Cambridgeshire Community Services NHS Trust

Infection Prevention and Control Board Assurance Framework

1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: 1. infection risk is assessed at the front door and this is documented in patient notes	CCS NHS Trust does not provide in patient facilities. For clinic based services, telephone / virtual assessment is undertaken prior to a face to face appointment being offered. If symptomatic, the service user is advised to follow national guidance re self isolation and testing. This is recorded in patient notes.	No gaps identified	
2. patients with possible or confirmed COVID-19 are not moved unless this is essential to their care or reduces the risk of transmission	This relates to in patient settings.	N/A	
3. compliance with the national guidance around discharge or transfer of COVID-19 positive patients	This relates to in patient settings. The CCS Discharge Planning Team based at Luton & Dunstable Hospital ensure that the COVID status of all patient discharges (including patients at the end of their lives) that they	No gaps identified	

	are responsible for is communicated to relevant parties including families and care homes. PPE is supplied for carers where appropriate.		
4. patients and staff are protected with PPE, as per the PHE national guidance	Pre COVID IPC Policy and IPC supporting manual in place with IPC guidance for infections. Appendix for COVID related information being prepared to bring our guidance into one place. COVID related IPC guidance specific to PPE is reviewed by the IPC group (Chief Nurse as Director of Infection Prevention & Control , Medical Director, Deputy Chief Nurse and IPC Matron and actions discussed, recorded and agreed through our Incident Management Team (IMT) process. Director Infection Prevention & Control, Medical Director and IPC Matron are all members of Incident Management Team. Updated communication to staff regarding changes in practice required are agreed through this route and shared via FAQ mechanism from Medical Director / Chief Nurse. Incident Management Team oversight of all IPC incidents and risks including those relating to PPE Robust PPE stock management system in place and overseen by Quality Team. Key PPE link for each service identified and joins weekly PPE oversight session led by Deputy Chief Nurse. Good engagement with Procurement and Estates Teams re PPE distribution and guidance. Regular Q&A sessions with all staff by directorate includes opportunities for staff to raise any PPE issues. Examples logged with Incident management Team re changes to practice that are outside specified guidance which have been agreed due to staff concern/anxiety or appropriate rational for particular scenarios. All guidance is updated on the appropriate intranet pages	COVID specifc guidance being collated into policy/manual appendix. Occasional reported evidence that some elements of guidance is not followed by individuals. Where this is raised, appropriate conversations with staff are held.	All relevant guidance is communicated via FAQs and queries handed directly from staff or via IMT Weekly incident oversight Plans for observations to be part of environmental audits for 2020/21 alongside opportunistic site visits by IPC Matron ie for Fit testing

5.	national IPC guidance is regularly checked for updates and any changes are effectively communicated to staff in a timely way	IPC Matron, Director of Infection Prevention & Control, Medical Director and deputy Chief Nurse all part of Incident Management Team where all PHE and other IPC guidance is directly received via EPRR route. This is then logged, reviewed by the IPC Team and actions agreed and disseminated via FAQs to all staff – directly from medical Director and Chief Nurse. Staff intranet updated as changes to practice made. Screen savers and an IPC Awareness week communicated to staff.	No gaps identified	
6.	changes to guidance are brought to the attention of boards and any risks and mitigating actions are highlighted	As above – any changes to IPC related guidance are reviewed by IPC group (members described above) and follow same process – relevant updates and associated risks managed through Incident Management Team Risks and incidents reported through internal governance processes IPC Committee to meet August 2020 – cycle of Business to focus on IPC compliance and assurance.	No gaps identified	
7.	risks are reflected in risk registers and the Board Assurance Framework where appropriate	All COVID 19 related risks are reviewed and monitored by the Incident Management Team i.e 2x risks relating to PPE (staff anxiety and supply are currently being monitored at trust level through this process. Daily sitreps to the Incident Management Team where risks, changes in guidance and PPE stocks are reviewed. Updates have been reported through the Clinical Operational Boards (May 2020) and Board (May 2020). Non Executives have been updated fortnightly by the Chief Executive and Deputy Chief Executive. The Datix risk management system is used to record all risks and incidents and was amended at the beginning of the pandemic to identify Covid risks and incidents.	No gaps identified	
8.	robust IPC risk assessment processes and practices are	As above- risks reported and monitored through the IMT and governance structures at service Clinical	No gaps identified	

