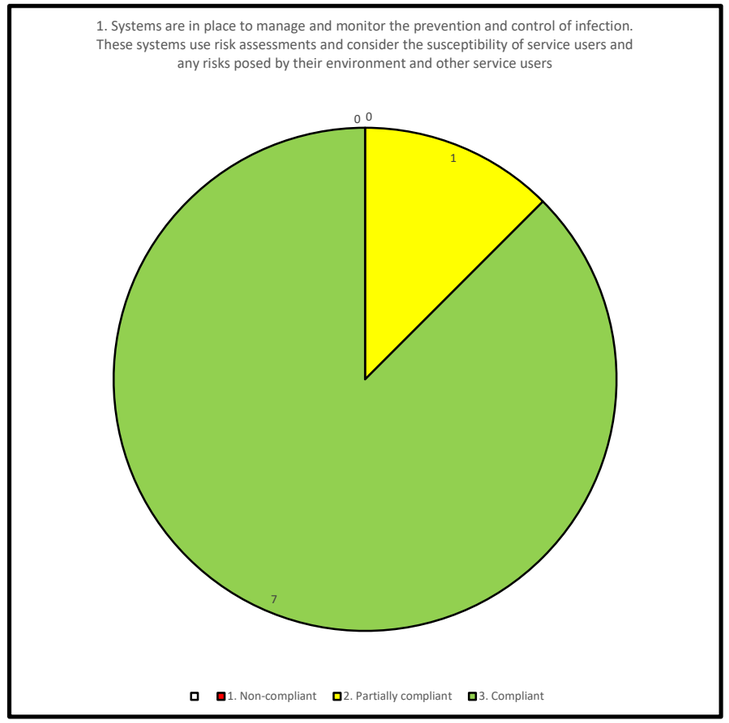
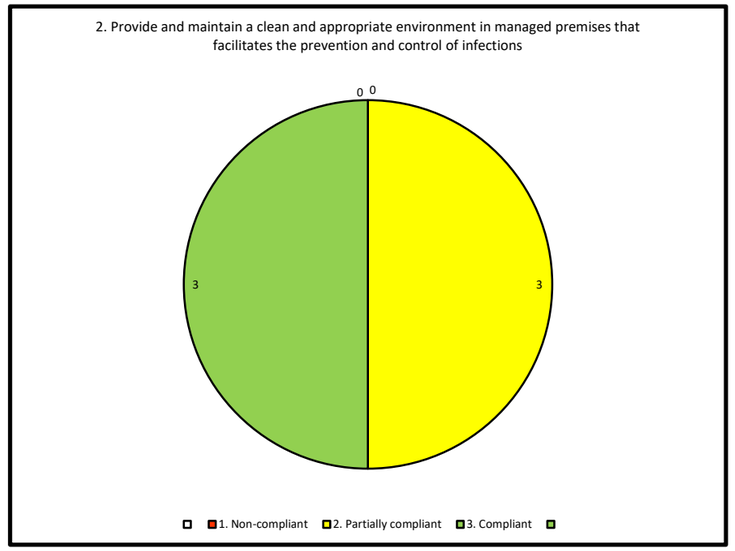
Infection Prevention and Control board assurance framework v0.1

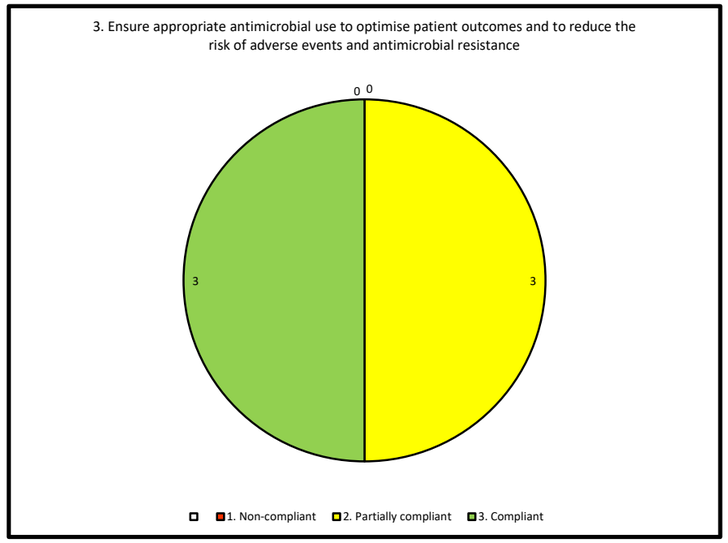
	Key Lines of Enquiry	Evidence	Gaps in Assuranc	itigating Actio	Comments	Compliance rating
1. Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks their environment and other users may pose to them						
Organisational or board systems and process should be in place to ensure that:						
1.1	There is a governance structure, which as a minimum should include an IPC committee or equivalent, including a Director of Infection Prevention and Control (DIPC) and an IPC lead, ensuring roles and responsibilities are clearly defined with clear lines of accountability to the IPC team.	Corporate Structure Chart IPAC Terms of Reference			In place. IPaC policy inplace. Contact details of the wider IPaC team are available via the IPaC intranet page inc DIPC and ICD.	3. Compliant
1.2	There is monitoring and reporting of infections with appropriate governance structures to mitigate the risk of infection transmission.	IPAC Huddle Minutes (Feb to March 23) IPAC Huddle Standing Agenda IPAC Committee Minutes (Apr 22-Jan 23) IPAC Committee Stadning Agenda IPAC Annual Report 2021-22 QISCOM Minutes Dec 22 QISCOM Action Log Dec 22			Infections discussed at weekly IPaC huddles, quarterly IPaCC, QISCOM and annual report.	3. Compliant
1.3	That there is a culture that promotes incident reporting, including near misses, while focusing on improving systemic failures and encouraging safe working practices, that is, that any workplace risk(s) are mitigated maximally for everyone.	IPAC Huddle Minutes (Feb to March 23) IPAC Huddle Standing Agenda IPAC Committee Minutes (Apr 22-Jan 23) IPAC Committee Stadning Agenda QISCOM Minutes Dec 22 QISCOM Action Log Dec 22 Health & Safety Group Apr 23 agenda Health & Safety Group Jan 23 minutes			Incident reporting is embraced by the Trust. IPaC related incidents are reported and reviewed via datix by the IPaC nursing team. Discussed at weekly IPaC huddle, IPaCC, Health and Safety group and at QISCOM.	3. Compliant
1.4	They implement, monitor, and report adherence to the NIPCM.	IPAC Manual- July 2021			IPaC incident reporting is currently based using the Trust's own IPaC manuual. The NIPCM will be used from May 2023 once agreed at IPaCC 27.04.23. Need sections that dont appear in the new Manual to be published seperately.	2. Partially compliant
1.5	They undertake surveillance (mandatory infectious agents as a minimum) to ensure identification, monitoring, and reporting of incidents/outbreaks with an associated action plan agreed at or with oversight at board level.	Lab Results fo Alert Organisms Dec22-Feb 23			surveillance data received from UKHSA laboratory in Cambridge. iCaSH services receive sexual health data from their contracted laboratory provider. We undertake own local surveillance when required eg Covid.	3. Compliant
