquiry given the recent decontamination issues.

10.0 Hygiene Code Update

The Health and Social Care Act (2008) Code of Practice on the prevention and control of infections, applies to all healthcare and social care settings in England. The Code of Practice sets out the 10 criteria with 243 elements against which the Care Quality Commission (CQC) will judge a registered provider on how it complies with the infection prevention requirements, which is set out in regulations. To ensure that consistently high levels of infection prevention (including cleanliness) are developed and maintained Trusts complete a self-assessment.

The Hygiene Code is reviewed monthly by the IPC team and presented at the IPC Operational Group. The Trust is 96.9% compliant, being RAG rated 'Green' for 233 elements, 'Amber' for 9 and RAG rated 'Red'. The Trust self-assessment compliance against each of the 10 domains and the current gaps and actions are shown:

	What the Trust must demonstrate	Current compliance	Current Gaps	Actions Required/Target date
1	Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider how susceptible service users are and any risks that their environment and other users may pose to them.	97%	IPC arrangements & responsibilities policy in place and found in every Job description. All staff should receive mandatory update & induction training. Contractors receive IPC training via estates (part of their induction to the Trust) Uptake of training for 2020-21 was 84% which is the same as 2019/2020	Continue to monitor attendance and report quarterly to IPCOG Care Groups to report compliance with training on report to IPCOG monthly
			There is a lack of an efficient automated surveillance system that triangulates data on outbreaks.	ICNET due to be in place September 2021
2	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.	95%	Daily Cleaning Checklists are completed by Cleanliness Technicians and housekeepers. These are reviewed by Ward managers and reported monthly through the ward assurance reports. Ward Managers complete (at least) Monthly verification checks that are also reported. IPCC Minutes. It is noted that these were inconsistently applied and the NHSE/I visit found failings in compliance	Daily cleaning checklists implemented Oct 2019 Meeting with facilities & IPC to have one check list for both technician & ward manager/matron to complete further meeting to be organised with Head of Nursing Agreement with facilities that cleanliness technicians will raise estate concerns when they complete audit" Clarify process for monitoring cleaning checklists

	What the Trust must demonstrate	Current compliance	Current Gaps	Actions Required/Target date
			Decontamination of the environment – including cleaning and disinfection of the fabric, fixtures and fittings of a building (walls, floors, ceilings and bathroom facilities) or vehicle.	This is currently not in the remit of the Decontamination Group and therefore Decontamination Lead (AD Estates). The TORs have been agreed to exclude these items which remain in the remit of IPC group.
			a record-keeping regime is in place to ensure that decontamination processes are fit for purpose and use the required quality systems	Following TRUS probe investigation (following outbreak) an audit is underway of all invasive devices requiring all departments to ensure they have adequate decontamination records, SOPs and training records. The responsibility is with the departments to ensure they have adequate processes and share information with the Decontamination Group to ensure satisfactory assurance is provided.
3	Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance	94%	All antibiotic prescriptions are reviewed by a pharmacist. The Trust has no e-Prescribing system Proactive work being undertaken relating to sepsis.	E-prescribing system required
4	Provide suitable accurate information on infections to any person concerned with providing further support or nursing/medical care in a timely fashion.	100%	None	None
5	Ensure that people who have or develop an infection are identified promptly and receive the appropriate treatment and care to reduce the risk of	100%	None	None

	What the Trust must demonstrate	Current compliance	Current Gaps	Actions Required/Target date
	passing on the infection to other people.			
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.	100%	None	None
7	Provide or secure adequate isolation facilities.	83%	The Trust has a relatively low percentage of side rooms such that patients requiring isolation may exceed the numbers of side rooms available. Patients may need to be cohort nursed if demand is high for example at outbreaks of norovirus or influenza during high activity periods. This is on the IPC Risk Register The Trust has no negative pressure isolation room, this is on the IPC Risk Register	Long term solution includes isolation facilities as part of planning regarding "Future Fit" and moving to possibly 50% of capacity being side rooms. Estates currently looking at the feasibility of having drop in pod to ITU & also side-room capacity including negative pressure Bioquell Pods now installed in ITU and redi-rooms.
8	Secure adequate access to laboratory support as appropriate.	100%	None	None
9	Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections.	99%	The Trust has a relatively low percentage of side rooms such that patients requiring isolation may exceed the numbers of side rooms available. Require assurance from CPE's that competency based assessments for aseptic technique are in place	None
10	Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection	100%	None	None

11.0 CONCLUSION

This IPC report has provided a summary of the performance in relation to the key performance indicators for IPC for Quarter 1, April to June 2021. Overall performance in relation to many of the IPC KPIs remains positive, with the improvement targets for C.Diff and MSSA achieved in Quarter 1 of 2021/2022. E.Coli bacteraemias increased in Quarter 1 although a majority of these cases did not relate to a device being identified as a source of the infection and there is ongoing work to improve catheter care across the Trust. There has been one MRSA bacteraemia in May 2021.