in place for non COVID-19 infections and pathogens	Governance and management meetings, Clinical Operational Boards and Board. Trust wide IPC Risks are owned by the Trust's Chief Nurse (Director Infection Prevention Control) and Medical Director (COVID-19 lead) with the support of the Deputy Chief Nurse and Matron Infection Prevention and Control. The Risks assessment are updated and discussed on a weekly basis at IMT. The IPC Team meet weekly to discuss all IPC issues including those that are non Covid related. IPC Committee to meet August 2020 reporting into QIS Committee. Liaison with the Trust's contracted Consultant Microbiologist by Chief Nurse and IPC matron throughout the pandemic. IPC training on line continues with monitoring via Quality Dashboard. Staff continue to risk assess processes and practices for non COVID infections and pathogens supported by the IPC team.		
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: 1. teams with appropriate training are assigned to care for and treat patients in COVID-19 isolation or cohort areas	Not fully applicable as no inpatient facilities within the Trust service portfolio. Dental services offer last appointments of the emergency sessions for known Covid positive patients and appropriate cleaning arrangements are in place.	No gaps identified	
2. designated cleaning teams with appropriate training in	This relates to in patient facilities. Dental areas as above	No gaps identified	

required techniques and use of PPE, are assigned to COVID-19 isolation or cohort areas.			
3. decontamination and terminal decontamination of isolation rooms or cohort areas is carried out in line with PHE and other national guidance	Rooms decontaminated as per national guidelines following Aerosol Generating Procedures within dentistry. Decontamination of equipment guidance circulated by the Trust and included within the IPC manual.	No gaps identified	
4. Increased frequency, at least twice daily, of cleaning in areas that have higher environmental contamination rates as set out in the PHE and other national guidance. Attention to the cleaning of toilets/bathrooms, as COVID-19 has frequently been found to contaminate surfaces in these areas cleaning is carried out with neutral detergent, a chlorine-based disinfectant, in the form of a solution at a minimum strength of 1,000ppm available chlorine, as per national guidance. If an alternative disinfectant is used, the local infection prevention and control team (IPCT) should be consulted on this to ensure that this is effective against enveloped viruses	Most clinical areas require daily cleaning only if cleaning undertaken at beginning or end of the day. Update on cleaning arrangements for specific areas if assessed as requiring additional hours being sought from Estates Team. All contracted environmental cleaning is conducted with neutral detergent and a chlorine-based disinfectant. Cleaning regimes form part of our standard cleaning contracts	Programme of environment audits paused since beginning of pandemic – timings to restart currently being considered. This will offer formal opportunity to test cleaning regimes in practice.	Monitoring of all cleaning related incidents Information in FAQs re additional cleaning that individuals should undertake in workplace ie surfaces and equipment.

manufacturers' guidance and recommended product 'contact time' must be followed for all cleaning/ disinfectant solutions/products as per national guidance frequently touched' surfaces, eg door/toilet handles, patient call bells, over-bed tables and bed rails, should be decontaminated at least twice daily and when known to be contaminated with secretions, excretions or body fluids electronic equipment, e.g. mobile phones, desk phones, tablets, desktops and keyboards should be cleaned at least twice daily rooms / areas where PPE is removed must be decontaminated, timed to coincide with periods immediately after PPE removal by groups of staff (at least twice daily	Mainly applicable to In patient areas. Covid secure work place risk assessments conducted with IPC Matron oversight. cleaning of frequent high touch surfaces such as keys, fobs, mobile phones - Information discussed at IPC group, Incident Management Team and with service leads. Information included within FAQ and screen savers for staff to access Appropriate cleaning schedules in place for clinic based areas ie Dental Dental services Standard Operating procedure		
5. linen from possible and confirmed COVID-19 patients is managed in line with PHE and other national guidance and the appropriate precautions are taken	No In Patient facilities	No gaps identified	

