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: • local risk assessments are based on the measures as prioritised in the hierarchy of controls. The risk assessment needs to be documented and communicated to staff;	Covid19 risk assessments in place and discussed at IMT Covid19 building / Environmental risk assessments updated by departments and reviewed weekly by IPaC and Estates.	No gaps identified 14/04/2021	
• the documented risk assessment includes: – a review of the effectiveness of the ventilation in the area; – operational capacity; – prevalence of infection/variants of concern in the local area.	Ventilation is included in the environmental risk assessments. It is also part of the IPAC Committee agenda with updates being provided by the Estates Team. Staff triaging in place when confirming patient appointments. Local positon across the patch in relation to covid figures, positive PCRs, hospital numbers, deaths etc we will also get an updated position on what the dominant strain is – but this comes through IPAC at the CCG's or via NHSE/I meetings		
• triaging and SARS-CoV-2 testing is undertaken for all patients either at point of admission or as soon as possible/practical following admission across all the pathways;	This relates to in-patient settings and is not applicable to CCS.		
• when an unacceptable risk of transmission remains following the	Included in the risk assessment.		

risk assessment, consideration to the extended use of Respiratory Protective Equipment RPE for patient care in specific situations should be given;			
• There are pathways in place which support minimal or avoid bed/ward transfers for duration of admission unless clinically imperative.	This relates to in-patient settings and is not applicable to CCS.		
• That on occasions when it is necessary to cohort Covid19 or non Covid19 patients, reliable application of IPC measures are implemented and that any vacated areas are cleaned as per guidance.	This relates to in-patient settings and is not applicable to CCS.		
• compliance and monitoring of IPC practice including: – staff adherence to hand hygiene; – patients, visitors and staff are able to maintain 2 metre social & physical distancing in all patient care areas, unless staff are providing clinical/personal care and are wearing appropriate PPE; – staff adherence to wearing fluid resistant surgical facemasks (FRSM) in: a) clinical; b) non-clinical setting; – monitoring of staff compliance with wearing appropriate PPE, within the clinical setting;	Hand hygiene assessment is now on ESR and is linked to peoples training records so we can monitor compliance via the quality dashboards / IPACC Monthly clinical Intervention audits are undertaken by clinical teams. Additional assurance feedback during quality site visits.	Limited assurance re compliance to mask wearing in non-clinical settings 27/07/21	Item to be discussed in the Trust's IPACC and IMT on 05.08.2021.

• that the role of PPE guardians/safety champions to embed and encourage best practice has been considered;	IPAC Link Champion programme in place. The majority of services are represented. The champions meet on a quarterly basis and a summary of the meeting is included in the IPAC Team's Quarterly report. The Champions have access to a dedicated intranet page where additional resources and notes / presentations from the link meetings are kept.		
• that twice weekly lateral flow antigen testing for NHS patient facing staff has been implemented and that organisational systems are in place to monitor results and staff test and trace;	Lateral flow testing in place for all patient facing staff. In addition all other CCS staff encouraged to test twice weekly. Results submitted to CCS LFD monitoring team for surveillance. This data is presented monthly at the Trust's IMT and Quarterly to the IPACC. Any operational issues are resolved during the weekly catch up meetings between IPAC and the LFD monitoring team.		
• additional targeted testing of all NHS staff, if your location/site has a high nosocomial rate, as recommended by your local and regional Infection Prevention and Control/Public Health team;	Process in place if required. Surveillance monitored as above.		
• training in IPC standard infection control and transmission-based precautions is provided to all staff;	Link Champions, Team meetings and CCS wide communications. IPAC training is part of the mandated training matrix within the Trust; compliance is monitored via the quality dashboard and by IPACC.		
• IPC measures in relation to Covid19 are included in all staff Induction and mandatory training;	IPAC Overview given at Trust induction, mandatory IPAC training and through staff virtual meetings. Additional local measures are discussed and put in place by the site and team leads		
• all staff (clinical and non-clinical) are trained in: – putting on and removing PPE; – what PPE they should wear for each setting and context; • all staff (clinical and non-clinical) have access to the PPE that protects them for the appropriate setting and context as per national guidance;	All departments submit their stock levels re PPE to the Trust. Where levels are low additional stock is sent out to the team as a planned programme. Where problems have been identified IPAC are brought in to assist with alternative solutions and risk assessments. PPE available for all. Stock is rotated to ensure PPE is within date.		

