NHS
Cambridgeshire
Community Services
NHS Trust

Infection Prevention and Control Board Assurance Framework - March 2022

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

	Key lines of enquiry	Evidence	Gaps in assurance	Mitigating actions
	Systems and processes are in place to ensure that:			
1.1	A respiratory season / winter plan is in place: ▪ that includes point of care testing (POCT) methods for seasonal respiratory viruses to support patient triage/placement and safe management according to local needs, prevalence, and care services ▪ to enable appropriate segregation of cases depending on the pathogen. ▪ a multidisciplinary team approach is adopted with hospital leadership, estates & facilities, IPC Teams and clinical staff to assess and plan for creation of adequate isolation rooms / units as part of the Trusts winter plan.	N/A refers to inpatient care. Monitoring of positive staff is initially managed by service leads, with the support of IPaC.	No Gaps identified 09.03.2022	
1.2	Health and care settings continue to apply Covid19 secure workplace requirements as far as practicable, and that any workplace risk(s) are mitigated for everyone.	Requirements within the safer environmental assessment tool Weekly IPaC huddle Weekly safe environment assessment reviews Weekly IMT	No Gaps identified 09.03.2022	

1.3	Organisational / employers risk assessments in the context of managing seasonal respiratory infectious agents are: ▪ based on the measures as prioritised in the hierarchy of controls. including evaluation of the ventilation in the area, operational capacity, and prevalence of infection/new variants of concern in the local area. ▪ applied in order and include elimination; substitution, engineering, administration and PPE / RPE. ▪ communicated to staff.	PPE assessments in place. National push stock received and distributed to services where stock levels are low. Air Quality assess through Trust's Air Quality Lead	No Gaps identified 09.03.2022	
1.4	Safe systems of working; including managing the risk associated with infectious agents through the completion of risk assessments have been approved through local governance procedures, for example Integrated Care Systems.	Remote working policy Local risk assessments re care homes	No Gaps identified 09.03.2022	
1.5	If the organisation has adopted practices that differ from those recommended/stated in the national guidance a risk assessment has been completed and it has been approved through local governance procedures, for example Integrated Care Systems.	(Predominately LSV) cleaning of chairs (As agreed with NHSI/E), needlesticks and ventilation entrance and exits to departments (building Risk assessments.	No Gaps identified 09.03.2022	
1.6	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 respiratory infectious agents.	Compliant – assessments are completed by the relevant expert.	No Gaps identified 09.03.2022	
1.7	If an unacceptable risk of transmission remains following the risk assessment, the extended use of Respiratory Protective Equipment (RPE) for patient care in specific situations should be considered.	Compliant	No Gaps identified 09.03.2022	

1.8	Ensure that patients are not transferred unnecessarily between care areas unless, there is a change in their infectious status, clinical need, or availability of services.	Patients only transferred on for clinical reasons.	No Gaps identified 09.03.2022	
1.9	The Trust Chief Executive, the Medical Director or the Chief Nurse has oversight of daily sitrep.in relation to Covid19, other seasonal respiratory infections, and hospital onset cases	Compliant – where appropriate this is undertaken.	No Gaps identified 09.03.2022	
1.10	There are check and challenge opportunities by the executive / senior leadership teams of IPC practice in both clinical and non-clinical areas.	Compliance reported when undertaking external visits.	No Gaps identified 09.03.2022	
1.11	Resources are in place to implement and measure adherence to good IPC practice. This must include all care areas and all staff (permanent, agency and external contractors).	Monthly CIA, environmental audits (monthly LSV and annual IPaC)	No Gaps identified 09.03.2022	
1.12	The application of IPC practices within this guidance is monitored, e.g.: ▪ hand hygiene. ▪ PPE donning and doffing training. ▪ cleaning and decontamination.	Monthly CIA, annual UV audit, team meeting updates, IPaC link champions	No Gaps identified 09.03.2022	
1.13	The IPC Board Assurance Framework is reviewed, and evidence of assessments are made available and discussed at Trust board.	Compliant – Board is sighted on the document and any gaps.	No Gaps identified 09.03.2022	
1.14	The Trust Board has oversight of ongoing outbreaks and action plans.	Compliant – this is included in the Board Report.	No Gaps identified 09.03.2022	
1.15	The Trust is not reliant on a particular mask type and ensure that a range of predominantly UK Make FFP3 masks are available to users as required.	Compliant – a number of masks are available.	No Gaps identified 09.03.2022	

