The Shrewsbury and Telford Hospital NHS Trust

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	26.05.2021	Janette Pritchard	Update
4.0	10.06.2021	Janette Pritchard, Joanne Yale, Rebecca Hawkins, Kath Titley	Update
4.1	11.06.2021	Kara Blackwell	Review and Update
5.0	05.07.2021	Janette Pritchard	Updated following publication of V1.6
5.1	01.09.2021	Janette Pritchard	Review and update
5.2	02.12.2021	Janette Pritchard	Review and update
6.0	06.01.2022	Janette Pritchard	Updated following publication of V1.8
6.1	11.05.2022	Janette Pritchard , Kath Titley	Ambers reviewed
6.2	29.06.2022	Janette Pritchard	Review and update following lates guidance changes
7.0	28.09.2022	Janette Pritchard, Emilia Chrusciel	Updated following publication of 1.11

Version	Date Presented	Committee	Presented by
5.0	04.08.2021	IPC Operational Group	Kara Blackwell
5.1	08.09.2021	IPC Operational Group	Janette Pritchard
5.2	09.12.2021	IPC Operational Group	Janette Pritchard
6.0	11.01.2022	IPC Operational Group	Janette Pritchard

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
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					
Systems and processes are in place to ensure:					
1.1	A respiratory plan incorporating respiratory seasonal viruses that includes:				
1.1a	point of care testing (POCT) methods for infectious patients known or suspected to have a respiratory infection to support patient triage/placement according to local needs, prevalence, and care services	The Trust undertake Radi/POCT which are run from the lab	The Trust do not have a POCT so this does not take place in emergency care	Rapid test takes place in the lab ED are happy to support POCT testing. They are awaiting confirmation of funding of resources (POCT devices)	Amber
1.1b	segregation of patients depending on the infectious agent taking into account those most vulnerable to infection e.g clinically immunocompromised	The Trust have an infectious respiratory pathway and non infectious respiratory pathway. Evidence\pathway posters.docx There is an infections/non infectious respiratory pathway in ED (insert SOP when completed	A QIA has been completed by the Trust relating to removal of beds to facilitate distancing, however this was deemed not possible and created further risk		Green
1.1c	A surge/escalation plan to manage increasing patient/staff infections.	Command control arrangements are In place and are ready to be activated in event of a surge.			Green

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
		Incidnet command centre is still operational in line with NHSE level 3 regional incident response. Pandemic influenza plan is being updated in light of the revised NHSEI call standards for EPRR. Departmental business continuity are in place.			
1.1d	A multidisciplinary team approach is adopted with hospital leadership, operational teams, estates & facilities, IPC teams and clinical and non- clinical staff to assess and plan for creation of adequate isolation rooms/cohort units as part of the plan.	Draft plan in place			Green
1.2	Organisational /employers risk assessments in the context of managing infectious agents are:				
1.2a	based on the measures as prioritised in the hierarchy of controls.	Hierarchy of control, ventilation, space/ capacity (social distancing at 1m+) are addressed. Where a concern regarding ventilation is observed, support from Estates is available with H&S Team input. At time of writing, ventilation is not evaluated on a room-by-room basis.			Green
1.2b	applied in order and include	Included in advice to managers			Green

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
	elimination; substitution, engineering, administration and PPE/RPE.	completing local covid-secure risk assessments where appropriate.			
1.2c	communicated to staff.	The Trust has adopted a model of local risk assessments, and managers are expected to communicate the outcome of the risk assessments to their own staff supported by posters, Communications Team updates, messages from Directors, etc. Risk assessments are published at SaTH Intranet - New Ways of Working in order to make them easily accessaible to staff.			Green
1.2d	further reassessed where there is a change or new risk identified eg. changes to local prevalence.	Risk assessment is currently reviewed fortnightly/monthly by H&S, IPC and Microbiology.			Green
1.3	the completion of risk assessments have been approved through local governance procedures, for example Integrated Care Systems	Risk Assessments are approved by DIPC when changes are made			Green
1.4	risk assessments are carried out in all areas by a competent person with the skills, knowledge, and experience to be able to recognise the hazards associated with the infectious agents	As above			Green
1.5	ensure that transfers of infectious patients between care areas are	Patients who are confirmed as positive are isolated in side rooms.	It has been identified that the	Patients who have been identified as	Amber