• there are visual reminders displayed communicating the importance of wearing face masks, compliance with hand hygiene and maintaining physical distance both in and out of the workplace;	Screen savers, laminated posters use of social media forums. Posters with updated guidance from 19 July 2021 will also be displayed across sites.		
• 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. IPAC reviewed current campaign materials with the Trust's Comms team to incorporate additional national materials e.g. Every Action Counts. 14/04/2021.	No gaps identified No gaps identified 14/04/2021 No Gaps identified 27//07/21	
• 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. IPC Committee to meet November 2020 – cycle of Business to focus on IPC compliance and assurance. IPC Committee to meet November 2020 – cycle of Business to focus on IPC compliance and assurance. IPC Committee to meet February 2021 – cycle of Business to focus on IPC compliance and assurance. IPAC BAF now a standing item on the IPACC agenda. The next meeting is 06/05/2021.	No gaps identified No gaps identified 14/04/2021 No Gaps identified 27//07/21	

	New Isolation exemption guidelines received and discussed on 21.07.21 to IMT. A SOP, Risk assessment including a flowchart was put in place and cascades to all staff via Trust's Comms Cascade.		
• 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 Covid19 risks and incidents. Covid19 related risks continue to be reviewed weekly at IMT. Risk related to PPE / Staff Morale and Service delivery updated to reflect on going nature of the pandemic 31/10/2020 Covid19 related risks continue to be reviewed weekly at IMT. Risk related to PPE /Staff Morale and Service delivery updated to reflect on going nature of the pandemic 31/12/2020 Covid19 related risks continue to be reviewed weekly at IMT. Risk related to PPE /Staff Morale and Service delivery updated to reflect on going nature of the pandemic 14/04/2021	No gaps identified No gaps identified 14/04/2021 No Gaps identified 27/07/21	
• Robust IPC risk assessment processes and practices are in place for non Covid19 infections and pathogens	As above - risks reported and monitored through the IMT and governance structures at service Clinical 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 (Covid19 lead) with the support of the Deputy Chief Nurse and Matron Infection Prevention and	No gaps identified No gaps identified 14/04/2021 No gaps identified	

	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 Covid19 related. IPC Committee to meet August 2020 reporting into QIS Committee. IPC Committee to meet November 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. IPC Committee to meet November 2020 reporting into QIS Committee. Following the small number of outbreaks within the Trust, departments and building site leads have been asked to update their risk assessment to maintain a COVID-19 secure area and minimise the possibility of cross contamination. 31/12/20 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. Teams provide updates on specific risk assessments via their quarterly IPAC report. 14/04/2021.	27/07/21	
• the Trust Chief Executive, the Medical Director or the Chief Nurse approves and personally signs off, all daily data submissions via the daily nosocomial sitrep;	Not applicable. This refers to inpatient facilities		
• the IPC Board Assurance Framework is reviewed, and evidence of assessments are made available and discussed at Trust board;	Reviewed by IPaCC and Trust Board. Standing agenda item.		

• the Trust Board has oversight of ongoing outbreaks and action plans; • There are check and challenge opportunities by the executive/senior leadership teams in both clinical and non-clinical areas.	Reported monthly via dashboard. If/when outbreaks occur, IpaC report on actions taken, plans and outbreak ended declared. Due to current national guidelines the Trust's executive / senior leadership teams are discouraged to undertake formal physical departmental visits unless clinically required. A limited number of senior clinicians are visiting key sites to undertake quality reviews, which are then feedback to the Trust. Service Director / Director visits, Senior leadership check and challenge in place via audit actions and team meetings / discussions.		
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: • teams with appropriate training are assigned to care for and treat patients in COVID-19 isolation or cohort areas	Not fully applicable as no in-patient facilities within the Trust service portfolio. *Dental services offer at risk patients early morning appointments and the last appointments of the emergency sessions for known Covid positive patients. Appropriate cleaning arrangements are in place.*	No gaps identified No gaps identified 14/04/2021 No Gaps identified 27/07/21	
• designated cleaning teams with appropriate training in required techniques and use of PPE, are assigned to COVID-19 isolation or cohort areas.	This relates to in-patient facilities. Dental areas as above	No gaps identified No gaps identified 14/04/2021	
• decontamination and terminal decontamination of isolation rooms	Rooms decontaminated as per national guidelines following Aerosol Generating Procedures within dentistry.	No gaps identified No gaps	