The impact of the Covid-19 pandemic declined April to June 2021 with no cases of nosocomial infections, ongoing risk mitigations are in place.

The Outcome of the NHSE/I IPC review which took place in July was positive with the Trust rated as green.

Appendix 1

Infection Prevention and Control Board Assurance Framework

RAG Key:

Action Complete	Action in Progress	Action off Track

Version Number	Date Reviewed	Reviewed by	Change made
3.1	23.02.2021	Janette Pritchard, Kara Blackwell	Full Review and update
3.2	09.03.2021	Janette Pritchard	Full review and update
3.3	04.04.2021	Kara Blackwell	Update
3.4	26.05.21	Janette Pritchard	Update
4.0	10.06.21	Janette Pritchard, Joanne Yale, Rebecca Hawkins, Kath Titley	Update
4.1	11.06.21	Kara Blackwell	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. 24-RSH-ED Management of poter Navigator flow chart for PRH			Green

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
		 Navigator flow chart for RSH  Update Management of Potential COVID Pa			
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. See link for policy at bottom of document	It has been identified that the trust has a lack of side rooms that will be addressed by the Hospital Transformation Plan	Patients who have been identified as positive COVID 19 will only be moved if they are being transferred to one of the COVID high risk wards. 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  SOP for Managing COVID Contacts whe	Amber
1.3	that on occasions when it is necessary to cohort COVID or non-COVID patients, reliable application of IPC measures are	• Any patients who are tested positive are isolated in side rooms.		If positive patients cannot be isolated in a side room, then	Green

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
	implemented and that any vacated areas are cleaned as per guidance.	• 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		they will be cohorted in a bay of positive patients	
1.4	monitoring of IPC practices, ensuring resources are in place to enable compliance with IPC practice • staff adherence to hand hygiene? • staff social distancing across the workplace • staff adherence to wearing fluid resistant surgical facemasks (FRSM) in: a) clinical b) non-clinical setting	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 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.			Green
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		Green
1.6	implementation of twice weekly lateral flow antigen testing for NHS patient facing staff, which include organisational systems in	From day one of phase one of testing in November 2020: Webform for			Green

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
	place to monitor results and staff test and trace	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.			
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
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:			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			Green

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
		mask stations in the Trust which provide guidance on how to don and doff a mask for non-clinical staff and visitors.			
1.11	there are visual reminders displayed communicating the importance of wearing face masks, compliance with hand hygiene and maintaining physical distance both in and out of the workplace	 Covid Aware Patient Hygiene.docx  leaflettemplateA5covid copy.pdf			Green
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 and		Business case being developed for	Green

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
		are updated monthly as a minimum. The Trust has a COVID risk 1771 on the BAF. BAF risk 1771 was last reviewed by the Trust Board on 5th May 2021 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.	substantive 7 day service provision Following discussion with the new DoN, business case for 7 day service currently not being progressed as mitigating actions include: -Consultant microbiology oncall 24/7 for advice -Weekly cohorting meeting Friday 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	"nosocomial" sitrep is signed off by either CE/MD/DoN			Green

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
	accurate measurement and testing of 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 and was included monthly in the IPC Report to Board. This is now reported Quarterly to Board 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	Reported monthly to IPCOG & IPCAC and was included monthly in the IPC Report to Board in Q3 and Q4 of 2020/21. This is now reported Quarterly to Board  Summary of COVID Outbreaks 03.02.21.pptx			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			Green

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
		Hand Hygiene. This has also been done for areas which are not identified as specific COVID wards. X:\StaffComplianceReports\Statutory & Mandatory Training Report			
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	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. Funding for this additional cleaning support has been extended until September 21 Supportive Peer Review Feedback Aug Full business case is progressing	Amber