6. single use items are used where possible and according to Single Use Policy	IPC manual outlines all relevant guidance re single use items	No gaps identified	
7. reusable equipment is appropriately decontaminated in line with local and PHE and other national policy	IPC manual outlines all relevant guidance re decontamination of equipment. No single use PPE items designated multiple use during pandemic period.	No gaps identified	
8. review and ensure good ventilation in admission and waiting areas to minimize opportunistic airborne transmission	Covid secure risk assessments undertaken with every service led by Service Directors and Estates Team. Review by IPC Matron. 3 phase plan in place for rectifying actions by order of priority. Process overseen at Incident management team	Gap due to prioritisation phases	Mitigating actions identified for services/properties where gaps identified and increased face to face contact is expected as part of restarting services ie temporary Perspex shields, additional face visors where appropriate
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 process are in place to ensure: 1. arrangements around antimicrobial stewardship are maintained	Arrangements for antimicrobial stewardship remain in place including a standardised formulary. This section applied mainly to iCaSH, Dental, Childrens Community Nursing and Adult Nursing services. Medical Director and Principal Pharmacist have oversight of prescribing data and all prescribing related incidents. Actions related to previous quarterly antimicrobial audits continue to be implemented by services	Quarterly Antimicrobial audits paused at beginning of pandemic by Medical Director and Principle Pharmacist. The timing for re introduction is currently being considered.	Continued oversight of prescribing data and prescribing/medicines incidents. Medicines Governance group continues to meet monthly

	No related patient safety incidents reported up to 30/06/2020.		
2. mandatory reporting requirements are adhered to and boards continue to maintain oversight	No external reporting required. Quarterly audits to resume	Quarterly Antimicrobial audits paused at beginning of pandemic by Medical Director and Principle Pharmacist. The timing for re introduction is currently being considered.	
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: 1.implementation of national guidance on visiting patients in a care setting	N/A – In patient settings only		
2.areas in which suspected or confirmed COVID-19 patients are where possible being treated in areas clearly marked with appropriate signage and have	All work places both clinical and non clinical have been assessed against the Covid secure workplace guidance. These risk assessments have been overseen by Service Directors with assistance from the Estates Team and IPC matron. 3 phase action	No gaps identified	

restricted access	plan identified with prioritisation to clinical areas. Posters re appropriate safety measures is social distancing have been circulated and are being displayed. These are a mixture of those produced by PHE and our Communications Team.		
3. information and guidance on COVID-19 is available on all Trust websites with easy read versions	Information for staff available via dedicated COVID-19 intranet page. The Trust's internet page direct users to the PHE national site.	Further information re information for patient required ie in accessible format	
4. infection status is communicated to the receiving organisation or department when a possible or confirmed COVID-19 patient needs to be moved	Mainly applicable to In patient settings - Information of any infectious status would be included in the patient's transfer information by clinicians. Messages to callers re COVID19 awareness available through a number of media sources e.g. social media and departments messaging services	No gaps identified	
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: 1. front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed COVID-19 symptoms and to segregate them from non COVID-19 cases to minimise the risk of cross-infection	This relates mainly to In patient settings Clinical based patients are currently triaged by the departments to ascertain the level of risk prior to their assessment / treatment by clinicians.	No gaps identified	

2.	mask usage is emphasized for suspected individuals.	Guidance relating to patients and visitors attending NHS premises has been shared widely in trust wide Medical Director and Chief Nurse FAQs and included within service environmental risk assessments. Patients will be asked to attend appointments with face coverings or offered masks upon entering the department.	No gaps identified	
3.	ideally segregation should be with separate spaces, but there is potential to use screens, e.g to protect reception staff	Part of the service Covid secure workplace risk assessments process. 3 phase action plan produced	Implementation time for all actions within phases 2 and 3	Services have identified appropriate interim mitigation ie temporary Perspex shields for some reception areas until permanent fixtures available.
4.	for patients with new-onset symptoms, it is important to achieve isolation and instigation of contract tracing as soon as possible	For in patient areas only. CCS staff would direct patients to the national PHE screening process if identified as symptomatic.	No gaps identified	
5.	patients with suspected COVID-19 are tested promptly	For in patient areas only. CCS staff would direct patients to the national PHE screening process if identified as symptomatic.	No gaps identified	
6.	patients that test negative but display or go on to develop symptoms of COVID-19 are segregated and promptly re-tested	For in patient areas only. CCS staff would direct patients to the national PHE screening process if identified as symptomatic.	No gaps identified	
7.	patients that attend for routine appointments who display symptoms of COVID-19 are managed appropriately	Many services operating a remote fist contact . Patients are assessed via the departments triage for COVID-19 service prior to being assessed. If deemed high risk a dedicated assessment / treatment room would already be organised. Staff would direct patients to the national PHE screening process if identified as symptomatic.	No gaps identified	