or cohort areas is carried out in line with PHE and other national guidance	Decontamination of equipment guidance circulated by the Trust and included within the IPC manual.	identified 14/04/2021 No gaps identified 27/07/21	
• 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. • assurance processes are in place for the monitoring and sign off following terminal cleans as part of outbreak management and actions are in place to mitigate any identified risk; • 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 • manufacturers' guidance and recommended product 'contact time' must be followed for all cleaning/ disinfectant solutions/products as per national guidance	Request for contracted cleaners to increase cleaning frequencies in clinical premises in place. Requests for enhanced and additional cleaning are sent to the Trust's Estates and IPAC team All completed terminal cleans are confirmed by the department All contracted environmental cleaning is conducted with neutral detergent and a chlorine-based disinfectant. Cleaning regimes form part of our standard cleaning contracts Relates to inpatient settings.	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. Program of environment audits pending dates 31/10/2020 Clinical Teams have been asked to complete their own environmental audit and submit their audit to the Trust's Clinical Audit team.	Monitoring of all cleaning related incidents Information in FAQs re additional cleaning that individuals should undertake in workplace i.e. surfaces and equipment.

• a minimum of twice daily cleaning of: – areas that have higher environmental contamination rates as set out in the PHE and other national guidance; – 'frequently touched' surfaces e.g. door/toilet handles, patient call bells, over bed tables and bed rails; – electronic equipment e.g. mobile phones, desk phones, tablets, desktops & keyboards; – rooms/areas where PPE is removed must be decontaminated, ideally timed to coincide with periods immediately after PPE removal by groups of staff; • 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 • 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	This relates to in-patient settings and is not applicable to CCS. Staff responsible for cleaning office equipment. Detergent wipes available at all sites. Doffing rooms in dental. This relates to in-patient settings and is not applicable to CCS. Cleaning schedules are in place within all departments as required by the national cleaning standards. Regular cleaning audits are undertaken by the contractor and a third party. Additional cleaning of items is the responsibility of the department Guidance is found within the Trust's IPAC manual. Guidance is found within the Trust's IPAC manual.	These will be discussed at the next Infection Prevention and Control Committee in February. 31/12/20. Some teams have undertaken their annual environmental IPAC audit which will be presented at the next IPACC. Mass Vaccination Centres completing monthly assessments which incorporates cleaning. 06/05/2021. Cleaning audits for Large Scale Vaccination sites are in place. 27/07/21	

repair equipment;			
• linen from possible and confirmed Covid19 patients is managed in line with PHE and other national guidance and the appropriate precautions are taken	No In Patient facilities	No gaps identified No gaps identified 14/04/2021 No gaps identified 27/07/21	
• 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 No gaps identified 14/04/2021 No gaps identified 27/07/21	
• reusable equipment is appropriately decontaminated in line with local and PHE and other national policy and that actions in place to mitigate any identified risk • Cleaning standards and frequencies are monitored in non-clinical areas with actions in place to resolve issues in maintaining a clean environment;	IPC manual outlines all relevant guidance re decontamination of equipment. No single use PPE items designated multiple use during pandemic period. Percentage scores for all environmental audits are displayed on the Trust's intranet according to the New National Cleaning Standards. Any actions taken to address any concerns are addressed in a timely manner with the IPAC team and discussed at the Trust's IPACC.	No gaps identified No gaps identified 14/04/2021 No gaps identified 27//07/21	