2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections

	Key lines of enquiry	Evidence	Gaps in assurance	Mitigating actions
	Systems and processes are in place to ensure that:			
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.	Compliant. Roll out of new Standards starts April 2022.	No Gaps identified 09.03.2022	
2.2	The organisation has systems and processes in place to identify and communicate changes in the functionality of areas / rooms	Compliant – process in place.	No Gaps identified 09.03.2022	
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.	Compliant – cleaning is monitored as per contractual arrangements.	No Gaps identified 09.03.2022	
2.4	Increased frequency of cleaning should be incorporated into the environmental decontamination schedules for patient isolation rooms and cohort areas.	Compliant. Increased frequency requested where appropriate as agreed with IPaC.	No Gaps identified 09.03.2022	
2.5	Where patients with respiratory infections are cared for: cleaning and decontamination are carried out with neutral detergent or a combined solution followed by a chlorine-based disinfectant, in the form of a solution at a minimum strength of 1,000ppm available chlorine as per national guidance.	Not applicable (inpatient)		
2.6	If an alternative disinfectant is used, the local infection prevention and control team (IPCT) are consulted on this to ensure that this is effective against enveloped viruses.	Compliance Disinfectants received as part of the national delivery system.	No Gaps identified 09.03.2022	

2.7	Manufacturers' guidance and recommended product 'contact time' is followed for all cleaning / disinfectant solutions / products.		No Gaps identified 09.03.2022	
2.8	A minimum of twice daily cleaning of: ▪ patient isolation rooms ▪ cohort areas ▪ Donning & doffing areas ▪ 'Frequently touched' surfaces e.g., door / toilet handles, patient call bells, over bed tables and bed rails ▪ where there may be higher environmental contamination rates, including: ▪ toilets / commodes particularly if patients have diarrhoea.	Donning and Doffing, frequently touched areas applicable	No Gaps identified 09.03.2022	
2.9	A terminal / deep clean of inpatient rooms is carried out: ▪ following resolutions of symptoms and removal of precautions ▪ when vacated following discharge or transfer (this includes removal and disposal/or laundering of all curtains and bed screens); ▪ following an AGP if room vacated (clearance of infectious particles after an AGP is dependent on the ventilation and air change within the room)	Toilets and high touch areas cleaned twice a day. No inpatients service Deep cleans undertaken for outbreaks.	No Gaps identified 09.03.2022	
2.10	A terminal / deep clean of inpatient rooms is carried out: ▪ following resolutions of symptoms and removal of precautions ▪ when vacated following discharge or transfer (this includes removal and disposal/or laundering of all curtains and bed screens); ▪ following an AGP if room vacated (clearance of infectious particles after an AGP is dependent on the ventilation and air change within the room)	No inpatient areas. Compliant with AGP i.e. dental.	No Gaps identified 09.03.2022	

2.11	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.	Audit reports received and compliance monitored and presented at IPaC Committee.	No Gaps identified 09.03.2022	
2.12	Compliance with regular cleaning regimes is monitored including that of reusable patient care equipment.	Not applicable as refers to inpatient service		
2.13	As part of the Hierarchy of controls assessment: ventilation systems, particularly in, patient care areas (natural or mechanical) meet national recommendations for minimum air changes refer to country specific guidance. In patient Care Health Building Note 04-01: Adult in-patient facilities.		No Gaps identified 09.03.2022	
2.14	The assessment is carried out in conjunction with organisational estates teams and or specialist advice from ventilation group and or the organisations, authorised engineer.	Trust ventilation lead for the Trust in discussion with Estates and IPaC. Lead reports to IPaC Committee.	No Gaps identified 09.03.2022	
2.15	A systematic review of ventilation and risk assessment is undertaken to support location of patient care areas for respiratory pathways.		No Gaps identified 09.03.2022	
2.16	Where possible air is diluted by natural ventilation by opening windows and doors where appropriate	Comms messages to all staff, team meetings and IPaC link champions	No Gaps identified 09.03.2022	
2.17	Where a clinical space has very low air changes and it is not possible to increase dilution effectively, alternative technologies are considered with Estates / Ventilation Group.	Scrubbers in place in high-risk areas e.g. Dental services	No Gaps identified 09.03.2022	