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
	minimised and made only when necessary for clinical reasons	The staff is advised to only move positive /suspected patients when necessary for clinical reasons. See link for policy at bottom of document	trust has a lack of side rooms that will be addressed by the Hospital Transformation Plan	positive COVID 19 will only be moved if they are being transferred to one of the side rooms or COVID high risk bays.	
1.6	resources are in place to monitor and measure adherence to the NIPCM. This must include all care areas and all staff (permanent, flexible, agency and external contractors)	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 and adherence to wearing surgical facemasks in clinical settings. The Ward Managers and Matrons are responsible for monitoring compliance with staff wearing appropriate PPE with support from the IPC Team. This is formally audited on the Gather platform (audit platform) in the Trust NHSEI have undertaken masterclass sessions within the Trust & all matrons & band 7 nurses have also undertaken this training from the IPC Team			Green

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
1.7	the application of IPC practices within the NIPCM is monitored e.g. 10 elements of SICPs	The application of IPC related practices is monitored frequently as part of routine Qality Ward Walks. Patient placement, safe management of linen, waste and environment are also audited yearly as per IPC annual plan			Green
1.8	the IPC Board Assurance Framework (BAF) is reviewed, and evidence of assessments are made available and discussed at Trust board level.	BAF is reviewed at IPCOG & IPCAC quarterly and is also included in the Quarterly IPC Report to Board.			Green
1.9	the Trust Board has oversight of incidents/outbreaks and associated action plans.	This information is included in the Quarterly IPC Report to Board			Green
1.10	the Trust is not reliant on a single respirator mask type and ensures that a range of predominantly UK made FFP3 masks are available to users as required.	The H&S Team runs RPE fit testing sessions via a core of 3 WTE staff plus 2 WTE Ashfield fit testers at Jan 22. The H&S Team Manager sets a priority order for a total of 10 FFP3s in fit testing practice which aims to fit as many staff as possible to a UK Make FFP3. In current fit testing data it is notable that there is a reliance on Alpha Solway (Globus) products, however this is considered tolerable as these are UK Make products. Fit testing results are published at			Green

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		SaTH Intranet - FFP3 Mask Fit Testing by the Corporate Education and H&S Teams on a regular basis, usually weekly and shared with Incident Command Centre, IPC, Procurement and Communications colleagues via email.			
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	The Trust has a plan in place for the implementation of the National Standards of Healthcare Cleanliness and this plan is monitored at board level.	Implementation reported via IPCOG and IPCAC which feeds through to Quality and Safety Committee. Paper being provided to IPCAC for February meeting on progress for implementation for 1 April 2022 • The Trust uses the national guidance for decontamination in all areas as per the guidance for pathways. • 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			Green

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
		proactive/reactive dashboard on HPV/UV cleaning which is kept on shared drive. This is monitored via IPCAC			
2.2	the organisation has systems and processes in place to identify and communicate changes in the functionality of areas/room	The Trust have a space utilisation group which is responsible to communicate changes			Green
2.3	cleaning standards and frequencies are monitored in clinical and non-clinical areas with actions in place to resolve issues in maintaining a clean environment.	Cleaning service is accessible across the Trust and the Trust COVID 19 policy indicates the need for twice daily detergent and water/tristel (dependant on pathway) cleaning of all areas and more frequent cleaning of touch points. Ward Staff are also cleaning lockers, tables and contact points twice daily (as per UKHSA guidance) and cleaning records are completed.			Green
2.4	enhanced/increased frequency of cleaning should be incorporated into environmental decontamination protocols for patients with suspected/known infections as per the NIPCM (Section 2.3) or local policy and staff are appropriately trained.	Heads of Nursing confirm that all electronic equipment is cleaned twice daily. This is reviewed by the IPC team on their ward visits. Facilities decontaminate these areas twice dail when requested by IPC. This is also monitored via Gather.			Green

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
2.5	manufacturers' guidance and recommended product 'contact time' is followed for all cleaning/disinfectant solutions/products.	Facilities SOP follows recommended contact time of 5 minutes.			Green
2.6	For patients with a suspected/known infectious agent the frequency of cleaning should be increased particularly in: • patient isolation rooms • cohort areas • donning & doffing areas – if applicable • 'Frequently touched' surfaces e.g., door/toilet handles, chair handles, patient call bells, over bed tables and bed/trolley rails • where there may be higher environmental contamination rates, including: ○ toilets/commodes particularly if patients have diarrhoea and/or vomiting.	Cleaning service is accessible across the Trust and the Trust COVID 19 policy indicates the need for twice daily detergent and water/tristel (dependant on pathway) cleaning of all areas and more frequent cleaning of touch points. Ward Staff are also cleaning lockers, tables and contact points twice daily (as per UKHSA guidance) and cleaning records are completed. Heads of Nursing confirm that all electronic equipment is cleaned twice daily. This is reviewed by the IPC team on their ward visits. Facilities decontaminate these areas twice daily. The Trust also additionally use HPV cleaning when able to access areas and Facilities keep an account of areas which have been HPV			Green