1.6	Systems and resources are available to implement and monitor compliance with infection prevention and control as outlined in the responsibilities section of the NIPCM.	IPAC Policy V6 Environmental Audits Clinical Intervention Audits Decontamination Audits (FP10s) Trust Dashboard May 2023 Sharps Audits Cleaning Audits (Audim Tracker) Peer reviews iCASH Fit Test Register 2022			IPaC policy inplace. Responsibilities clearly identified within the document.	3. Compliant
1.7	All staff receive the required training commensurate with their duties to minimise the risks of infection transmission.	IPAC Team Reports Q1 to Q4 2022-23 Monthly Quality Dashboards - May 22 to March 23 Trust Dashboard May 2023			IPaC training is inline with the national requirements. Staff compliance is reported monthly through the Quality Dashboard, discussed at IPaCC.	3. Compliant
1.8	There is support in clinical areas to undertake a local dynamic risk assessment based on the hierarchy of controls to prevent/reduce or control infection transmission and provide mitigations. (primary care, community care and outpatient settings, acute inpatient areas, and primary and community care dental settings)	In place. Covid +ve Risk Assessment for line managers Mpox SOP			Covid risk assessment including staff and the built environment, Specific support given to teams where required e.g. The use of accomodation to assess asylum seekers in non clinical settings.	3. Compliant

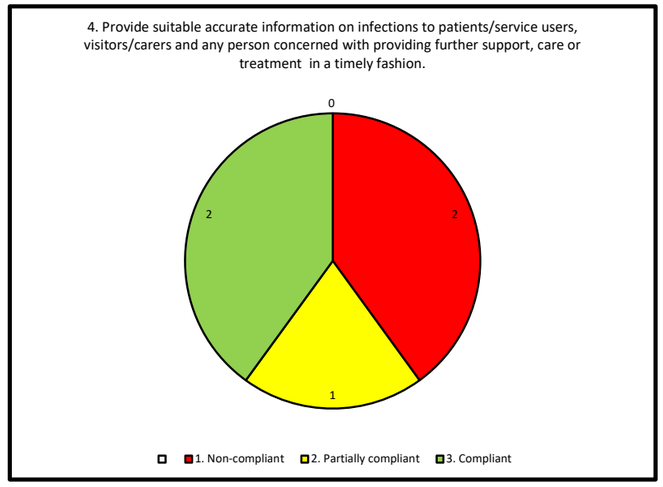


2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections						
System and process are in place to ensure that:						
2.1	There is evidence of compliance with National cleanliness standards including monitoring and mitigations (**excludes some settings e.g. ambulance, primary care/dental unless part of the NHS standard contract** these setting will have locally agreed processes in place).	Cleaning Posters Distribution list CBRE Report Q1 22-23 IPAC Report Q2 Cleaning Standards Audim Tracker CCS Cleaning Report Dec 22			Able to demonstrate a good level of assurance via main cleaning contractor (OCS). Reports provided to the Trust. Awaiting compliance data from other contractors e.g. NHS Property Services.	2. Partially compliant
2.2	There is an annual programme of Patient-Led Assessments of the Care Environment (PLACE) visits and completion of action plans monitored by the board.	Not applicable due to no inpatient facilities				0. Not applicable
2.3	There are clear guidelines to identify roles and responsibilities for maintaining a clean environment (including patient care equipment) in line with the national cleanliness standards.				Unsure whether cleaning is specific in JD's or appraisals. Specific details / requirement in NIPCM and IPaC policy. Service specific SOPs	2. Partially compliant
2.4	There is monitoring and reporting of water and ventilation safety, this must include a water and ventilation safety group and plan. **2.4.1** Ventilation systems are appropriate and evidence of regular ventilation assessments in compliance with the regulations set out in HTM:03-01. **2.4.2** Water safety plans are in place for addressing all actions highlighted from water safety risk assessments in compliance with the regulations set out in HTM:04-01.	IPAC Committee Facilities Reports 2022-23 Estates Strategy (inc Ventilation) Water Safety Policy Water Safety Management Plan			No evidence as yet re Ventilation strategy being reviewed ie action plan or minutes. Partial compliance for Ventilation, full compliance for Water	2. Partially compliant
