The Leeds Teaching Hospitals NHS Trust

Infection Prevention and Control Board Assurance Framework update

Public Board

25 November 2021

Presented for:	Information.
Presented by:	Gillian Hodgson Deputy Director of Infection Prevention and Control.
Author:	Louise Lowry Matron Infection Prevention & Control
Previous Committees:	Infection Prevention and Control Sub-Committee 25 October 2021 HCAI Group (19th July 2021). Quality Assurance Committee, (April 2021 (Version 2.0) Quality Assurance Committee (18 November (Version 4.0)

Trust Goals	
The best for patient safety, quality and experience	✓
The best place to work	✓
A centre for excellence for research, education and innovation	
Seamless integrated care across organisational boundaries	
Financial sustainability	

Trust Risks (Type & Category)				
Level 1 Risk	(✓)	**Level 2 Risks**	**(Risk Appetite Scale)**	**Risk**
Workforce Risk			Choose an item	Choose an item.
Operational Risk			Choose an item	Choose an item.
Clinical Risk	√	Infection Prevention & Control Risk - We will manage the risks related to infection prevention and control to reduce the transmission of infection in our hospitals.	Minimal	↔ (same)
Financial Risk			Choose an item	Choose an item.
External Risk			Choose an item	Choose an item.

Key points	
1. Inform the Committee of progress against the updated Infection Prevention and Control Board Assurance Framework (IPC BAF)	Information

1. Summary

The purpose of this paper is to provide an update:

- Infection Prevention and Control Board Assurance Framework (IPC BAF) and the IPC Annual Programme
- Actions taken to ensure oversight and assurance.

This paper was presented and approved at the Infection Prevention and Control Sub-committee on the 25 October 2021.

2. Background

The Quality Assurance Committee last received an update April 2021(Version 2.0). LTHT continues to measure performance against the BAF and the IPC Annual Programme through the IPC governance structure and both the BAF (Version 3.0) and IPC Annual Programme were presented to the HCAI Group (19th July 2021).

In October the IPC BAF V4.0 was updated to include the latest published guidance (August) from Public Health England (PHE) and the National Patient Safety Alert (NPSA) also circulated in August 2021.

The National Patient Safety Alert (NPSA) August 2021 -Infection risk when using FFP3 respirators with valves or Powered Air Purifying Respirators with Valves (PAPRs) during surgical and invasive procedures, identified valved respirators should not be worn by a healthcare worker/operator when sterility directly over the surgical field is required, eg in theatres/surgical settings or when undertaking a sterile procedure

In addition the Department Of Health and Social Care PPE Programme requested that Trusts should only be using the masks available via the National Supply Chain. The FSM16 and FSM18 masks would not be part of this range, which were the masks of choice for the Trust pre-pandemic. Therefore, staff required fit testing on alternative masks that were supplied through the NHS Supply Chain.

3. Monitoring and Assurance

The BAF and IPC Annual Programmes are focused on assurance relating to the 10 Criterion of the Health Care Act, relating in the main to Regulations 12:

- Regulation 12h - assessing the risk of, and preventing, detecting and controlling the spread of infections, including those that are health care associated.

Each CSU provide assurance against the BAF & IPC Annual Programme to the HCAI group quarterly and by exception. In addition the OIPC oversees the operational implementation.

4. Current position

The Operational Infection Prevention Committee (OIPC) agreed to discontinue the use and supply of valved FFP 3 masks in 2 phases. Phase 1 in March 2021 included Theatres, Critical Care, RCU and the resuscitation areas of both Emergency

Departments. Phase 2 in June 2021 extended the discontinuation to the rest of the organisation in any setting.

The Trust is now working to address the new NPSA issued August 2021 within the time frame allocated (November 2021), and this will be overseen and monitored through the Operational Infection Prevention Control (OIPC) group.

The CSU's are reviewing the staff that are only fit tested to FSM 16 & 18 FFP3 masks, prioritising these staff members for re testing on alternative FFP3 masks.

5. Risk

There are two potential risks:

- Any new staff to the Trust will have to be fit tested on the available masks within LTHT. This may place a pressure on the CSU's if staff fail fit testing on the masks available.
- All staff requiring fit testing to provide an alternative to FSM 16 & 18 FFP3 masks may not be complete prior to the available stock being depleted.