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
		cleaned. Facilities have compiled a proactive/reactive dashboard on HPV/UV cleaning which is kept on shared drive. Z:\Facilities\Cleanliness Decontamination Dashboard			
2.7	The responsibility of staff groups for cleaning/decontamination are clearly defined and all staff are aware of these as outlined in the National Standards of Healthcare Cleanliness	The Cleaning schedules identify which staff group is responsible for cleaning which element. These schedules are displayed and every ward and department and have been recently updated to comply with the revised National Standards of Healthcare Cleanliness	Assurance of cleaning by staff group is monitored as part of the C4C Cleanliness Monitoring Programme which is reported at the monthly IPCOG meeting		Green
2.8	A terminal clean of inpatient rooms is carried out: • when the patient is no longer considered infectious • when vacated following discharge or transfer (this includes removal and disposal/or laundering of all curtains and bed screens) • following an AGP if clinical	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

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
	area/room is vacated (clearance of infectious particles after an AGP is dependent on the ventilation and air change within the room).	Actions and mitigations are discussed during COVID outbreak meetings with support of senior nursing team and external partners			
2.9	reusable non-invasive care equipment is decontaminated: • between each use • after blood and/or body fluid contamination • at regular predefined intervals as part of an equipment cleaning protocol • before inspection, servicing, or repair equipment.	Decontamination of all non-invasive care equipment is detailed in the Cleaning, Disinfection and Sterilization policy which is available on the Intranet https://intranet.sath.nhs.uk/infection_control/Infection_control_policies_and_related_information.asp			Green
2.10	compliance with regular cleaning regimes is monitored including that of reusable patient care equipment.	The Cleanliness of patient equipment is monitored as part of the C4C audit process Cleaning Check lists are used on wards			Green
2.11	ventilation systems, should comply with HBN 03:01 and meet national recommendations for minimum air changes https://www.england.nhs.uk/publicatio	• Increased air-changes via mechanical ventilation to ensure air dilution. • Areas have been encouraged to open windows where possible			Green

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
	n/specialised-ventilationfor- healthcare-buildings/	• 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 • Ventilation assurance is provided at COVID outbreak meetings			
2.12	ventilation assessment is carried out in conjunction with organisational estates teams and or specialist advice from the ventilation group and/ or the organisations, authorised engineer and plans are in place to improve/ mitigate inadequate ventilation systems wherever possible.	Annual audit undertaken by AE. This took place in Nov 2021 The estates department & ventilation group reviewed the report in February & reported no significant failings			Green
2.13	where possible air is diluted by natural ventilation by opening windows and doors where appropriate	• Increased air-changes via mechanical ventilation to ensure air dilution. • Areas have been encouraged to open windows where possible • Non circulating portable air			Green

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
		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 Ventilation assurance is provided at COVID outbreak meetings			
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 for antimicrobial stewardship (AMS) are maintained and a formal lead for AMS is nominated	• Antibiotic Policy in place. • 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 in 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	Pharmacy seeks to 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	Amber

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
		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. Antimicrobial Management Group (AMG) should meet every 2 months membership includes representatives from microbiology, pharmacy, nursing and clinicians from each care group.	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. Vacancy for Antimicrobial	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. Vacancy readvertised several times, Pharmacy Board	

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			Pharmacist at PRH since February 2022. Regular AMG meetings have been difficult to hold and often not quorate due to staffing pressures and lack of clinical representation.	review and advert out for Antimicrobial Technician with future restructuring of the Antimicrobial Stewardship Team. Continue to seek engagement from clinicians to attend AMG from care groups.	
3.2	NICE Guideline NG15 https://www.nice.org.uk/guidance/ng15 is implemented – Antimicrobial Stewardship: systems and processes for effective antimicrobial medicine use	• Monthly audits • Pharmacy medicines management team interventions. • Samples sent to microbiology • Antibiotic Policy in place	Vacancies in both microbiology and pharmacy mean antimicrobial stewardship activities such as ward rounds not currently possible. No current antimicrobial stewardship lead.	Pharmacy medicines management teams review antimicrobial prescribing as part of the ward pharmacy service. Microbiology and Antimicrobial Pharmacist available for advice. Critical care ward rounds	Amber