2.5	There is evidence of a programme of planned preventative maintenance for buildings and care environments and IPC involvement in the development new builds or refurbishments to ensure the estate is fit for purpose in compliance with the recommendations set out in HBN:00-09	Planned programme of PPMs (see comments) Water Safety Group notes			Both CCS and CPFT have monthly joint service review meetings with both CBRE (Hard Facilities Management) and OCS (Soft FM). Trust Contracts are also present. Summary report presentation from CBRE would be sufficient. (Compliance updated TC 4/7/23)	3. Compliant
2.6	The storage, supply and provision of linen and laundry are appropriate for the level and type of care delivered and compliant with the recommendations set out in HTM:01-04 and the NIPCM.	Linen and laundry supply contracts eg Dynamic Health			Contacted Jharna Kumawat for latest contracts.	3. Compliant
2.7	The classification, segregation, storage etc of healthcare waste is consistent with HTM:07:01 which contains the regulatory waste management guidance for all health and care settings (NHS and non-NHS) in England and Wales including waste classification, segregation, storage, packaging, transport, treatment, and disposal.					0. Not applicable
2.8	There is evidence of compliance and monitoring of decontamination processes for reusable devices/surgical instruments as set out in HTM:01-01, HTM:01-05, and HTM:01-06.	IPAC Committee Service Lead Reports Q1-3 Environmental Audits Decontamination Audits (Dental) (FP10s)			Decontamination log books held within the dental departments. Audited via annual environmental inspection. Datix quarterly IPaC reports. iCASH send to CSSD.	3. Compliant
2.9	Food hygiene training is commensurate with the duties of staff **as per food hygiene regulations**. If food is brought into the care setting by a patient/service user, family/carer or staff this must be stored in line with food hygiene regulations.					0. Not applicable

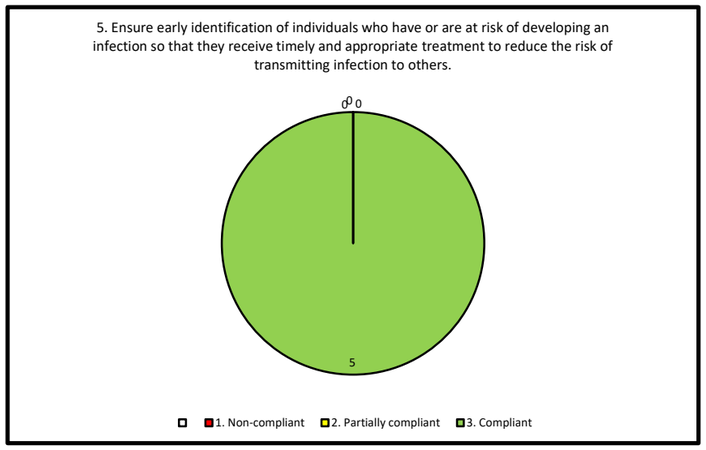


3. Ensure appropriate antimicrobial stewardship to optimise service user outcomes and to reduce the risk of adverse events and antimicrobial resistance						
Systems and process are in place to ensure that:						
3.1	If antimicrobial prescribing is indicated, arrangements for antimicrobial stewardship (AMS) are maintained and where appropriate a formal lead for AMS is nominated.	Antimicrobial stewardship in place and is monitored at MSGG and IPaCC IPAC Committee Pharmacy reports MSGG Minutes Antimicrobial Stewardship Policy DRAFT Prescription Pads audit			AMS POlicy discussed at MSGG May 23 minor amendment to be made before uploading to Doc Library	3. Compliant
3.2	The board receives a formal report on antimicrobial stewardship activities annually which includes the organisation's progress with achieving the UK AMR National Action Plan goals.	MSGG Minutes			AMR audits discussed at MSGG re services usage in compliance with national and locally agreed formularies.	3. Compliant