2.18	When considering screens/partitions in reception/ waiting areas, consult with estates/facilities teams, to ensure that air flow is not affected, and cleaning schedules are in place.	Included within the building risk assessments completed by services and reviewed by the Trust.	No Gaps identified 09.03.2022	

3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance

	Key lines of enquiry	Evidence	Gaps in assurance	Mitigating actions
	Systems and processes are in place to ensure that:			
3.1	Arrangements for antimicrobial stewardship are maintained	Anti-microbial usage is audited and reported quarterly. Data is presented to the MSGG and IPaC Committee.	No Gaps identified 09.03.2022	
3.2	Previous antimicrobial history is considered.		Need further information and assurance that this is carried out.	Added to action plan for IPaC committee.
3.3	The use of antimicrobials is managed and monitored: ▪ to reduce inappropriate prescribing ▪ to ensure patients with infections are treated promptly with correct antibiotic	Reviewed at IPaC committee as separate action planning.	No Gaps identified 09.03.2022	
3.4	Mandatory reporting requirements are adhered to, and boards continue to maintain oversight.		Need further information and assurance that this is carried out.	Added to action plan for IPaC committee.
3.5	Risk assessments and mitigations are in place to avoid unintended consequences from other pathogens.		Need further information and assurance that this is carried out.	Added to action plan for IPaC committee.

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.

	Key lines of enquiry	Evidence	Gaps in assurance	Mitigating actions
	Systems and processes are in place to ensure that:			
4.1	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	Not applicable (inpatient services)		
4.2	National guidance on visiting patients in a care setting is implemented.	Not applicable (inpatient services)		
4.3	Restrictive visiting may be considered appropriate during outbreaks within inpatient areas. This is an organisational decision following a risk assessment.	Not applicable (inpatient services)		
4.4	There is clearly displayed, written information available to prompt patients' visitors and staff to comply with handwashing, wearing of facemask / face covering and physical distancing.	Patient is risk assessed prior to face-to-face appointments and upon arriving to Trust sites and departments.	No Gaps identified 09.03.2022	
4.5	If visitors are attending a care area with infectious patients, they should be made aware of any infection risks and offered appropriate PPE. This would routinely be an FRSM.	Posters, screen savers within waiting areas, banners, Internet, floor art (e.g. stickers).	No Gaps identified 09.03.2022	
4.6	Visitors with respiratory symptoms should not be permitted to enter a care area. However, if 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 wherever possible.	Compliant.	No Gaps identified 09.03.2022	

4.7	Visitors are not present during AGPs on infectious patients unless they are considered essential following a risk assessment e.g., carer / parent / guardian.	Compliant – process in place.	No Gaps identified 09.03.2022	
4.8	Implementation of the Supporting excellence in infection prevention and control behaviours Implementation Toolkit has been adopted C1116-supporting-excellence-in-ipc-behaviours-imp-toolkit.pdf (england.nhs.uk).	Compliant – toolkit reviewed and implemented.	No Gaps identified 09.03.2022	