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: 1. all staff (clinical and non-clinical) have appropriate training, in line with latest PHE and other guidance, to ensure their personal safety and working environment is safe	All 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.	No gaps identified	
2. all staff providing patient care are trained in the selection and use of PPE appropriate for the clinical situation and on how to safely don and doff it	Revised national guidance distributed to all staff via the FAQ bulletins from the Medical Director and Chief Nurse. Relevant information available on trust intranet. Queries received either via the Incident Control centre or directly to IPC Team. Frequent Q&A sessions with all staff offer further opportunity to raise queries. Specific IPC Q7A sessions undertaken by Medical Director/Chief Nurse as requested – recent examples include iCaSH and Community Paediatrics Enhanced training on additional precautions including donning and doffing is discussed / demonstrated during respirator fit testing for staff undertaking AGP.	No gaps identified	

3. a record of staff training is maintained	Via Electronic Staff Record. A record of all respirator fit testing is held by the IPC matron supported by the Quality Team in collaboration with service leads.	No gaps identified	
4. appropriate arrangements are in place that any reuse of PPE in line with the CAS alert is properly monitored and managed	Any items reused would be designated single patient use and disinfected where required e.g. eye goggles or as sessional use e.g. gowns. Both would be risk assessed and agreed with the Trust's IPCTeam.	No gaps identified	
5. any incidents relating to the re-use of PPE are monitored and appropriate action taken	Incidents are reported via the Trust's Datix system. All COVID-19 related incidents are monitored via Incident Management Team.	No gaps identified	
6. adherence to PHE national guidance on the use of PPE is regularly audited	No formal PPE audit of practice programme in place currently. Need to consider as part of other IPC audits ie environmental audits, Clinical Intervention audits etc	No formal audits in place	Incidents monitored via individual services and highlighted on daily sit reps to Incident management Team.
7. staff regularly undertake hand hygiene and observe standard infection control precautions	Various methods employed for reminding staff re hand hygiene through the pandemic ie at Q&A sessions, in FAQs from medical Director and Chief Nurse, screen savers and IPC awareness week. Limited annual hand hygiene standards audits in place – challenges with compliance due to limited opportunities for some staff to access facilities. Quarterly patient feedback on staff hand hygiene practice currently on hold. Re introduction of Clinical Intervention Audits currently being planned. This will provide an additional route of assurance for relevant clinical services going forward.	Limited audits in place	Multiple routes of sharing relevant messages re importance of increased hand hygiene
8. hand dryers in toilets are associated with greater risk of droplet spread than paper towels.	All clinical areas have paper towels in place to dry hands.		

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	IPC Matron to work with Estates Team to review use of hand dryers in non clinical areas and relate to latest national guidance.	Unknown number of hand dryers still in use in non clinical areas.	
9. guidance on hand hygiene, including drying, should be clearly displayed in all public toilet areas as well as staff areas	Hand washing techniques are displayed on walls and on the soap / hand sanitizer dispensers.	No gaps identified	
10. staff understand the requirements for uniform laundering where this is not provided for on site	Staff reminded of revised national guidance from PHE. An update to staff had been included in the Trust's FAQ. IPC Team have supported services with conversations re appropriate uniform/work wear in a number of settings.	No gaps identified	
11. all staff understand the symptoms of COVID-19 and take appropriate action in line with PHE and other national guidance if they or a member of their household display any of the symptoms.	Staff reminded of symptoms and processes through FAQ, intranet and PHE website. Management of Staff Outbreak Standard Operating Procedure currently being approved through IPC Team and Incident management team. Queries raised through Incident Control centre or directly with IPC Team Q&A sessions provide additional opportunities for staff to raise issues. .	No gaps identified	
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: 1. patients with suspected or confirmed COVID-19 are	N/A In patient facilities only		

isolated in appropriate facilities or designated areas where appropriate			
2. areas used to cohort patients with suspected or confirmed COVID-19 are compliant with the environmental requirements set out in the current PHE national guidance	N/A in patient areas only		
3. patients with resistant/alert organisms are managed according to local IPC guidance, including ensuring appropriate patient placement	Community services based guidance continues as previously and is outlined in the IPC manual.	No gaps identified	
8. Secure adequate access to laboratory support as appropriate			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
There are systems and processes in place to ensure: 1. testing is undertaken by competent and trained individuals	Where staff have been involved in taking swabs from patients, they have been trained by appropriate experts ie Luton Adult services by members of the Clinical Professional Development Team. Other testing has been undertaken by appropriately trained staff ie for antibody testing iCaSH staff and Luton based Phlebotomists	No gaps identified	
2. patient and staff COVID-19 testing is undertaken promptly and in line with PHE and other national guidance	Staff testing via national swabbing system through local swabbing centres. Patient testing only as part of initial Luton based support to care Homes	No gaps identified	
3. screening for other potential infections takes place	This continues as clinically indicated	No gaps identified	