3.3	There is an executive on the board with responsibility for antimicrobial stewardship (AMS), as set out in the UK AMR National Action Plan.	Chief Nurse Job Description 2020			Chief Nurse is designated Board lead for AMR programme with support of Medical Director.	3. Compliant
3.4	NICE Guideline NG15 'Antimicrobial Stewardship: systems and processes for effective antimicrobial medicine use' or Treat Antibiotics Responsibly, Guidance, Education, Tools (TARGET) are implemented and adherence to the use of antimicrobials is managed and monitored: •to optimise patient outcomes. •to minimise inappropriate prescribing. •to ensure the principles of Start Smart, Then Focus are followed.	IPAC Committee Pharmacy reports MSGG Minutes Antimicrobial Stewardship Policy DRAFT Prescription Pads audit			Antimicrobial stewardship in place and is monitored at MSGG and IPaCC	2. Partially compliant
3.5	Contractual reporting requirements are adhered to, progress with incentive and performance improvement schemes relating to AMR are reported to the board where relevant, and boards continue to maintain oversight of key performance indicators for prescribing, including: •total antimicrobial prescribing. •broad-spectrum prescribing. •intravenous route prescribing. •treatment course length.	DRAFT Antimicrobial Stewardship Policy DRAFT 22-23 IPACC AMS Programme				2. Partially compliant
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).	DRAFT Antimicrobial Stewardship Policy DRAFT 22-23 IPACC AMS Programme				2. Partially compliant
4. Provide suitable accurate information on infections to patients/service users, visitors/carers and any person concerned with providing further support, care or treatment nursing/medical in a timely fashion						
Systems and processes are in place to ensure that:						
4.1	Information is developed with local service-user representative organisations, which should recognise and reflect local population demographics, diversity, inclusion, and health and care needs.	Priorities and How We are doing/Performance/Infection Prevention and Control https://www.icash.nhs.uk/ https://www.cambscommunityservices.nhs.uk/advice/childhood-illnesses/meningitis https://www.cambscommunityservices.nhs.uk/what-we-do/children-young-people-health-services-cambridgeshire/cambridgeshire-0-19-healthy-child-programme/commonconcerns/common-illnesses https://www.cambscommunityservices.nhs.uk/coronavirus-guidance https://www.justonenorfolk.nhs.uk/childhood-illnesses/how-to-stop-germs-from-spreading/ (includes video)			Need to ask teams. New website being created with input from Co-Production team, trial due in September likely to be Childrens Services. Corporate rollout likely to be last and could take from pages on the exisitng website. Trust Wide Working Together reports on co-producing website etc	2. Partially compliant

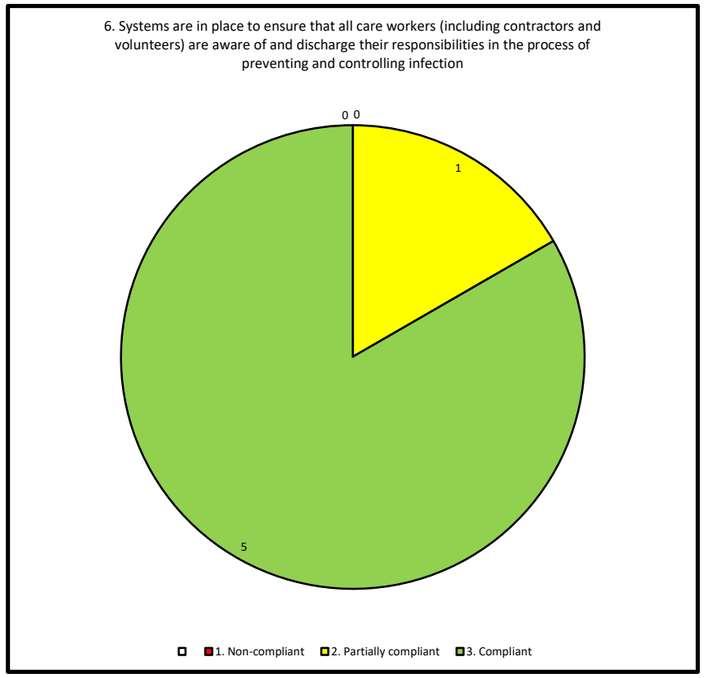




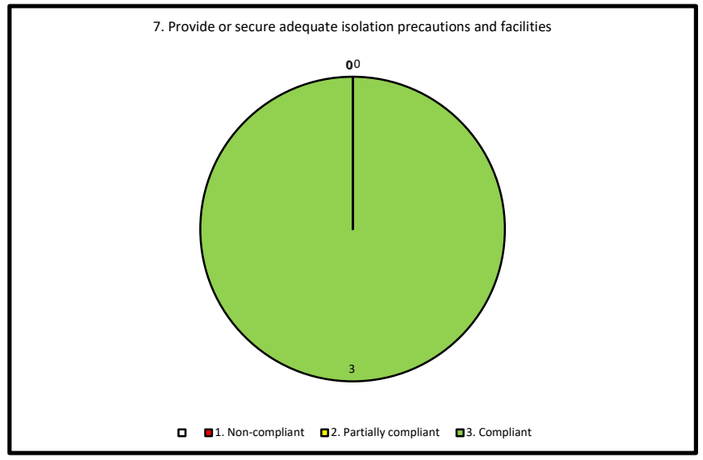
4.2	Information is appropriate to the target audience, remains accurate and up to date, is provided in a timely manner and is easily accessible in a range of formats (eg digital and paper) and platforms, taking account of the communication needs of the patient/service user/care giver/visitor/advocate.	As above			Need to ask teams.	3. Compliant