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

	Key lines of enquiry	Evidence	Gaps in assurance	Mitigating actions
	Systems and processes are in place to ensure that:			
5.1	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.	Compliant – signs observed in all settings.	No Gaps identified 09.03.2022	
5.2	Infection status of the patient is communicated to the receiving organization, department or transferring services, when a possible or confirmed seasonal respiratory infection needs to be transferred.	Compliant	No Gaps identified 09.03.2022	
5.3	Staff are aware of agreed template for screening questions to ask.	Compliant – screening questions in place these are reviewed as and when guidance is updated.	No Gaps identified 09.03.2022	
5.4	Screening for Covid19 is undertaken prior to attendance wherever possible to enable early recognition and to clinically assess patients prior to any patient attending a healthcare environment.	Compliant – triage processes in place.	No Gaps identified 09.03.2022	
5.5	Front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed Covid19 other respiratory infection symptoms and segregation of cases to minimise the risk of cross-infection as per national guidance.	Compliant – triage processes in place.	No Gaps identified 09.03.2022	
5.6	Triage is undertaken by clinical staff who are trained and competent in the clinical case definition and patient is allocated appropriate pathway as soon as possible.	Compliant – triage processes in place.	No Gaps identified 09.03.2022	

5.7	There is evidence of compliance with routine patient testing protocols in line with trust approved hierarchies of control risk assessment and approved.	Not Applicable		
5.8	Patients with suspected or confirmed respiratory infection are provided with a surgical facemask (Type II or Type IIR) to be worn in multi-bedded bays and communal areas if this can be tolerated.	Not Applicable		
5.9	Patients with respiratory symptoms are assessed in a segregated area, ideally a single room, and away from other patients pending their test result.	Not Applicable		
5.10	Patients with excessive cough and sputum production are prioritised for placement in single rooms whilst awaiting testing.	Not Applicable		
5.11	Patients at risk of severe outcomes of respiratory infection receive protective IPC measures depending on their medical condition and treatment whilst receiving healthcare e.g., priority for single room isolation and risk for their families and carers accompanying them for treatments / procedures must be considered.	Not Applicable		
5.12	Where treatment is not urgent consider delaying this until resolution of symptoms providing this does not impact negatively on patient outcomes.	Compliant – consideration is in place across the relevant services e.g., dental.	No Gaps identified 09.03.2022	
5.13	Face masks / coverings are worn by staff and patients in all health and care facilities.	Compliant where possible. Some patients have refused to wear masks on CCS property, despite several	No Gaps identified 09.03.2022	

		interventions being undertaken.		
5.14	Where infectious respiratory patients are cared for physical distancing remains at 2 metres distance.	Compliant – monitored via risk assessment process.	No Gaps identified 09.03.2022	
5.15	Patients, visitors, and staff can maintain 1 metre or greater social & physical distancing in all patient care areas; ideally segregation should be with separate spaces, but there is potential to use screens, e.g., to protect reception staff.	Compliant – monitored via the risk assessment process.	No Gaps identified 09.03.2022	
5.16	Patients that test negative but display or go on to develop symptoms of Covid19 are segregated and promptly re-tested and contacts traced promptly.	Not Applicable		
5.17	Isolation, testing and instigation of contact tracing is achieved for all patients with new-onset symptoms, until proven negative.	Compliant (including staff contact tracing support for line managers from IPaC Team.	No Gaps identified 09.03.2022	
5.18	Patients that attend for routine appointments who display symptoms of Covid19 are managed appropriately.	Compliant – processes in place to support patients and staff.	No Gaps identified 09.03.2022	

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

	Key lines of enquiry	Evidence	Gaps in assurance	Mitigating actions
	Systems and processes are in place to ensure that:			
6.1	Appropriate infection prevention education is provided for staff, patients, and visitors.	Patients and visitors are reminded of IPaC best practice through posters, letters (PPE) etc.	No Gaps identified 09.03.2022	
6.2	Training in IPC measures is provided to all staff, including: the correct use of PPE including an initial face fit test/and fit check each time when wearing a filtering face piece (FFP3) respirator and the correct technique for putting on and removing (donning / doffing) PPE safely.	All clinical staff undertake IPC training which incorporates standard precautions. This is recorded on the Electronic Staff Record and reported on the Quality Dashboard. This is monitored for each service via the relevant clinical Operational Board. Enhanced training on additional precautions including donning and doffing is discussed / demonstrated during respirator fit testing for staff undertaking Aerosol Generating Procedures. IPaC Manual and national Covid19 guidelines available to staff.	No Gaps identified 09.03.2022	