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
		covered for cleaning 24/7			
2.3	Decontamination and terminal decontamination of isolation rooms or cohort areas is carried out in line with PHE and other national guidance	The Trust uses Tristel to decontaminate areas as per guidelines. The Trust also additionally use HPV cleaning when able to access areas and Facilities keep an account of areas which have been HPV cleaned. Facilities have compiled a proactive/reactive dashboard on HPV/UV cleaning which is kept on shared drive. Z:\Facilities\Cleanliness Decontamination Dashboard			Green
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  Operational Cleaning Policy.pdf			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	Environmental cleaning is carried out			Green

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

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
2.12	Single use items are used where possible and according to Single Use Policy	Single use items are used as per policy.		If this cannot be followed then reuse should follow PHE guidelines: https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control/managing-shortages-in-personal-protective-equipment-ppe	Green
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		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
		FFP3 respirators beyond a single task or session. Re-useable (communal) non-invasive equipment is decontaminated: • Between each patient and after patient use • After blood and body fluid contamination • At regular intervals as part of equipment cleaning http://intranet.sath.nhs.uk/document_library/viewPDFDocument.asp?DocumentID=10065 If required the Trust have a plan and SOP (attached below) for reusable (washable) surgical gown but this has not been required as yet.  Lauderable Gowns SOP 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

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
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			Green
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 HPV cleans Environmental swabbing post HPV/UV cleans will commence in September 21	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	• Antibiotic Policy in place.	Antibiotic policy in	Pharmacy seeks to	Amber

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
	stewardship is maintained	• Antibiotic prescriptions are reviewed by a pharmacist wherever possible. • E-Script 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 average see Fingertips Portal. High usage of WHO access group antibiotics due to longstanding antibiotic policy decisions which are reviewed regularly. • Monthly internal snapshot audits undertaken and fed back to care groups.	place. Pharmacy medicines management under increasing pressure, not all antibiotic prescriptions are able to be reviewed daily or seen at start of course meaning possible delay in querying prescribing. E-Script program still in use and antibiotics are entered and recorded when seen by pharmacy staff and doctors undertaking discharge summaries, no electronic prescribing so some antibiotic prescriptions may be missed. All reviewed antibiotic prescriptions are checked against the antibiotic policy, where not in line they are queried with the medical team, course lengths and route are also queried.	prioritise undertaking a full Medicines Reconciliation as soon as possible after admission and to see all patients at discharge. Restriction of stock antibiotics on wards to guide prescribing. Antibiotics not stocked must be requested through a pharmacist and be reviewed against antibiotic policy/microbiologist recommendations See Trust board sign off for Wave 3 of NHSE/I funding for EPMA system. This is a 2-3 year plan. Business case submitted on 15th September 2020 and approved by Trust however delayed until at least 2023 due to requirements from NHSE/I.	

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

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
4.3	Information and guidance on COVID-19 is available on all Trust websites with easy read versions	The Trust has a designated COVID 19 page on the intranet where all information is easily accessible. http://intranet.sath.nhs.uk/coronavirus/default.asp Easy read versions available:  Testing for the COVID v0.7 - Inpatie  Mixed Sex Bay COVID v0.1.docx  COVID v0.1 - Visitor Guidance.docx  Testing for the COVID v0.3 - Pre-Op			Green
4.4	Infection status is communicated to the receiving organisation or department when a possible or confirmed COVID-19 patient needs to be moved	• All infection status information is included in any transfer information including COVID status. • The Trust is trialing use of a COVID sticker in the patients' notes. • Lead Nurse SC has requested approval for costing of stickers before this can be rolled out Trust wide. • 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	Posters have been produced & are displayed in patient environment			Green

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
	and space advice.	 leafletemplateA5cov id copy.pdf  Covid Aware Patient Hygiene.docx			
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 COVID-19 cases, to minimise the risk of cross-infection as per national guidance	See Section 1: Emergency Department SOP (1.1).			Green
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	Outpatients & visitors wear face			Green

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
	and visitors	coverings  COVID19 Mask Posters.pdf			
5.6	face masks are available for all patients and they are always advised to wear them	 covid.pdf 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 be tolerated and does not compromise their clinical care	Following PHE guidance, all patients where possible should be wearing facemasks - SOP for this completed  1.4 Patient Wearing Masks - Flow Diagram			Green
5.8	monitoring of Inpatients compliance with wearing face masks particularly when moving around the ward (if clinically ok to	Staff encourage patients to wear facemasks, it this cannot be tolerated or patients refuse this is documented in			Green