4.3	The provision of information includes and supports general principles on the prevention and control of infection and antimicrobial resistance, setting out expectations and key aspects of the registered provider's policies on IPC and AMR.				AMR information available for patient's and staff.	1. Non-compliant
4.4	Roles and responsibilities of specific individuals, carers, visitors, and advocates when attending with or visiting patients/service users in care settings, are clearly outlined to support good standards of IPC and AMR and include: •hand hygiene, respiratory hygiene, PPE (mask use if applicable) •Supporting patients/service users' awareness and involvement in the safe provision of care in relation to IPC (eg cleanliness) •Explanations of infections such as incident/outbreak management and action taken to prevent recurrence. •Provide published materials from national/local public health campaigns (eg AMR awareness/vaccination programmes/seasonal and respiratory infections) should be utilised to inform and improve the knowledge of patients/service users, care givers, visitors and advocates to minimise the risk of transmission of infections.	Roles and responsibilities of the team and service users included as above.			Trust is currently in the process of redevelop[ing the internet site. Awaiting for AMR information to be finalised	3. Compliant
4.5	Relevant information, including infectious status, invasive device passports/care plans, is provided across organisation boundaries to support safe and appropriate management of patients/service users.		Community teams confirmation about local processes		Discuss with clinical teams re patient referral pathways re infectious status	1. Non-compliant
5.Ensure early identification of individuals 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 others.						
Systems and processes are in place to ensure that patient placement decisions are in line with the NIPCM:						
5.1	All patients/individuals are promptly assessed for infection and/or colonisation risk on arrival/transfer at the care area. Those who have, or are at risk of developing, an infection receive timely and appropriate treatment to reduce the risk of infection transmission.	Patient's infectious status reported using systemone.				3. Compliant
5.2	Patients' infectious status should be continuously reviewed throughout their **stay/period of care**. This assessment should influence placement decisions in accordance with clinical/care need(s). If required, the patient is placed /isolated or cohorted accordingly whilst awaiting test results and documented in the patient's notes.	Placement of patient not applicable as the Trust has no inpatient facilities. However, patient's infectious status is reviewed whilst receiving planned care.				3. Compliant
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.	Patient's infectious status reported using systemone.				3. Compliant
5.4	Signage is displayed prior to and on entry to all health and care settings instructing patients with respiratory symptoms to inform receiving reception staff, immediately on their arrival.	Use of signage in place during periods of increased incidence in line with national guidelines Environmental Audits			Patient transfer circumstance. Own home visits.	3. Compliant