• where possible ventilation is maximised by opening windows where possible to assist the dilution of air.	Windows opened in work areas to facilitate ventilation as per national guidance. Reminders to staff to open windows are shared in Trust communications and as part of individual team discussions.		
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: • arrangements for antimicrobial stewardship are maintained	Arrangements for antimicrobial stewardship remain in place including a standardised formulary. This section applied mainly to iCaSH, Dental, Children's 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 No related patient safety incidents reported up to 30/06/2020. Actions related to previous quarterly antimicrobial audits continue to be implemented by services. 11 related patient safety incidents reported during quarter 2 (July- September) related to lack of PPE usage / availability within care homes / care staff. Antimicrobial audits continue to be undertaken by clinical teams. Quarter 2 report is currently being reviewed by the Trust's Principle Pharmacist. 31/12/2020. The report will be discussed at the next Infection Prevention and Control Committee in February 2021. Audits to be presented at Medicine management committee and IPACC. 14/04/2021. Q3 and 4 audits to be presented to IPACC on 05/08/21	Quarterly Antimicrobial audits paused at beginning of pandemic by Medical Director and Principle Pharmacist. The timing for re-introduction is currently being considered. No gaps identified as antimicrobial audit reintroduced for quarter 1. 31/10/2020 Awaiting Q2 antimicrobial audit report 14/04/21 Awaiting Q3&4 antimicrobial audit report	Continued oversight of prescribing data and prescribing/medicines incidents. Medicines Governance group continues to meet monthly

		27/07/21	
• mandatory reporting requirements are adhered to and boards continue to maintain oversight	Reporting requirements have continued.		
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 restricted access	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 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. Clinical teams currently updating their building risk assessments. 14/04/2021. Building risk assessments are being reviewed by the Trust's IPAC and Estates on a weekly basis or sooner when required.	No gaps identified No gaps identified 14/04/2021 No gaps identified 27/07/2021	
• information and guidance on Covid19 is available on all Trust websites with easy read versions	Information for staff available via dedicated Covid19 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	
• infection status is communicated to the receiving organisation or department when a possible or confirmed Covid19 patient needs to be moved • there is clearly displayed, written information available to prompt patients' visitors and staff to comply with hands, face and space advice. • Implementation of the Supporting excellence in infection prevention and control behaviors Implementation Toolkit has been considered C1116-supporting-excellence-in-ipc-behaviours-imp-toolkit.pdf (england.nhs.uk)	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 Posters have been update following the 19th July relaxation of restrictions. Supporting excellence in IPaC toolkit used to inform screen savers, IPaC newsletters, Link Champion training and meeting session and through posters.	No gaps identified No gaps identified 14/04/2021 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: • screening and triaging of all patients as per IPC and NICE guidance within all health and other care facilities is undertaken to enable early recognition of COVID-19 cases; • front door areas have appropriate triaging arrangements in place to cohort patients with possible or	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. Discussed at virtual appointments, phone messages and prior to appointments. CCS does not have in-patient facilities so the true meaning of triage is amended for clinic visits.	No gaps identified No gaps identified 14/04/2021 No gaps identified 27/07/21	

confirmed Covid19 symptoms and to segregate them from non Covid19 cases to minimise the risk of cross-infection • staff are aware of agreed template for triage questions to ask; • 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;	Staff have an agreed set of questions to ask as per national guidelines.		
• face coverings are used by all outpatients and visitors; • individuals who are clinically extremely vulnerable from Covid19 receive protective IPC measures depending on their medical condition and treatment whilst receiving healthcare e.g. priority for single room isolation; • clear advice on the use of face masks is provided to patients and all inpatients are encouraged and supported to use surgical facemasks (particularly when moving around the ward) providing it is tolerated and is not detrimental to their (physical or mental) care needs;	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. This relates to in-patient settings and is not applicable to CCS. Patients encouraged to bring their own face masks, but masks available in each CCS facility. The bullet point on facemasks when moving around the ward relates to in-patient settings and is not applicable to CCS.	No gaps identified No gaps identified 14/04/2021 No gaps identified 27/07/21	

• monitoring of Inpatients compliance with wearing face masks (particularly when moving around the ward) providing it is tolerated and is not detrimental to their (physical or mental) care needs; • patients, visitors and staff are able to maintain 2 metre 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. • isolation, testing and instigation of contact tracing is achieved for patients with new-onset symptoms, until proven negative;	This relates to in-patient settings and is not applicable to CCS. Appointment times arranged to ensure minimal amount of patients in a department at any one time. 2 metre distancing signage of the floor and in poster form. Perspex screens to protect staff are employed in the appropriate areas. This relates to in-patient settings and is not applicable to CCS.		
• patients that test negative but display or go on to develop symptoms of COVID-19 are segregated and promptly re-tested • there is evidence of compliance with routine patient testing protocols in line with Key actions: infection prevention and control and testing document;	For in patient areas only. CCS staff would direct patients to the national PHE screening process if identified as symptomatic. For in patient areas only. CCS staff would direct patients to the national PHE screening process if identified as symptomatic.	No gaps identified No gaps identified 14/04/2021 No gaps identified 27/07/21	
• patients that attend for routine appointments who display symptoms of Covid19 are managed appropriately	Many services operating a remote first contact. Patients are assessed via the departments triage for Covid19 service prior to being assessed. If deemed high risk a dedicated assessment / treatment room would already be organised.	No gaps identified No gaps identified 14/04/2021	