Each CSU will identify their risks and mitigating actions, escalating any unresolved risks to the HCAI Group. Additionally the mitigations received at the HCAI Group, through the IPC Sub-Committee will be reported to Quality Assurance Committee through the minutes and continue to provide assurance through a six monthly update to Board and by exception.

Following the IPCSC meeting an escalation process was requested by DIPC to identify the names of staff who are only fit tested on the FSM16 by Monday 1 November to allow priority fit testing to occur.

6. Financial Implications

The removal of valved FFP3 masks may put pressure on the current resources within the CSU's and on procurement for sourcing FFP3 masks and /or Hoods that are compatible to the current guidance. However this will be absorbed through the individual CSU's.

7. Publication Under Freedom of Information Act

- This paper is exempt from publication under Section 22 of the Freedom of Information Act 2000, as it contains information which is in draft format and may not reflect the organisation's final decision.

8. Recommendation

The Quality Assurance Committee is asked to:

- Be assured that LTHT has a robust process for monitoring and receiving assurance from CSUs for both the IPC BAF and IPC Annual Programme , including review of new published updates.
- Be assured work is on-going to complete the NPSA within the allocated timeframe.

Louise Lowry
Matron IPC
26/10/2021

LEEDS TEACHING HOSPITALS NHS TRUST - Infection Prevention and Control Board Assurance Framework (v3.0)
(Update 06/07/2021)

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 risk posed by their environment and other service users (NHSE Update 12 February 2021)				
Key Lines of Enquiry		**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
1.1	Systems and processes are in place to ensure: • Local risk assessments are based on the measures as prioritized in the hierarchy of controls. The risk assessment needs to be documented and communicated to staff	On the Trust's intranet site, there is a specific section where COVID-19 information and guidance is located; this is accessible to all Trust staff and includes guidance relating to infection prevention and control (IPC) COVID- 19 risk assessments. Patients, on admission, have a 'nursing specialist assessment' document completed, which covers COVID-19 risks. In the Emergency Department (ED), there are specific COVID-19 pathways High (Red) and Medium (Amber) for patients arriving via ambulance and walk-in patients. There is an IPC risk assessment screening tool on PPM+ that supports judgments around infection risk. A General Practitioner (GP) patient triage process is in place, managed via the Trust's		

		Patient Call Advice Line (PCAL). HOC risk assessment undertaken in June 2021 and identified risks addressed within the CSU **Supporting Evidence/Documents:** - IPC Policy - Managing the risks associated with infection prevention and control - Adult Nursing Specialist Assessment IPC Section - Point of Care (PoC) Covid and Flu Test Results - Postive result alert on PPM+ patient record. Operational Update 22/04/2021 **Standard Operating Procedures (SOP):** Covid-19 testing for adult patients before surgery/treatment/attendance at LTHT SOP(V8-18/01/2021) - COVID-19 testing of elective paediatric admissions (including resident parent) [27/05/2020] - COVID-19 testing of non-elective paediatric		

		admission - parent/carer SOP [27/05/2020] Clinical/radiological diagnosis of Covid-19 - Covid-19 testing for patients with Learning Disabilities and/or Autism before surgery/ treatment/attendance [19/06/2020] - Management of adult patients with suspected COVID- 19 (excluding ICU) (31.3.20) - LGI COVID-19 Streaming Reception (30.3.20) - ED COVID-19 Operational Response v.1.3 - COVID-19 ED Process Flow 2.0 - Operational Beds Plan v12 - COVID-19 Patient Flow 1.2		
1.2	• 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	PHE guidance on Covid-19: Guidance for maintaining services within health and care settings version 1.2 published in June 2021which strengthens the inclusion of the HOC		
1.3	• 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 pathways	SARS-CoV-2 test are performed on all patients admitted to the Trust and then on days 1,3, and 5. This is then followed by weekly testing for the duration of the patients stay.		
1.4	• When an unacceptable risk of	-CSU's to complete the Hierarchy		