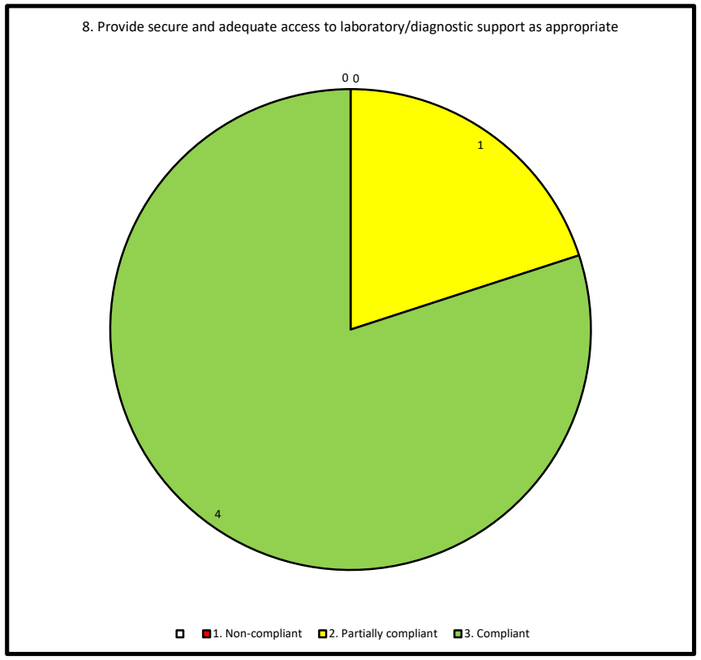


5.5	Two or more infection cases (or a single case of serious infection) linked by time, place, and person triggers an incident/outbreak investigation and this must be reported via governance reporting structures.	IPAC Huddle standing agenda IPAC Huddle minutes IPAC Committee Reports QISCOM Minutes			compliant. Outbreaks reported via the national outbreak portal.Outbreaks are reported through the Trust's incident reporting system (Datix). Outbreak meetings held when required and discussed at weekly IPaC huddle, IPaCC and to the board (QISCOM).	3. Compliant
6.Systems are in place 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 processes are in place to ensure:						
6.1	Induction and mandatory training on IPC includes the key criteria (SICPs/TBPs) for preventing and controlling infection within the context of the care setting.	Volunteer Mandatory Training Booklet v11 Trust Induction Booklet 2021 Mandatory Training Requrement on ESR June 23			IPaC guidelines / training produced for contractors and volunteers.	3. Compliant
6.2	The workforce is competent in IPC commensurate with roles and responsibilities.	IPAC Committee Reports				3. Compliant
6.3	Monitoring compliance and update IPC training programs as required.	IPAC Committee Reports			Monitoring of IPaC training reported monthly via ESR and presented in the Monthly Quality Dashboard. Servive leads report quarterly uptake via their Service IPaC report.	3. Compliant
6.4	All identified staff are trained in the selection and use of personal protective equipment / respiratory protective equipment (PPE/RPE) appropriate for their place of work including how to safely put on and remove (donning and doffing) PPE and RPE.	iCASH Fit Test Register 2022			The use of PPE / RPE is identified by the IPaC team and services where required. Staff undertaking higher risk proceedures have received training on donning and doffing of PPE and fit testing for the use of FFP3 / respirators. The majority of Dental clinical staff have been fit tested to reusable face respirators. addition face hoods have been acquired for staff to wear if not fit tested to a respirator. All fit testings are recorded via ESR as per national requirement.	3. Compliant
6.5	That all identified staff are fit-tested as per Health and Safety Executive requirements and that a record is kept.	iCASH Fit Test register 2022			As above	3. Compliant
6.6	If clinical staff undertake procedures that require additional clinical skills, for example, medical device insertion, there is evidence staff are trained to an agreed standard and the staff member has completed a competency assessment which is recorded in their records before being allowed to undertake the procedures independently.	Mandatory Training Requirements - June 23 ESR Clinical Competencies recorded on ESR			clinical competencies in place e.g. urinary catheters, suctions. ?competencies held by departments or ESR? Flu vaccinators competencies are done on assignment number not on position number. Ask via Clinical and Professional Group.	2. Partially compliant