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 put it on and remove it.	As above	No Gaps identified 09.03.2022	
6.4	Adherence to national guidance on the use of PPE is regularly audited with actions in place to mitigate any identified risk.	As above	No Gaps identified 09.03.2022	
6.5	Gloves 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.	As above	No Gaps identified 09.03.2022	
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 as per national guidance.	Compliant	No Gaps identified 09.03.2022	
6.7	Staff maintaining physical and social distancing of 1 metre or greater wherever possible in the workplace	As per Trust policy	No Gaps identified 09.03.2022	
6.8	Staff understand the requirements for uniform laundering where this is not provided for onsite.	Guidelines communicated through regular comms messages, team meetings and vis the Trust's IPaC guidelines.	No Gaps identified 09.03.2022	
6.9	All staff understand the symptoms of COVID-19 and take appropriate action if they or a member of their household display any of the symptoms (even if experiencing mild symptoms) in line with national guidance.	Compliant – communication processes in place (written and verbal updates provided).	No Gaps identified 09.03.2022	
6.10	To monitor compliance and reporting for asymptomatic staff testing	Staff assessments forwarded to positive staff	No Gaps identified	

		line manager for completion and then forwarding to IPaC review. Data collated and presented at weekly IPaC huddle at monthly at IMT.	09.03.2022	
6.11	There is a rapid and continued response to ongoing surveillance of rates of infection transmission within the local population and for hospital / organisation onset cases (staff and patients/individuals).	Messages to staff via Chief Nurse's and Medical Director's staff messages 9including virtual team messages).	No Gaps identified 09.03.2022	
6.12	Positive cases identified after admission who fit the criteria for investigation should trigger a case investigation. Two or more positive cases linked in time and place trigger an outbreak investigation and are reported.	Where two or more cases of staff working in the same area are reported, an initial investigation is initiated and a subsequent Outbreak meeting is formed as per Trust policy and information cascaded throughout the Trust.	No Gaps identified 09.03.2022	

7. Provide or secure adequate isolation facilities

	Key lines of enquiry	Evidence	Gaps in assurance	Mitigating actions
	Systems and processes are in place to ensure that:			
7.1	That clear advice is provided, and monitoring is carried out of inpatients compliance with wearing face masks (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.	Not applicable inpatient services		
7.2	Separation in space and / or time is maintained between patients with and without suspected respiratory infection by appointment or clinic scheduling to reduce waiting times in reception areas and avoid mixing of infectious and non-infectious patients.	Not applicable inpatient services		
7.3	Patients who are known or suspected to be positive with a respiratory pathogen including Covid19 where their treatment cannot be deferred, their care is provided from services able to operate in a way which minimise the risk of spread of the virus to other patients / individuals.	Not applicable inpatient services		
7.4	Patients are appropriately placed i.e., infectious patients in isolation or cohorts.	Not applicable inpatient services		
7.5	Ongoing regular assessments of physical distancing and bed spacing, considering potential increases in staff to patient ratios and equipment needs (dependent on clinical care requirements).	Not applicable inpatient services		
7.6	Standard infection control precautions (SIPC's) are used at point of care for patients who have been screened, triaged, and tested and have a negative result.	Not applicable inpatient services		

7.7	The principles of SICPs and TBPs continued to be applied when caring for the deceased	Not applicable inpatient services		

8. Secure adequate access to laboratory support as appropriate

	Key lines of enquiry	Evidence	Gaps in assurance	Mitigating actions
	Systems and processes are in place to ensure that:	Acute Trust orientated copy paste from previous version	UKHSA (located at CUHFT) laboratory services review was postponed by UKAS due to unprecedented work demands.	To be rescheduled for May 2022.
8.1	Testing is undertaken by competent and trained individuals.	Staff registered to receive LFT's have been given training to undertake LFT.	No Gaps identified 09.03.2022	
8.2	Patient testing for all respiratory viruses testing is undertaken promptly and in line with national guidance.	Not applicable		
8.3	Staff testing protocols are in place.	Compliant – protocols are in place and regularly reviewed.	No Gaps identified 09.03.2022	
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.	Not applicable		
8.5	Screening for other potential infections takes place.	Not applicable		
8.6	That all emergency patients are tested for Covid19 and other respiratory infections as appropriate on admission.	Not applicable		