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
				undertaken by microbiologist. Monthly snapshot audits of antibiotic use undertaken by medicines management team.	
3.3	the use of antimicrobials is managed and monitored: o to optimise patient outcomes o to minimise inappropriate prescribing o to ensure the principles of Start Smart, Then Focus https://www.gov.uk/government/publications/antimicrobialstewardship-start-smart-then-focus are followed	• Medicines management pharmacy team review antibiotics prescribed on drug chart and query off guideline usage, long courses, intravenous to oral switch etc. • Interventions recorded in escript pharmacy program. Wards have specific stock lists of antibiotics appropriate to their area. In addition all areas have either a sepsis box/drawer or trolley stocked with antibiotics required for the prompt treatment of sepsis.	Availability of electronic prescribing will assist in ability to monitor and query antimicrobial prescribing. Feedback at time if any issues identified in prescribing, followed up by ward pharmacy teams.	See section 3.1	Amber
3.4	contractual reporting requirements are adhered to, and boards continue to maintain oversight of key performance indicators for prescribing including:	• Monthly reports on antimicrobial spend sent out to care groups. • Monthly snapshot audit of antimicrobial prescribing undertaken by medicines	Only generalised reports available currently due to lack of electronic prescribing.	See section 3.1	Green

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	o total antimicrobial prescribing; o broad-spectrum prescribing; o intravenous route prescribing;	management team. Quarterly reporting to IPCOG and IPCAG.			
3.5	adherence to AMS clinical and organisational audit standards set by NICE: https://www.nice.org.uk/guidance/ng15/resources	Monthly snapshot audits fed back to IPC and clinical governance.	Detailed audits as set out in NG15 not currently possible due to lack of EPMA and workforce restrictions	Undertake monthly snapshot audits to maintain oversight of antimicrobial prescribing. More detailed audits undertaken where issues identified.	Amber
3.6	resources are in place to support and measure adherence to good practice and quality improvement in AMS. This must include all care areas and staff (permanent, flexible, agency and external contractors).	Monthly snapshot audits Consultant Microbiologists Antimicrobial Pharmacist	No EPMA to provide more detailed prescribing data and ability to feed back to individuals. Vacancies in Pharmacy and Microbiology mean unable to undertake stewardship activities.	Use of locum microbiologists to support workforce. Advertising of Antimicrobial Technician to support Antimicrobial Pharmacist as struggling with recruitment. EPMA still in progress.	Amber
4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with					

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providing further support or nursing/ medical care in a timely fashion					
Systems and process are in place to ensure:					
4.1	IPC advice/resources/information is available to support visitors, carers, escorts, and patients with good practices e.g. hand hygiene, respiratory etiquette, appropriate PPE use	All clinical hand hygiene facilities are provided with Hand Wash posters indicating correct HH technique. Patients/carers leaflets are available in IPC policies for ward staff to print for patients and visitors/carers. Hand hygiene advice is included in number of them. Posters encouraging visitors and patients to wear a mask while in the hospital – available throughout the Trust.	Respiratory etiquette poster in process of being designed.		Amber
4.2	visits from patient's relatives and/or carers (formal/informal) should be encouraged and supported whilst maintaining the safety and wellbeing of patients, staff and visitors	Currently the Trust has started to allow visiting again. 3330 Visiting Re-introduction of v			Green
4.3	national principles on inpatient hospital visiting and maternity/neonatal services will remain in place as an absolute minimum standard. national guidance	The Trust has adopted the national guidance and this is on the Trust public facing internet website.			Green

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
	on visiting patients in a care setting is implemented.				
4.4	patients being accompanied in urgent and emergency care (UEC), outpatients or primary care services, should not be alone during their episode of care or treatment unless this is their choice.	As above 4.3			Green
4.5	restrictive visiting may be considered by the incident management team during outbreaks within inpatient areas This is an organisational decision following a risk assessment and should be communicated to patients and relatives.	As above 4.3			Green
4.6	there is clearly displayed, written information available to prompt patients' visitors and staff to comply with handwashing, respiratory hygiene and cough etiquette. The use of facemasks/face coverings should be determined following a local risk assessment.	Posters have been prodcued and are displayed in patient enviroment leaflettemplateA5covid copy.pdf Covid Aware Patient Hygiene.docx			Green
4.7	if visitors are attending a care area to	Nurse in charge would inform visitor.			Green