	transmission remains following the risk assessment, consideration to the extended use of Respiratory Protective Equipment RPE for patient care in specific situations should be given	of Controls risk assessment to identify risk and any mitigating actions. LTHT Ward Nomenclature Guidance (PPE Guidelines - Ward Designation Posters) - NHSE/I IPC Operational Framework - IPC discharge and step down guidance [11/11/2020) -		
1.5	• There are pathways in place which support minimal or avoid patient bed/ward transfers for duration of admission unless clinically imperative	For patients with possible or confirmed COVID-19 infection, each potential 'move' is carefully considered. There are High, Medium and Low risk pathways that have been established to minimise patient movement; these are in line with the NHSE/I Operational Framework. **Supporting Evidence/Documents:** - LTHT Ward Nomenclature Guidance (PPE Guidelines - Ward Designation Posters) - NHSE/I IPC Operational Framework - IPC discharge and step down guidance [11/11/2020) - COVID Patient Flow 1.2 - Operational Weekly Bed Plan (Example, 20 November 2020) - IPC guidance for patient in contact with confirmed		

		COVID-19 case [26/06/2020] - https://www.rcog.org.uk/en/guidelines-research-services/guidelines/coronavirus-pregnancy/ - https://www.gov.uk/government/publications/wuhan-novel-coronavirus-initial-investigation-of-possible-cases		
1.6	• That on occasions when it is necessary to cohort COVID-19 or non-COVID-19 patients, reliable application of IPC measures are implemented and that any vacated areas are cleaned as per national guidance	PHE guidance on the low, medium and high risk pathways implemented. All clinical areas have signage indicating which pathway. Facilities have checklists for terminal cleans. During the pandemic, increase cleaning of frequent touch points occurs; assurance is gained through completion of the frequent touch point records (FTPC). Relaunch of 'I am clean' green label undertaken to support additional assurance around the cleaning of patient shared equipment. **Supporting Evidence/Documents:** – ID Now update for Tactical – ED Desegregation 25 March 2021		

1.7	• Resources are in place to enable compliance and monitoring of IPC practice including: – staff adherence to hand hygiene – patients, visitors and staff are able to maintain 2 metre social and 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	All bed holding CSU's undertake daily ward assurance visits and weekly assurance visits by the Matrons. Introduced cleaning monitoring forms for non-clinical areas to complete for frequent touch points cleaning. All areas completed a covid-19 secure working environment risk assessment and submitted to H&S. Daily hand hygiene audits undertaken and submitted for entry to the Trust central database. Results are shared with the Matrons on a weekly basis. Deputy Medical Director lead, on the monitoring of PPE stock levels, maintaining a projected 14 days' supply. Established process for FFP3 mask fit testing Trust wide. Established material management process to supply the clinical areas with PPE, and an escalation process both in hours (via procurement) and out of hours (via CSM) if a clinical area identifies a		

		shortage of any element of PPE.		
1.8	• That the role of PPE guardians/safety champions to embed and encourage best practice has been considered.	We have asked our Matrons to provide the oversight and assurance that our staff and patients are adhering to correct PPE and to embed and encourage best practice.		
1.9	• 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	Implementation of voluntary PHE guidance on twice weekly lateral flow antigen testing. Staff individually responsible for submitting results to the national database with reports sent to line managers. Staff aware to report to their line manager if they develop systems reflective of Covid-19 and to self-isolate and arrange a test.	As this is a voluntary requirement not all staff are undertaking the lateral flow antigen testing.	All staff are offered the opportunity to discuss any concerns or access support to enable lateral flow testing. This is re-evaluated in light of new evidence or at the request of the staff member.
1.10	• 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	The Trust outbreak guidance is triggered on two or more nosocomial cases which includes additional targeted testing.		
1.11	• Training in IPC standard infection control and transmission-based precautions is provided to all staff	Trust has an established corporate induction programme which has been updated to include Covid-19 in the IPC section.		
1.12	• IPC measures in relation to COVID-19 are included in all staff induction and mandatory training	Mandatory IPC training incorporates standard IPC which includes hand hygiene, environmental cleaning transmission based precautions such as droplet. IPC measures relating to Covid-19		