8.7	That those inpatients who go on to develop symptoms of respiratory infection / Covid19 after admission are retested at the point symptoms arise.	Not applicable		
8.8	That all emergency admissions who test negative on admission are retested for Covid19 on day 3 of admission, and again between 5-7 days post admission.	Not applicable		
8.9	That sites with high nosocomial rates should consider testing Covid19 negative patients daily.	Not applicable		
8.10	That those being discharged to a care home are tested for Covid19, 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.	Not applicable		
8.11	Those patients being discharged to a care facility within their 14-day isolation period are discharged to a designated care setting, where they should complete their remaining isolation as per national guidance.	Not applicable		
8.12	That those being discharged to a care home are tested for Covid19, 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.	Not applicable		
8.13	Those patients being discharged to a care facility within their 14-day isolation period are discharged to a designated care setting, where they should complete their remaining isolation as per national guidance	Not applicable		

9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections

	Key lines of enquiry	Evidence	Gaps in assurance	Mitigating actions
	Systems and processes are in place to ensure that:			
9.1	The application of IPC practices is monitored and that resources are in place to implement and measure adherence to good IPC practice. This must include all care areas and all staff (permanent, agency and external contractors).	Safer working building risk assessments. Monthly audits (Clinical Interventions, monthly and annual environmental audits, staff risk assessments including vulnerable staff re isolation / working from home. Building risk assessments undertaken by departmental leads and reviewed by Estates and IPaC. Datix reports, monthly quality reports. Daily sit reps. All IPC guidelines continue to be implemented. Covid19 related guidance is communicated through FAQs, via Q&A sessions and on the Intranet. IPC Team support all services with ad hoc queries and requests for specific guidance.	No Gaps identified 09.03.2022	

9.2	Staff are supported in adhering to all IPC policies, including those for other alert organisms.	staff risk assessments including vulnerable staff re isolation / working from home.	No Gaps identified 09.03.2022	
9.3	Safe spaces for staff break areas / changing facilities are provided.	Safer working building risk assessments.	No Gaps identified 09.03.2022	
9.4	Robust policies and procedures are in place for the identification of and management of outbreaks of infection. This includes the documented recording of an outbreak.	Outbreak policy in place. Monitoring of reported positive LFT's, PCR test in place with an additional staff assessment if positive or as a close contact of a positive case.	No Gaps identified 09.03.2022	
9.5	All clinical waste and linen/laundry related to confirmed or suspected COVID-19 cases is handled, stored and managed in accordance with current national guidance.	Compliant – policy in place to support compliance.	No Gaps identified 09.03.2022	

10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection

	Key lines of enquiry	Evidence	Gaps in assurance	Mitigating actions
	Systems and processes are in place to ensure that:			
10.1	Staff seek advice when required from their IPCT/occupational health department/GP or employer as per their local policy.	Staff have access to OH services including Large Scale Vaccination centres, IPaC as described within the Trust's IPaC manual.	No Gaps identified 09.03.2022	
10.2	Bank, agency, and locum staff follow the same deployment advice as permanent staff.	Compliant as per HR policies.	No Gaps identified 09.03.2022	
10.3	Staff who are fully vaccinated against Covid19 and are a close contact of a case of Covid19 are enabled to return to work without the need to self-isolate (see Staff isolation: approach following updated government guidance)	Guidelines revised in line with national self-isolation guidelines available via the Trust's intranet and communicated via the Trust's comms team.	No Gaps identified 09.03.2022	
10.4	Staff understand and are adequately trained in safe systems of working, including donning, and doffing of PPE.	Compliant – processes and policies in place – training also provided as required	No Gaps identified 09.03.2022	
10.5	A fit testing programme is in place for those who may need to wear respiratory protection.	Staff undertaking AGP's are fit tested. Local database currently held, awaiting confirmation to upload data into ESR.	No Gaps identified 09.03.2022	