7. Provide or secure adequate isolation precautions and facilities						
Systems and processes are in place in line with the NIPCM to ensure that:						
7.1	Patients that are known or suspected to be infectious as per criterion 5 are individually clinically risk assessed for infectious status when entering a care facility. The result of individual clinical assessments should determine patient placement decisions and the required IPC precautions. Clinical care should not be delayed based on infectious status.	Outpatients. Evidence supporting the SOPS for MPOX (Local SOP re rooms etc) and Covid for iCaSH services, Covid SOPs for Dental services.			?Luton adults patient transfer	3. Compliant



7.2	Isolation facilities are prioritised, depending on the known or suspected infectious agent and all decisions made are clearly documented in the patient's notes. Patients can be cohorted together if: •single rooms are in short supply and if there are two or more patients with the same confirmed infection. •there are situations of service pressure, for example, winter, and patients may have different or multiple infections. In these situations, a preparedness plan must be in place ensuring that organisation/board level assurance on IPC systems and processes are in place to mitigate risk.	Outpatients. Patients that have been identified as infectious would either be seen at the end of a clinic session, or via assessed in designated areas.				3. Compliant
7.3	Transmission based precautions (TBPs) in conjunction with SICPs are applied and monitored and there is clear signage where isolation is in progress, outlining the precautions required.	N/A				0. Not applicable
7.4	Infectious patients should only be transferred if clinically necessary. The receiving area (ward, hospital, care home etc.) must be made aware of the required precautions.	Patient's infectious status reported using systemone.				3. Compliant
8.Provide secure and adequate access to laboratory/diagnostic support as appropriate						
Systems and processes to ensure that pathogen-specific guidance and testing in line with UKHSA are in place:						
8.1	Patient/service user testing for infectious agents is undertaken by competent and trained individuals and meet the standards required within a nationally recognised accreditation system.	UKHSA 2021-22 contract with CCS UKHSA 2021-22 Addendum to contract UKHSA UKAS accreditaton update HSL Analystics Schedule of Accreditation			Currently Addenbrooke's laboratory awaiting accreditation evidence submitted expect confirmation in July 2023.	2. Partially compliant
8.2	Early identification and reporting of the infectious agent using the relevant test is required with reporting structures in place to escalate the result if necessary.	Lab results for alert organisms			Trust currently have a Covid 19 SoP, providing specific guidelines for staff to follow re LFD testing and sourcing. Confirmation of results for laboratory testing is provided to the Trust as per contract with providers.	3. Compliant