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
	visit an infectious patient, they should be made aware of any infection risks and offered appropriate PPE.	There are also posters that have been produced & are displayed in patient environment as above 4.6			
4.8	Visitors, carers, escorts who are feeling unwell and/or who have symptoms of an infectious illness should not visit. Where the visit is considered essential for compassionate (end of life) or other care reasons (e.g., parent/child) a risk assessment may be undertaken, and mitigations put in place to support visiting	Information asking not to visit if unwell provided by each entrance on the masks dispencers.  3330 Visiting Re-introduction of v			Green
4.9	Visitors, carers, escorts should not be present during AGPs on infectious patients unless they are considered essential following a risk assessment e.g., carer/parent/guardian	A conversation with the Health and Safety Team will be required, a risk assessment undertaken and provision of a Hood may be required. During office hours it may be possible to fit test a visitor to an FFP3 depending on timescales and the Health and Safety Team can advise on availability of this service on request.			Green
4.10	implementation of the supporting excellence in infection prevention and control behaviours Implementation Toolkit has been adopted where required C1116-supporting-excellence-inipc-	This has been circuated to all staff via comms with Every Action Counts. Some of the posters within this			Green

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	behaviours-imp-toolkit.pdf (england.nhs.uk)	toolkit have been utilised throughout the Trust			
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	all patients are risk assessed, if possible, for signs and symptoms of infection prior to treatment or as soon as possible after admission, to ensure appropriate placement and actions are taken to mitigate identified infection risks (to staff and other patients).	The Emergency department have a SOP for admissions, which covers a process to risk assess all patients as they arrive in ED. ED have also introduced an ASK 5 audit to ensure that screening questions are asked during the booking in process and details entered to SEMA. The new footprint at RSH also means a higher number of isolation cubicles available within the majors dept. Navigator flow chart for PRH.docx Navigator flow chart for RSH.docx SOP Management of potential Coronavirus Samples from patients in both ED's have rapid tests performed.			Green

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5.2	signage is displayed prior to and on entry to all health and care settings instructing patients with symptoms of infection to inform receiving reception staff, immediately on their arrival (see NIPCM).	All wards have appropriate signage to differentiate pathways			Green
5.3	the infection status of the patient is communicated prior to transfer to the receiving organisation, department or transferring services ensuring correct management /placement	All infection status information is included in any transfer information including COVID status. COVID 19 cases are flagged on the trust PAS and PSAG boards			Green
5.4	triaging of patients for infectious illnesses is undertaken by clinical staff based on the patients' symptoms/clinical assessment and previous contact with infectious individuals, the patient is placed /isolated or cohorted accordingly whilst awaiting test results. This should be carried out as soon as possible following admission and a facemask worn by the patient where appropriate and tolerated	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 Screening questions also asked as part of the booking in process and are monitored via an ASK 5 audit. 100% compliance for both sites recorded since early Sept 2021			Green
5.5	patients in multiple occupancy rooms with suspected or confirmed respiratory infections are provided with a surgical facemask (Type II or Type IIR) if this can be tolerated	Masks available at the entrance to all wards and bays. Staff should be offering face masks to patients and encouraging them to wear masks if tolerated	Masks stored on the trolleys by entrances to bays. In process of designing PPE	Masks to continue to be offered to the patients.	Amber

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
		All patients should be offered a surgical face mask. Patients can be given the patient information leaflets which support the wearing of masks whilst an inpatient. – included in Trust's Seasonal respiratory policy.	dispenser including maks to be installed by the entrance of each bay.		
5.6	patients with a suspected respiratory infection are assessed in a separate area, ideally a single room, and away from other patients pending their test result and a facemask worn by the patient where appropriate and tolerated (unless in a single room/isolation suite)	Use updated ED SOP from 5.1			Green
5.7	patients with excessive cough and sputum production are prioritised for placement in single rooms whilst awaiting test results and a facemask worn by the patient where appropriate and tolerated only required if single room accommodation is not available.	As above 5.6			Green
5.8	patients at risk of severe outcomes of infection receive protective IPC measures depending on their medical condition and treatment whilst receiving healthcare e.g., priority for single room protective isolation	Individuals who are clinically extremely vulnerable are prioritised for isolation as per Trust COVID policy (link below)	The Trust has a low number of side rooms, therefore in areas where a large number of patients are clinically extremely	Renal Ward has moved to an area with more side rooms. Oncology and Haematology have reduced their bed base to ensure	Green

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			vulnerable they may need to be cohorted together (Oncology, Haematology and Renal)	2 metre distancing is in place	
5.9	if a patient presents with signs of infection where treatment is not urgent consider delaying this until resolution of symptoms providing this does not impact negatively on patient outcomes	Outpatients/individuals should not attend if they have symptoms of a respiratory infection and communication with the individual should advise actions to take in such circumstances.			Green
5.10	The use of facemasks/face coverings should be determined following a local risk assessment	Frequent Risk Assessment reviewes scheduled with IPC, Microbiologists and H&S.	Risk assessment reviewed every 2 weeks		Green
5.11	patients that attend for routine appointments who display symptoms of infection are managed appropriately, sensitively and according to local policy	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.			Green
5.12	Staff and patients are encouraged to take up appropriate vaccinations to prevent developing infection	Staff are encouraged to have Flu and COVID vaccinations. Flu vaccination available on site for staff.			Green
5.13	Two or more infection cases linked in time, place and person trigger an incident/outbreak investigation and are reported via reporting structures	Outbreaks are continue to be declared and investigated as per outbreak definition.			Green