	Staff would direct patients to the national PHE screening process if identified as symptomatic.	No gaps identified 27/07/21	
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: • patient pathways and staff flow are separated to minimise contact between pathways. For example, this could include provision of separate entrances/exits (if available) or use of one-way entrance/exit systems, clear signage, and restricted access to communal areas; • 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	Many shared entrances and exits, however, appointment times set so as not to occur during shift changes. One way system throughout departments. 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. Clinical teams currently undertaking annual IPAC environmental audits and monthly assessments at the Mass Vaccination Centres. Audits reviewed by IPAC and appropriate action taken immediately by auditor. These will be presented and discussed at the IPACC. 14/04/2021	No gaps identified No gaps identified 14/04/2021 No gaps identified 27/07/21	
• all staff providing patient care are trained in the selection and use of PPE appropriate for the clinical	Revised national guidance distributed to all staff via the FAQ bulletins from the Medical Director and Chief Nurse. Relevant information available on trust intranet.	No gaps identified No gaps	

situation and on how to safely don and doff it	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.	identified 14/04/2021 No gaps identified 27/07/21	
• 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 No gaps identified 14/04/2021 No gaps identified 27/07/21	
• Adherence to PHE national guidance on the use of PPE is regularly audited with actions in place to mitigate any identified risk. • Hygiene facilities (IPC measures) and messaging are available for all patients/individuals, staff and visitors to minimise COVID-19 transmission such as: – hand hygiene facilities including instructional posters; – good respiratory hygiene measures; – staff maintaining physical and social distancing of 2 metres wherever possible in the workplace unless wearing PPE	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 Clinical teams currently undertaking annual IPAC environmental audits and monthly assessments at the Large Scale Vaccination Centres. Audits reviewed by IPAC and appropriate action taken immediately by auditor. These will be presented and discussed at the IPACC. 14/04/2021 LSV now included in the monthly Clinical Intervention Audits 27/07/21	No formal audits in place Audit planned for social distancing and face mask used in addition to the IPAC intervention audit 31/10/2020 An audit tool has been developed will be rolled out in January. The tool is to aide	Incidents monitored via individual services and highlighted on daily sit reps to Incident management Team.

as part of direct care; – staff are maintaining physical and social distancing of 2 metres when travelling to work (including avoiding car sharing) and remind staff to follow public health guidance outside of the workplace; – frequent decontamination of equipment and environment in both clinical and non-clinical areas; – clear visually displayed advice on use of face coverings and facemasks by patients/individuals, visitors and by staff in non-patient facing areas.		spot checks by staff to demonstrate compliance to national guidance. 31/12/20. Audit tools now rolled out to clinical teams 14/04/2021	
• Staff regularly undertake hand hygiene and observe standard infection control precautions	Posters from the supporting excellence in IPaC are used throughout the Trust (including Every Action Counts). All facilities have hand hygiene instructional illustrations, either via laminated poster or directly pictured on dispensers. Detergent wipes provided for staff to decontaminate equipment between tasks in both clinical and non-clinical areas. 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	Limited audits in place IPAC audits reintroduced September 2020, steady increase in compliance with these noted.31/10/20 UV Hand hygiene compliance continues to increase. Details of the increase will be discussed at the next	Multiple routes of sharing relevant messages re importance of increased hand hygiene

	going forward. Clinical Intervention audits have resumed and are now included within the Quality Monthly Dashboard. These are included in the service's quarterly report which is discussed at the IPACC. 14/04/2021.	Infection Prevention and Control Committee in February 2021. No gaps identified 14/04/2021. No gaps identified 27/07/21	
• 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;	All clinical areas have paper towels in place to dry hands. Where practical, hand dryers have been replaced with hand towels in non-clinical areas. To be confirmed by the Trust's Estates lead. Services are reviewing their building risk assessment. 14/04/2021 Services continue to update their building risk assessments. 27/07/21	To be confirmed by the Trust's Estates lead. 31/10/2020 Confirmation of the statement has been received. 31/12/20 No gaps identified 14/04/2021. No gaps identified 27/07/21	
• 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 No gaps identified 14/04/2021 No gaps identified 27/07/21	