		are incorporated into the Trust new staff induction, this is delivered on a weekly basis.		
1.13	• All staff (clinical and non-clinical) are trained in: – putting on and removing PPE; – what PPE they should wear for each setting and context	Trust staff are regularly updated regarding PPE via the COVID-19 Chief Medical Officer (CMO) trust-wide bulletins, these updates include links to guidance for staff to follow on how to put on and remove PPE. All areas have been provided with posters describing how to put on and take off PPE. With respirator masks, namely FFP3 masks, staff are trained in their use via the fit testing process. During fit testing, staff are shown how to use respirator masks, including fit checking before each use, the situations in which they are required and safe removal/disposal. On the Trust's COVID-19 intranet resource page, there is guidance on the appropriate use of PPE and this follows PHE guidance. Every clinical area has been provided with pictorial guides and training videos are accessible to all staff. Training is managed via the clinical service units (CSU) and staff attendance is recorded and		

		populated in to the Trust's electronic staff record system (ESR). In addition training support is provided by commercial companies coordinated by procurement. Fit testing is provided via the clinical service units (CSU) and the pass rates for each FFP3 mask are centrally logged to ensure stock levels for all types of FFP3 masks match the CSU need. A stock level tracker provides the ability to monitor PPE usage centrally and forecast requirements for the next four weeks. Staff working in high risk areas receive additional PPE training due to the extra PPE required in such areas, this includes how to put on the PPE, remove the PPE and where this should be done. Following the published guidance by PHE in June 2021, all FFP3 valved masks were removed from All critical care units, theatres and areas where sterile procedures would be undertaken that would risk the health care worker exhaling unfiltered breathe over a patient having a sterile procedure. **Supporting Evidence/Documents:**		

		- PPE Guidelines - PPE FAQs [7.4.20] - Staff FFP3 Respirator Fit Testing Records - PPE Guidelines - Re-use of eye protection guidance [14/08/2020] - PPE Guidelines - Theatres checklist [15/05/2020] - PPE Guidelines - Social distancing and PPE requirements in LTHT [02/10/2020] - PPE Guidelines - PPE requirements for surgery [15/05/2020] - PPE Guidelines - PPE order form. All orders should now be made by completing the order form and emailing to leedsth-tr.clinicalprocurement@nhs.net [19/10/2020]		
1.14	• All staff (clinical and non-clinical) have access to the PPE that protects them for the appropriate setting and context as per national guidance	Please see figure 1.13 above		
1.15	• 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	Trust has implemented PHE guidance on advice to patients, visitors and staff to comply with hands, face, space. Stations at the entrance to hospital providing hand decontamination and surgical face masks to visitors. Posters displaying hands, face, space in clinical areas.		

		Supporting Evidence/Documents: – Posters, resources and links		
1.16	• IPC national guidance is regularly checked for updates and any changes are effectively communicated to staff in a timely way	The Incident Command Centre (ICC) team review all guidance daily and specialty-specific guidance is reviewed by specialty teams. Guidance is then presented at the Tactical Group for discussion and disseminated via a variety of channels to all relevant staff through the CSU Tri Team, Tactical Group members, CMO Brief. Key messages are lifted from the guidance and disseminated to all staff via the CMO COVID-19 staff bulletin. The tactical groups led by clinical directors and the clinical advisory group, chaired by CMO. **Supporting Evidence/Documents:** - Board update example - Tactical work streams - CMO COVID-19 brief		
1.17	• Changes to national guidance are brought to the attention of boards and any risks and mitigating actions are highlighted	The COVID-19 pandemic is a regular Board agenda item. Updates are provided to the Board and changes in guidance		

		are also presented where applicable. Changes to national guidance are reviewed by Executive Directors following publication on behalf of the Board and discussed through tactical groups. An operational Bulletin is sent out by the Chief Medical Officer and key changes are included in the Chief Executive's report to the Board. The Trust established a Clinical Advisory Group, represented by the Chief Medical Officer and Chief Nurse together with clinical representatives focusing on critical care, infection prevention and control and medical ethics, to advise clinical teams. This has been included in reports to the Board through a quality and safety report. IPC BAF reviewed and updated, presented to Trust Board November 2020. **Supporting Evidence/Documents:** - Board update example		
1.18	• Risks are reflected in risk registers and the Board Assurance Framework where appropriate	The COVID-19 pandemic is reflected on the Trust's risk register, CRSS6 - Risk of a Viral Pandemic. Two additional risks have been developed: CRSS16 - Risk of secondary harms due to		