8.3	Protocols/service contracts for testing and reporting laboratory/pathology results, including turnaround times, should be in place. These should be agreed and monitored with relevant service users as part of contract monitoring and laboratory accreditation systems.	UKHSA 2021-22 contract with CCS UKHSA 2021-22 Addendum to contract UKHSA UKAS accreditaton update HSL Analystics Schedule of Accreditation			Two seperate contracts in place. Main contract with Addenbrooke's and the other with TDL for iCaSH.	3. Compliant
8.4	Patient/service user testing on admission, transfer, and discharge should be in line with national guidance, local protocols and results should be communicated to the relevant organisation.				? inpatient	0. Not applicable
8.5	Patients/service users who develops symptom of infection are tested / retested at the point symptoms arise and in line with national guidance and local protocols.				?inpatient	0. Not applicable
8.6	There should be protocols agreed between laboratory services and the service user organisations for laboratory support during outbreak investigation and management of known/ emerging/novel and high-risk pathogens.				acute hospital orientated. However, where a wider outbreak occurs , support given by UKHSA re laboratory testing.	3. Compliant
8.7	There should be protocols agreed between laboratory services and service user organisations for the transportation of specimens including routine/ novel/ emerging/high risk pathogens. This protocol should be regularly tested to ensure compliance.				Transportation of specimens included in the IPaC national manual.	3. Compliant





9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections						
9.1	Systems and processes are in place to ensure that guidance for the management of specific infectious agents is followed (as per UKHSA, A to Z pathogen resource, and the NIPCM). Policies and procedures are in place for the identification of and management of outbreaks/incidence of infection. This includes monitoring, recording, escalation and reporting of an outbreak/incident by the registered provider.				Local arrangements in place. The adoption of the national IPaC manual was agreed at the Trust's IPaCC 27.04.2023. The implementation of the new IPaCM will be by the end of May 2023.	2. Partially compliant
10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection						
Systems and processes are in place to ensure that any workplace risk(s) are mitigated maximally for everyone. This includes access to an occupational health or an equivalent service to ensure:						
10.1	Staff who may be at high risk of complications from infection (including pregnancy) have an individual risk assessment.					3. Compliant
10.2	Staff who have had an occupational exposure are referred promptly to the relevant agency, for example, GP, occupational health, or accident and emergency, and understand immediate actions, for example, first aid, following an occupational exposure including process for reporting.	SOP for how to contact OH (2 contracts) nothing in Sickness Policy iCASH BBV SOP				3. Compliant
10.3	Staff have had the required health checks, immunisations and clearance undertaken by a competent advisor (including those undertaking exposure prone procedures (EPPs).					3. Compliant