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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	IPC education is provided in line with national guidance/recommendations for all staff commensurate with their duties.	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. The Heads of Nursing report that the specific COVID data provided by corporate education	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	Amber

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			does not match the monthly mandatory training report.	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	
6.2	training in IPC measures is provided to all staff, including: the correct use of PPE	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 Matrons audit PPE usage as part of their monthly audits	As above	As above Donning and doffing training has been provided by IPC Team and videos are available on the Trust intranet	Amber

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6.3	all staff providing patient care and working within the clinical environment are trained in hand hygiene technique as per the NIPCM and the selection and use of PPE appropriate for the clinical situation and on how to safely put it on and remove it (NIPCM);	All staff are trained on hand hygiene during the induction and are required to have Hand Hygiene assessments every 3 years. All staff are required to watch the PPE donning and doffing video. Each ward/department has a pathway posters displayed by each clinical room to indicate what PPE is required to be worn.	As above	As above	Amber
6.4	adherence to NIPCM, on the use of PPE is regularly monitored with actions in place to mitigate any identified risk	IPC Team undertake PPE audits as part of QWW for wards Matrons undertake audits on this via gather.			Green
6.5	gloves and aprons are worn when exposure to blood and/or other body fluids, non-intact skin or mucous membranes is anticipated or in line with SICP's and TBP's.	The Trust has a standard precautions policy for staff to follow Microsoft Word - 608001865_0786.doc (sath.nhs.uk)			Green
6.6	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 (NIPCM)	Hand dryers have been removed and replaced with paper towel dispensers			Green
6.7	staff understand the requirements for	All staff are asked change into their			Green

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
	uniform laundering where this is not provided for onsite.	uniform at work. There is no provision for uniform to be laundered on site, and scrubs only are sent to an off-site laundary. 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			
7. Provide or secure adequate isolation facilities					
Systems and process are in place to ensure:					
7.1	that clear advice is provided; and the compliance of facemask wearing for patients with respiratory viruses is monitored (particularly when moving around the ward or healthcare facility) providing it can be tolerated and is not detrimental to their (physical or mental) care needs	Staff encourage patients to wear facemasks, it this cannot be tolerated or patients refuse this is documented in the patients notes			Green
7.2	patients who are known or suspected to be positive with an infectious agent where their treatment cannot be deferred, care is provided following	If patient is known or suspected to be positive and their treatment cannot be postponed the care is provided ensuring IPC precautions		If positive patients cannot be isolated in a side room, then they will be cohorted in a bay	Green

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
	the NIPCM.	are in place. PPE is available to staff members. Patient is isolated to protect other patients		of positive patients	
7.3	patients are appropriately placed i.e.; infectious patients are ideally placed in a single isolation room. If a single/isolation room is not available, cohort patients with confirmed respiratory infection with other patients confirmed to have the same infectious agent	All patients with alert/resistant organisms are managed as per normal Trust policy. The Trust also have an isolation risk assessment tool that is available to all staff http://intranet.sath.nhs.uk/Library_Intranet/documents/infection_control/Ward_guidance_folder/isolation on admission tools poster.pdf			Green
7.4	standard infection control precautions (SIPC's) are applied for all, patients, at all times in all care settings	Any patients who are tested positive are isolated in side rooms. Patient placement is based on infectious/non-infectious risk pathways. Patients who fall into the infectious pathway are either isolated or cohorted appropriately. Patients who fall into the non-infectious pathway are placed according to pathway.		If positive patients cannot be isolated in a side room, then they will be cohorted in a bay of positive patients	Green
7.5	Transmission Based Precautions (TBP) may be required when caring for patients with known / suspected	All staff are advised to use transmission Based Precautions (TBP) when caring for infectious			Green

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
	infection or colonization	patients. PPE is available in all wards/departments. Correct management of infections is listed in policies and also quick guide is included on intranet in A to Z . Isolation rooms and Redi rooms are in use to isolate patients with infection/colonisation.			
8. Secure adequate access to laboratory support as appropriate					
Systems and process are in place to ensure:					
8.1	Laboratory testing for infectious illnesses 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 testing for infectious agents is undertaken promptly and in line with national guidance	Patient testing is in place in (for COVID, Influenza and RSV) in accordance with National and UKHSA guidance for all inpatients if symptomatic and for patients who are discharged to a care setting. In addition to this any patients transferred to ward 23 Oncology, 35 Renal and peadiatric oncology are			Green