• 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 No gaps identified 14/04/2021 No gaps identified 27/07/21	
• All staff understand the symptoms of Covid19 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. • a rapid and continued response through ongoing surveillance of rates of infection transmission within the local population and for hospital / organisation onset cases (staff and patients/individuals); • 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;	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. Where staff have arrived to their workplace displaying symptoms, they have been told to go home and self-isolate as per national guidelines. 31/12/20 Positive reported LFD tests, initiate a response from the team to electronically send a risk assessment to the manager. The information is shared with the IPaC team for monitoring and surveillance purposes.	No gaps identified No gaps identified 14/04/2021 No gaps identified 27/07/2021	
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: • restricted access between pathways	N/A In-patient facilities only	N/A	

if possible, (depending on size of the facility, prevalence/incidence rate low/high) by other patients/individuals, visitors or staff; • areas/wards are clearly signposted, using physical barriers as appropriate to patients/individuals and staff understand the different risk areas; 1. patients with suspected or confirmed Covid19 are isolated in appropriate facilities or designated areas where appropriate			
2. areas used to cohort patients with suspected or confirmed Covid19 are compliant with the environmental requirements set out in the current PHE national guidance	N/A in patient areas only	N/A	
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 No gaps identified 14/04/2021 No gaps identified 27/07/21	
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.	No gaps identified No gaps identified	

	Other testing has been undertaken by appropriately trained staff ie for antibody testing iCaSH staff and Luton based Phlebotomists	14/04/2021 No gaps identified 27/07/21	
• patient and staff COVID-19 testing is undertaken promptly and in line with PHE and other national guidance • regular monitoring and reporting of the testing turnaround times with focus on the time taken from the patient to time result is available; • regular monitoring and reporting that identified cases have been tested and reported in line with the testing protocols (correctly recorded data);	Staff testing via national swabbing system through local swabbing centres. Patient testing only as part of initial Luton based support to care Homes Lateral flow testing kit initially distributed to patient facing clinical staff as per volume dictates. 31/12/20 Lateral flow kits now distributed to the majority of clinical areas including Mass Vaccination Centres, Dental and iCaSH.14/04/2021. Regular reports of staff uptake are discussed at the Trust's IMT. 14/04/2021. Everyone has to do a risk assessment which is reviewed by the IPaC team, with the team and manager monitoring the situation post a positive test.	No gaps identified No gaps identified 14/04/2021 No gaps identified 27/07/21	
• screening for other potential infections takes place • that all emergency patients are tested for Covid19 on admission; • that those inpatients who go on to develop symptoms of Covid19 after admission are retested at the point symptoms arise; • that emergency admissions who test negative on admission are retested on day 3 of admission, and again between 5-7 days post	This continues as clinically indicated This relates to in-patient settings and is not applicable to CCS.	No gaps identified	

admission; • that sites with high nosocomial rates should consider testing Covid19 negative patients daily; • 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; • that 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; • that all Elective patients are tested 3 days prior to admission and are asked to self-isolate from the day of their test until the day of admission.			
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. Covid19 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 No gaps identified 14/04/2021 No gaps identified 27/07/21	

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 No gaps identified 14/04/2021 No gaps identified 27/07/21	
6. all clinical waste related to confirmed or suspected COVID-19 cases is handled, stored and managed in accordance with current national guidance • PPE stock is appropriately stored and accessible to staff who require it.	Guidance distributed through FAQ in conjunction with the Trust's Waste lead. Stock received from the national push are received, stored and distributed to services by the Trust. Departments are now able to order stock that is no longer included in the national distribution themselves.	Environmental audits which include correct disposal of waste have been paused during the pandemic. No gaps identified 14/04/2021 No gaps identified 27/04/21	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. Clinical Teams have been asked to complete their own environmental audit and submit their audit to the Trust's Clinical Audit team. These will be discussed at the next Infection Prevention and Control Committee in February. 31/12/20.
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: • staff in 'at-risk' groups are identified	Individual staff risk assessments have been undertaken throughout the pandemic. This included staff in extremely high risk groups so that	No gaps identified to date	