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: 4. staff are supported in adhering to all IPC policies, including those for other alert organisms	All IPC guidelines continue to be implemented. Covid related guidance is communicated through FAQs, via Q&A sessions and on the Intranet. IPC Team are supporting all services with ad hoc queries and requests for specific guidance.	No gaps identified	
5. any changes to the PHE national guidance on PPE are quickly identified and effectively communicated to staff	All changes to national guidance are reviewed by the IPC team and logged at Incident Management Team. Staff are informed of all changes and alerts relating to PPE through the trust wide FAQs from the Medical Director and Chief Nurse and updated on the staff intranet. This is coordinated by the Trust's PPE lead (Head of Clinical Quality) with the support of the Trust's Deputy Chief Nurse and IPC Matron.	No gaps identified	
6. all clinical waste related to confirmed or suspected COVID-19 cases is handled, stored and managed in accordance with current national guidance	Guidance distributed through FAQ in conjunction with the Trust's Waste lead.	Environmental audits which include correct disposal of waste have been paused during the pandemic.	Environmental audits currently being re scoped and timeframe for re introduction to be agreed. Incidents related to waste are reviewed by IPC matron in liaison with our Waste Lead.

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**
Appropriate systems and processes are in place to ensure: 1. staff in 'at-risk' groups are identified and managed appropriately including ensuring their physical and psychological wellbeing is supported	Individual staff risk assessments have been undertaken throughout the pandemic. This included staff in extremely high risk groups so that they could be identified as 'shielding'. All staff have been encouraged to have a conversation with their line manager to identify any additional support that they require ie working from home. Comprehensive details of a variety of support available to staff is communicated via FAQs including MSK exercise and Mindfulness sessions (run by our MSK Physios and Psychologists) The Health and well being Group has continued to meet to ensure that appropriate levels of support are offered to our staff. Our Staff side representatives have been fully engaged with helping to identify additional support that staff tell us they would like. Q&A sessions also held with BAME staff	No gaps identified to date	
2. staff required to wear FFP reusable respirators undergo training that is compliant with PHE national guidance and a record of this training is maintained	All staff that are required to wear FFP3 respirators are trained by experts identified by the IPC matron. As different types of masks arrive through our supply chain, staff are re tested. Individual requirements are supported where staff fail multiple types of masks. Those trained are recorded locally with oversight by the IPC matron	No gaps identified	
3. consistency in staff allocation is maintained, with reductions in the movement of staff between different areas and the cross-over of care	Mainly applies to Acute settings – where possible, Community teams try to ensure consistency of staff members attending different patients to minimise risk of spread of infection	No gaps identified	

	pathways between planned and elective care pathways and urgent and emergency care pathways, as per national guidance			
4.	all staff adhere to national guidance on social distancing (2 metres) wherever possible, particularly if not wearing a facemask and in non-clinical areas	Multiple messages out to staff re the importance of social distancing through FAQS from Medical Director/Chief Nurse, posters, Q&A sessions, screen savers and IPC awareness week. Regular messages re appropriate us of face masks and face coverings (ie if staff travel to work on public transport) Staff reminded that NHS guidance is 2 metres despite national public move to 1m plus. Risk assessments for Covid secure work places undertaken.	No gaps identified	
5.	consideration is given to staggering staff breaks to limit the density of healthcare workers in specific areas	Assessed as part of the service and building risk assessments	No gaps identified	
6.	staff absence and well-being are monitored and staff who are self-isolating are supported and able to access testing	Line managers are supported by HR colleagues to ensure that staff who are absent from work through sickness, shielding or self isolating are supported. All usuall Occupational Health service support remains available. Staff working remotely are encouraged to join the regular Q&A sessions Access to testing arrangements is in place for staff and arrangements have been communicated via FAQs and on the intranet.	No gaps identified	
7.	staff that test positive have adequate information and support to aid their recovery and return to work.	Links to all relevant PHE guidance for staff and their households are communicated through FAQs and available on staff intranet. Support from line managers and HR team.	No gaps identified	

Version Control
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