10.6	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 absence. ▪ facilitate access of staff to antiviral treatment where necessary and implement a vaccination programme for the healthcare workforce ▪ lead on the implementation of systems to monitor staff illness, absence, and vaccination against seasonal influenza and Covid19 ▪ encourage staff vaccine uptake.	IPaC wider team lead this process rather than OH as this is not included within the OH contract. OH, referrals in place for staff to self-refer if required.	No Gaps identified 09.03.2022	
10.7	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 national guidance.	Compliant – monitoring is in place via staff feedback, datix reporting	No Gaps identified 09.03.2022	
10.8	A risk assessment is carried 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 and severe illness from Covid19: ▪ 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	Risk assessments in place for staff and their line manager to complete and record in their personal file.	Trust notified staff of the new OH provider for all staff (with the exception of Luton employees) on 08.03.22. Heales Medical, starting from 01.04.2022. Policies should be in place at the start of the contract.	

10.9	Vaccination and testing policies are in place as advised by occupational health/public health.	Compliant Within OH contract, iCaSH SOP re sharp's injuries / BBV's, Mass vaccination plan including seasonal influenza, Covid19 vaccination programme.	No Gaps identified 09.03.2022	
10.10	Staff required to wear FFP3 reusable respirators undergo training that is compliant with HSE guidance, and a record of this training is maintained and held centrally / ESR records.	Partial Compliant. The Trust's ESR and OLM operational lead has confirmed that staff required to wear FFP3 will be able to have their competencies confirmed for each type of FFP3 assessed on (both pass and fail). Quality Administrators are due to be trained and authorised to upload the data into staff ESR records.	No Gaps identified 09.03.2022	
10.11	Staff who carry out fit test training are trained and competent to do so.	Original records for training on spreadsheet.	Most Fit testing staff was trained inhouse via a competent Trainer (Head of Infection Prevention and Control). 2 Dental nurses and the Infection Prevention and	Added to action plan for IPaC committee.

			Control Clinical Nurse Specialist have been trained more recently within the last 2 years 21.04.2022	
10.12	All staff required to wear an FFP3 respirator have been fit tested for the model being used and this should be repeated each time a different model is used.	As per FFP3 register	No Gaps identified 09.03.2022	
10.13	All staff required to wear an FFP3 respirator should be fit tested to use at least two different masks	Partial compliance	Some staff are currently fitted to one type due to FFP3's received centrally.	Added to action plan for IPaC committee.
10.14	A record of the fit test and result is given to and kept by the trainee and centrally within the organisation.	Compliant – records are kept	No Gaps identified 09.03.2022	
10.15	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 and hoods.	Compliant Information to be stored via ESR.	No Gaps identified 09.03.2022	
10.16	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.	Compliant –advice provided as needed	No Gaps identified 09.03.2022	
10.17	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	Compliant – process in place as needed	No Gaps identified 09.03.2022	

	members skills and experience and in line with nationally agreed algorithm.			
10.18	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.	Information held with line manager and HR.	No Gaps identified 09.03.2022	
10.19	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.	Partial compliant. Compliance with agreed IPaC AGP procedures for services. Data to be included within IPaC reports once updated to ESR. Completed building risk assessments reviewed by IPaC and Estates and discussed weekly at IMT.	No Gaps identified 09.03.2022	
10.20	Consistency in staff allocation should be maintained, reducing movement of staff and the crossover of care pathways between planned/elective care pathways and urgent / emergency care pathways as per national guidance.	Predominately acute Trust focused, though transferable to some community teams e.g., Dynamic Health, Children's Continuing Care.	No Gaps identified 09.03.2022	
10.21	Health and care settings are Covid19 secure workplaces as far as practical, that is, that any workplace risk(s) are mitigated maximally for everyone.	As per building risk assessments completed by departmental staff and assessed centrally.	No Gaps identified 09.03.2022	
10.22	Staff absence and well-being are monitored and staff who are self-isolating are supported and able to access testing.	Compliant – support process in place through	No Gaps identified	

		the central inbox. Information on where to get LFT's readily available.	09.03.2022	
10.23	Staff who test positive have adequate information and support to aid their recovery and return to work.	Complaint – processes in place, information available.	No Gaps identified 09.03.2022	