and managed appropriately including ensuring their physical and psychological wellbeing is supported • that risk assessments are undertaken and documented for any staff members in an at risk or shielding groups, including Black, Asian and Minority Ethnic and pregnant staff;	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 Additional support staff's wellbeing is located here. https://nww.cambscommunityservices.nhs.uk/docs/default-source/coronavirus/health-and-wellbeing-stepped-offer-09-10-2020.pdf?sfvrsn=9f76cad1_2	No gaps identified 14/04/21 No gaps identified 27/07/21	
• staff required to wear FFP reusable respirators undergo training that is compliant with PHE national guidance and a record of this training is maintained and held centrally • staff who carry out fit test training are trained and competent to do so; • all staff required to wear an FFP respirator have been fit tested for the model being used and this should be repeated each time a different model is used; • a record of the fit test and result is given to and kept by the trainee and	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 According to the guidance set out in the FFP3 Resilience letter from the Department of Health and Social Care, all staff involved in AGPs are fit tested for at least 3 different types of FFP3 and will undergo a fit test at least every 2 years. Currently The Trust has a central database managed by the Trust's Corporate Quality Team. This has staff details e.g. name, job title, team and location. All completed forms	No gaps identified No gaps identified 14/04/21 No gaps identified 27/07/21	

centrally within the organisation; • those who fail a fit test, there is a record given to and held by trainee and centrally within the organisation of repeated testing on alternative respirators and hoods; • members of staff who fail to be adequately fit tested a discussion should be had, regarding re deployment opportunities and options commensurate with the staff members skills and experience and in line with nationally agreed algorithm; • 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; • following consideration of reasonable adjustments e.g. respiratory hoods, personal re-usable FFP3, staff who are unable to pass a fit test for an FFP respirator are redeployed using the nationally agreed algorithm and a record kept in staff members personal record and Occupational health service record; • 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	(including unsuccessful) are submitted to the team to upload. This includes all masks staff have tried (this includes disposable and single staff reusable. Plans to upload this data to staff's ESR is being reviewed. Summary of Information will be included in the IPAC quarterly report. Service leads are notified of any staff who have not successfully passed wearing any respirators. Staff are redeployed to another area of the department when respirators are not required to be worn. Information on the number of staff who has been fit tested is included in the IPAC Quarterly report. This includes staff who have been unsuccessful.		

should include a centrally held record of results which is regularly reviewed by the board;			
• consistency in staff allocation is maintained, with reductions in the movement of staff between different areas and the cross-over of care pathways between planned and elective care pathways and urgent and emergency care pathways, as per national guidance	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 No gaps identified 14/04/21 No gaps identified 27/07/21	
• all staff adhere to national guidance on social distancing (2 metres) wherever possible, particularly if not wearing a facemask and in non-clinical areas • health and care settings are Cocid19 secure workplaces as far as practical, that is, that any workplace risk(s) are mitigated maximally for everyone; • staff are aware of the need to wear facemask when moving through Covid19 secure areas; • staff are aware of the need to wear facemask when moving through Covid19 secure 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 Covid19 secure work places undertaken. The Trust will be using the national supporting excellence in Infection Prevention Control 'Every Action Counts' campaign toolkit. Campaign materials currently being reviewed by IPAC and Comms. 14/04/2021	No gaps identified No gaps identified 14/04/21 No gaps identified 27/07/21	
• 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 usual Occupational Health service support remains available.	No gaps identified No gaps identified 14/04/2021	

	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 27/07/21	
• 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 No gaps identified 14/04/2021 No gaps identified 27/04/21	

Version Control
V1 July 2020 – approved by
30 June 2020 - IPC Team / DIPC and Medical Director
IMT - 6 July 2020
Trust Board - 15 July 2020
Revised October 31 2020
Reviewed IPC Team/DIPC
IMT tbc
*Trust board ****
Revised April 14 2021
Reviewed IPC Team
Revised July 2nd 2021
Reflects V1.6 published June 30th 2021
Review IPC Team
Revised 27/07/2021
Reviewed IPC Team