Infection Prevention and Control board assurance framework January 2024

	Key Lines of Enquiry	Evidence	Gaps in Assurance	Mitigating Actions	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					
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			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 Standing Agenda IPAC Annual Report 2021-22 QISCOM Minutes Dec 22 QISCOM Action Log Dec 22			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 Standing Agenda QISCOM Minutes Dec 22 QISCOM Action Log Dec 22 Health & Safety Group Apr 23 agenda Health & Safety Group Jan 23 minutes			3. Compliant
1.4	They implement, monitor, and report adherence to the NIPCM.	National IPAC Manual and associated SOPs			3. 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 iCaSH laboratories monitor for antimicrobial resistant Gonorrhoea. 634 SOP Supporting and managing healthcare staff with positive COVID-19 tst result Outbreak reports			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			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			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)	634 SOP Supporting and managing healthcare staff with positive COVID-19 tst result Covid +ve Risk Assessment for line managers Mpox SOP			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 Monthly reports CCS Cleaning Report Dec 22 CCS Sites Charter Posters and Star ratings tracker Peer Reviews Efficacy Audits (ICAT)	Data inconsistent from contractors on smaller sites i.e. NHSP and MITIE. Able to demonstrate a high level of assurance via main cleaning contractor (OCS). Reports provided to the Trust are compliant.	Efficacy audits being done via ICAT system and forwarded to services for display. Monthly contractual meetings with IPAC and OCS Auditor and CCS Auditor. Admin support for OCS Auditor in place. Meetings are being held with the contractors on the outlying sites to develop a formal reporting structure, this is expected to be compliant July 2024.	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.	Generic statement in job description IPAC Policy Efficacy Audits The Dental Services Procedure for Infection Control and Decontamination refers to cleaning standards and includes the following sections, Environmental cleaning Decontamination of Treatment areas Decontamination of Public areas Cleaning schedules Hot desking		Statement in all job descriptions plus sections in IPAC Policy to confirm objectives and responsibilibities.	3. 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.	IPAC Committee Facilities Reports 2022-23 2023-24 Estates Strategy Water Safety Policy Water Safety Management Plan Management of Building Ventilation Systems Policy	Partial compliance for Ventilation, full compliance for Water. Ventilation reports not yet completed and require Variation to Contract with CBRE.	Ventilation Strategy sits under the Estates Strategy. Ventilation Group now included in Water Group. TOR for IPAC Committee confirms that is acts as Water and Ventilation Safety Group for the Trust.	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.	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			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.	Waste Policy v5 National IPAC Manual Estates reports ERIC reports Waste consignment reports			3. Compliant
2.8	There is evidence of compliance and monitoring of decontamination processes for reusable devices/surgical instruments as set out in HTM:01-01,	IPAC Committee Service Lead Reports Q1-3 Environmental Audits Decontamination Audits (Dental) (FP10s)			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 Prescription Pads audit			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			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			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 Prescription Pads audit		AMS Policy and 2022-23 Programme now uploaded June 23	3. 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.	Antimicrobial Stewardship Policy 22-23 IPACC AMS Programme		AMS Policy and 2022-23 Programme now uploaded June 23	3. 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)	Antimicrobial Stewardship Policy 22-23 IPACC AMS Programme		AMS Policy and 2022-23 Programme now uploaded June 23	3. 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.	Services have own local internet pages with information for patients and service users. IPAC Committee Minutes TWWTG or Co-Production meeting minutes	No over view of available information on local service internet pages.	Healthwatch Cambs & Pboro, B all contacted. Bedfordshre reported no concerns with CCS. IPAC internet page being reviewed in comparison with similar organisations to include a quality expectation statement.	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			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.	Antimicrobial Sterwardship Policy Cambridgeshire ICS Antimicrobial Prescribing Guidelines Norfolk and Waveney formulary, and antibiotic guidelines BLMK Antimicrobial Prescribing (Primary Care) Links to all ICB formularies from our Pharmacy/Useful links intranet page iCASH and Dental antibiotic fourmularies in the Document Library. These are based on national guidelines but with local microbiologist input.		AMR information available for patient's and staff. Formulary and drug classification and Anti Microbial Treatment Guidelines (specific for different ICBs) available on internet.	3. 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.	Antimicrobial Stewardship Policy 22-23 IPACC AMS Programme		Roles and responsibilities of the team and service users included as above. Social media awareness around respiratory infections, infections in the community, vaccines. Health promotion on internet together with NHS infection leaflets.	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.	S1 Discharge letters Transfer letters Lab confirmation and flags would come from the GP S1.		Discharge letters, Mpox SOP re OP appts, Dentaly and Lillie software data systems.	3. 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.		Previously recorded as not applicable and changed to compliant after review following IPAC Committee 23rd October 2023.	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			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			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			3. Compliant
6.2	The workforce is competent in IPC commensurate with roles and responsibilities.	IPAC Committee Reports, job descriptions, Trust Dashboard.			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. Service 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			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	Up to clinical leads to decide what competencies are required for the job role. Discussed at IPAC Committee and no auditting of competencies currently undertaken.	List of clinical competencies on ESR obtained. Invasive devices to be identified from the Medical Devices record and individual services contacted to identify how they are ensuring compliance.	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.			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 2022-23 contract UKHSA 2023-24 contract UKHSA 2021-22 Addendum to contract UKHSA UKAS accreditaton update UKHSA 2022-2023 contract template with CCS HSL Analystics Schedule of Accreditation Email from contracts regarding TDL contract renewal.	Addenbrookes have withdrawn from the accreditation scheme as outstanding actions were unlikely to be completed. They are expecting to rejoin in January 24.	Currently Addenbrooke's laboratory awaiting accreditation. Due to staffing issues CUH has currently withdrawn from the UKAS but is picking up the accreditaton process and re-asessment in early 2024. Contract with UKHSA 2022-23 and 23-24 are signed and returned to UKHSA. Contract with TDL is regularly extended (10 year rolling contract).	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 2022-23 contract UKHSA 2023-24 contract UKHSA UKAS accreditaton update HSL Analystics Schedule of Accreditation			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.				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.				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.	Courier contract is with HSL as part of their accreditation. https://www.hslpathology.com/tests/specimen-transport/ UKHSA 2022-23 contract UKHSA 2023-24 contract UKHSA User Handbook Jan 2022 TDL website links to packaging and rejection criteria	Assurance that the transport protocol is regularly auditted required.	Transportation of specimens included in the IPaC national manual. Issues regarding transportation of iCASH specimens are Datixed and TDL has access to these reports.	2. Partially 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.	UKHSA signed contract 2023-24 National IPAC Manual and associated SOPs			3. 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.	UKHSA User Handbook Jan 2022			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.	Contract for Beds, Luton and Dunstable Hospital provision for BLMK staff Contract for Heales Health Services (all other staff)			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).	Contract for Beds, Luton and Dunstable Hospital provision for BLMK staff Contract for Heales Health Services (all other staff)			3. Compliant