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
	do so)	the patients noted			
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
5.13	there is evidence of compliance with routine patient testing protocols in line with Infection prevention and control and testing document:	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	Where possible routine appointments			Green

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
	appointments who display symptoms of COVID-19 are managed appropriately	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.			
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
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.	There are some members of staff who have not accessed this training or have not recorded their compliance.	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	Amber

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
			The Heads of Nursing report that the specific COVID data provided by corporate education does not match the monthly mandatory training report.	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 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_d	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	As above	As above Donning and doffing training has been provided by IPC Team	Amber

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
	onning_doffing_PPE_standard_health_and_social_care_settings.pdf	On 28 May all departments completed a PPE audit.			
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 to Corporate Education	Green
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	The Trust policy advises actions Current COVID Policy.pdf http://intranet.sath.nhs.uk/coronavirus/ppevideos.asp			Green

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

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
	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
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	All patients who are positive on day 8 or after will trigger an RCA			Green

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
	trigger an outbreak investigation and are reported.	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			
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.	 Current COVID Policy.pdf			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	The Trust follows national guidance (section 4.4.3).			Green

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
	compliant with the environmental requirements set out in the current PHE national guidance				
7.5	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 and other national guidance	Staff testing programme is in place for all symptomatic staff who contact the helpline in line with PHE and national guidance  STW STP FINAL COVID19 Testing Prot Patient testing is in place in accordance with National and PHE guidance for all admissions over 24hours, and for patients who are discharged to a care setting.			Green

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

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
		 Staff and Patient Testing Programme -			
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  Current COVID Policy.pdf			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		If laboratory capacity is too high to allow daily testing, then alternate day testing for COVID negative patients would be the option	Green
8.10	that those being discharged to a care home 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	Discharge testing is completed by a newly dedicated 'Swab Squad'			Green
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.			Green

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
		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			
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. This is also reported to Trust IPCC committee, via Divisional 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			Green

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
		reported through to the Covid 19 Incident Control Room which is in place 7 days a week 8-8pm coordinated by a Strategic commander. • There is a daily message sent out to staff from a member of the executive team which communicates any changes. • The IPC team are visiting the clinical areas in the Trust daily.			
9.3	All clinical waste related to confirmed or suspected COVID-19 cases is handled, stored and managed in accordance with current national guidance	All clinical waste is disposed of as per national guidance. See section 10 of SaTH COVID Policy linked at bottom of document.			Green
9.4	PPE stock is appropriately stored and accessible to staff who require it	The stock of PPE is continually monitored, there is a procurement conference call daily, and the Trust send a daily PPE submission to the Regional West Midlands COVID. Procurement are available from 7.30am until 11pm Monday to Friday. Saturday and Sunday 7.30am until 1pm from 11.30pm-7.30am daily there is a stores and procurement person on call to allow staff to contact if required. SaTH are also part of the LHRP PPE Task and Finish group.			Green
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 • Freedom to Speak Up Guardians • Accommodation for Staff in Critical Service Roles	**Risk Category Total % Assessed** BAME 55+ 100% White Over 60 85% Male 85% 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
		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 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			Green

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
		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.			
10.4	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	Records of fit tests are recorded on	A copy of the fit test	Staff are encouraged	Green

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
	the organisation	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 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.	record is not given to the staff member at the time of the fit test.	to access the fit testing report on the intranet to look up their own records.	
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,	If staff cannot be fitted – this is recorded on ESR – these people then become hood users			Green

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
	as part of employment record including Occupational health				
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 kept in staff members personal record and Occupational health service record	If staff still cannot tolerate a hood, they are recalled to be retested if new masks are introduced. Further options are then explored, if staff still cannot be fitted, they are referred to Occupational Health who will keep a record on the member of staffs personal file and their line manager will also receive this information. Please see national supporting document below. supporting-fit-testing-steps-actions-to-be-undertaken-use-of-ffp3-masks.pdf (england.nhs.uk)			Green
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.	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	Amber

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
		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. **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		Clinical Site Team out for out of hours. Monthly staffing report provided to Workforce assurance committee	
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			Green

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
		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.			
10.15	staff are aware of the need to wear facemask when moving through COVID-19 secure areas.	The need for facemasks is addressed in covid-secure guidance and risk 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.			Green
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			Green

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

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