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
		also tested. All screening for other organisms usually monitored continue to be performed in the trust as per guidelines			
8.3	staff testing protocols are in place for the required health checks, immunisations and clearance	Team Prevent provide the Pre employment health checks			Green
8.4	there is 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
COVID 19 Specific					
8.5	patients discharged to a care home are tested for SARS-CoV-2, 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. Coronavirus (COVID-19) testing for adult social care services - GOV.UK (www.gov.uk)	Patients who are being discharged to nursing/care homes are tested for COVID by PCR prior discharge. If they were positive to COVID within last 90 days the test is being performed by LFT. All results are communicated to the receiving care setting.			Green
for testing protocols please refer to: • COVID-19: testing during periods of low prevalence - GOV.UK (www.gov.uk) • C1662_covid-testing-in-periods-of-low-prevalence.pdf (england.nhs.uk)					

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
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	resources are in place to implement, measure and monitor adherence to good IPC and AMS practice. This must include all care areas and all staff (permanent, flexible, agency and external contractors).	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 IPCOG committee, via Divisional reports and IPC team QWW reports.			Green
9.2	staff are supported in adhering to all IPC and AMS policies	As above			Green
9.3	policies and procedures are in place for the identification of and management of outbreaks of infection. This includes the documented recording of an outbreak.	The Trust also has a policy for the management of outbreaks which includes the documented recording of an outbreak.			Green
9.4	all clinical waste and infectious linen/laundry used in the care of known or suspected infectious patients is handled, stored and managed in accordance with current national guidance as per NIPCM	All clinical waste and linen/laundry is handled, stored, managed & disposed of as per national guidance. See section 7.9 & 7.10 of SaTH COVID Policy linked at bottom of document. Management, storage and disposal of linen in also reference in Linen Policy CS02 https://intranet.sath.nhs.uk/infection			Green

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
		control/Infection_control_policies_and_related_information.asp			
9.5	PPE stock is appropriately stored and accessible to staff when required as per NIPCM	The stock of PPE is held in Internal Stores via National Push stock currently. Internal stores stock are checked three times a week and uploaded to foundry National PPE portal one a week. Wards and departments PPE is ordered on a weely basis as part of the EDC ordering. Ward areas and critical admission areas are also checked on a Friday afternoon. Stores are available 8.00 - 16:00 on a weekday. There is no cover at Weekends but there is an on call rota that can be accessed via switchboard for items that are held in Internal stores as an emergency			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:					
10.1	staff seek advice when required from their occupational health department/IPCT/GP or employer as per their local policy	Staff can seek advice from our occupational hrealth as per Human Resources Policy No. HR65			Green

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
10.2	bank, flexible, agency, and locum staff follow the same deployment advice as permanent staff	All staff including bank and agency are provided the same advice.			Green
10.3	staff understand and are adequately trained in safe systems of working commensurate with their duties	The Trust have a policy regards to staff infections. All ward managers can refer staff to occupational health via an online portal IPC Policies available on the intranet. Indcution and mandatory training is in place for staff.			Green
10.4	a fit testing programme is in place for those who may need to wear respiratory protection.	An RPE fit testing service is currently available office hours on most weekdays at RSH and PRH. This is staffed by fit testers trained in qualitative and quantitative methods by a Fit2Fit accredited training provider, Fire Safe International of Atcham. Outcomes are recorded on staff ESR records and summary reports published at SaTH Intranet - FFP3 Mask Fit Testing.			Green
10.5	where there has been a breach in infection control procedures staff are reviewed by occupational health. Who will: • lead on the implementation of systems to monitor for illness and	Occupational Health not provide anti-viral treatment and have no facilities to do so. However do implement vaccination programmes, excluding covid-19. Staff will be reviewed by OH if they are referred,	Occupational health do not currently provide anti-viral treatment	As part of reviewing future service provision requirements this will be considered in service	Amber

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
	absence. • facilitate access of staff to treatment where necessary and implement a vaccination programme for the healthcare workforce as per public health advice. • lead on the implementation of systems to monitor staff illness, absence and vaccination. • encourage staff vaccine uptake	or contacted by IPCC to become involved in a breach, for example a TB exposure. Occupational health support delivery of Flu programme each and help encourage vaccine uptake.		specification going forward.	
10.6	staff who have had and recovered from or have received vaccination for a specific respiratory pathogen continue to follow the infection control precautions, including PPE, as outlined in NIPCM.	All patient facing clinical and non-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			Green
10.7	risk assessment is carried out for health and social care staff including pregnant and specific ethnic minority groups who may be at high risk of complications from respiratory infections such as influenza or severe illness from COVID-19.	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			Green

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
	• A discussion is had with employees who are in the at risk groups, including those who are pregnant and specific ethnic minority groups. • that advice is available to all health and social care staff, including specific advice to those at risk from complications. • Bank, agency, and locum staff who fall into these categories should follow the same deployment advice as permanent staff. • A risk assessment is required for health and social care staff at high risk of complications, including pregnant staff.	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			

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
		Guardians • Accommodation for Staff in Critical Service Roles Staff are being risk assessed taking into consideration the health, age, ethnicity and gender. Risk assessment process in place with support also available via occupational health (as required). Documents available on intranet and SaTH app.			
10.8	testing policies are in place locally as advised by occupational health/public health	Occupational Health have an immunisation policy in line with PHE/DOH.			Green
10.9	NHS staff should follow current guidance for testing protocols: C1662_covid-testing-in-periods-of-low-prevalence.pdf (england.nhs.uk)	Comms message sent to all staff detailing the testing guidance. Information on testing also included in Seasonal Resiratory Policy. Positive staff completes day 5 and 6 LFT to reduce the isolation period. Risk assessment must be completed following 2 negative tests and uploaded to DMG for decision.			Green
10.10	staff required to wear fit tested FFP3 respirators undergo training that is compliant with HSE guidance and a	Records of fit tests are recorded on each staff member's ESR record, and a report on current fit test data	A copy of the fit test record is not given to the staff member	Staff are encouraged to access the fit	Green

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
	record of this training is maintained by the staff member and held centrally/ESR records.	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. Staff are not given a copy of the fit test record at the time of the fit test, but are given a sticker with the makes/ model they do and do not fit to, and encouraged to make a note/ take a photograph of the FFP3 they fit to in order to foster familiarity, and are informed that their name will be published on the intranet within a week for future reference.	at the time of the fit test, but a sticker summarising fits and fails to specific makes and models is provided for immediate reference pending update of records at SaTH Intranet - FFP3 Mask Fit Testing.	testing report on the intranet to look up their own records. The H&S Team support staff and managers who ask for help to do so.	
10.11	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 29 March 21			Green

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
		and remains correct. This includes dates of in-house refresher training and competency assessments.			
10.12	fit testing is repeated each time a different FFP3 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
10.13	all staff required to wear an FFP3 respirator should be fit tested to use at least two different masks	All staff are requested to come forward to be fit tested to two, ideally three FFP3s as a contingency plan in case of stock shortages. Progress is reported to HSSFC, IPCOG, IPCAC and the Incident Command Centre.			Green
10.14	those who fail a fit test, there is a record given to and held by employee and centrally within the organisation of repeated testing on alternative respirators or an alternative is offered such as a powered hood.	Records of failed fit tests are managed in the same way as records of successful fit tests, as described above. Staff who cannot wear an FFP3 in stock have access to loose-fitting RPE and, in Critical Care areas, reusable tight-fitting RPE.			Green

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
		SOPs for decontamination of hoods and reusable respirators are published at SaTH Intranet - PPE			
10.15	that where fit testing fails, suitable alternative equipment is provided. Reusable respirators can be used by individuals if they comply with HSE recommendations and should be decontaminated and maintained according to the manufacturer's instructions	Staff who cannot wear an FFP3 in stock have access to loose-fitting RPE and, in Critical Care areas, reusable tight-fitting RPE. SOPs for decontamination of hoods and reusable respirators are published at SaTH Intranet - PPE			Green
10.16	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 any of the alternatives to FFP3s are assigned to suitable duties by their own line managers, with HR support. 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-			Green

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
		masks.pdf (england.nhs.uk)			
10.17	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.	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.	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
10.18	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 to the IPC Operational Group and the IPC Assurance Committee, and also to the quarterly Health, Safety, Security and Fire Committee.			Green
10.19	staff who have symptoms of infection or test positive for an infectious agent should have adequate information and support to aid their recovery and return to work.	The feedback of results is provided via our system occupational health team. The information on results and advice is provided to staff via qualified occupational health professionals that can provide support and advice to aid recovery. Staff only return to work when fully fit and do so as part of the return to work process. This includes a return to work discussion with their			Green

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

Criterion	1	2	3	4	5	6	7	8	9	10	TOTAL
	14	13	1	9	12	4	5	5	5	18	86
	2	0	5	1	1	3	0	0	0	1	13
	0	0	0	0	0	0	0	0	0	0	0
TOTAL	16	13	6	10	13	7	5	5	5	19	99