		reduced capacity (COVID-19) and CRSS17 - Staff Health, Safety and Wellbeing During the COVID-19 Pandemic. These risks are reviewed monthly at the Risk Management Committee, Chaired by the Chief Executive. CSU risk registers are reviewed through the local Quality Assurance (governance) forum and risks scoring > 10 are presented to Risk Management Committee in line with the annual programme, focusing on risks related to COVID-19. **Supporting Evidence/Documents:** - LTHT Corporate Risk Register - Trust Risk Register, Sections CRSS6, CRSS16 and CRSS17 (below): CRSS6 - Risk of a Viral Pandemic. There is a risk that the Trust may have to invoke its Emergency Response Arrangements due to a viral pandemic causing the absence of significant numbers of Trust staff and large increase in demand which could overwhelm the Trust's ability to deliver routine care and result in potential fatalities and significant financial loss.		

		The COVID-19 pandemic is reflected on the Trust's risk register, CRSS6 - Risk of a Viral Pandemic (COVID-19). Two additional risks are also cited including CRSS16 - Risk of secondary harms due to reduced capacity (COVID-19) and CRSS17 - Staff Health, Safety and Wellbeing During the COVID-19 Pandemic. **Supporting Evidence/Documents:** - LTHT Corporate Risk Register - Trust Risk Register, Sections CRSS6, CRSS16 and CRSS17 (below). **CRSS6 - Risk of a Viral Pandemic (COVID-19)** There is a risk that the Trust may have to invoke its Emergency Response Arrangements due to a viral pandemic (e.g. influenza or COVID-19) causing the absence of significant numbers of Trust staff and large increase in demand which could overwhelm the Trust's ability to deliver routine care and result in potential fatalities and significant financial loss.		

		CRSS16 - Risk of secondary harms due to reduced capacity (COVID-19) There is a risk of secondary harms to patients and potential fatalities as a consequence of delayed treatment due to a reduction in inpatient and outpatient capacity. **CRSS17 - Staff Health, Safety and Wellbeing During the COVID-19 Pandemic** There is a risk that the Trust fails in its duty of care to staff health and wellbeing during the COVID-19 Pandemic due to the failure to comply with Government Guidelines (Working Safely during COVID-19), resulting in potentially fatal harm and a further depleted and dispirited workforce		
1.19	• Robust IPC risk assessment processes and practices are in place for non COVID-19 infections and pathogens	Surveillance of infections, other than COVID-19, continues and is monitored through IPC team daily safety huddles. A new weekly IPC meeting has been introduced and includes virology, infectious diseases and microbiology consultants. There is a healthcare-associated infection (HCAI) Action Team meeting and an IPCT meeting which is held monthly. **Supporting Evidence/Documents:** - HCAI meeting minutes - IPCT meeting minutes		

		- Consultant Microbiologist Meeting Action Tracker		
1.20	• 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	The Chief Medical officer and Chief Nurse on behalf of the Trust Chief Executive review all daily data submissions. The Deputy Chief Operating Officer submits the nosocomial sitrep on their behalf		
1.21	• This Board Assurance Framework is reviewed, and evidence of assessments are made available and discussed at Trust board	The BAF is reviewed and assessed in the Infection Prevention and Control Committee, Quality Assurance Committee and Trust Board. The BAF has been presented at the following meetings: IPCC, COVID-19 Assurance - January 2021 (verbal update) Quality Account Committee - 02/07/2020 and 04/01/2021 (paper submitted) From March the BAF will also be reviewed monthly at the Operational Infection Control Meeting :workstream of the COVID-19 Tactical Group.		
1.22	• The Trust Board has oversight of ongoing outbreaks and action plans	Outbreak reports and action plans are presented through the IPC governance structure as follows: Reviewed and evaluated at the HCAI action team meetings. Presented and lessons learnt noted at IPCC. The minutes of IPCC are submitted to the Quality and Safety Assurance Group and Quality		

		Assurance Committee. Before submission to board.		
1.23	• There are check and challenge opportunities by the executive/senior leadership teams in both clinical and non-clinical areas	The Chief Medical Officer and the Chief Nurse continue to provide executive leadership and undertake virtual leadership visits in line with Covid-19 restrictions. The Chief Nurse visits clinical areas three times a week to provide Nursing leadership.		

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**
2.1	Systems and processes are in place to ensure: • Designated nursing/medical teams with appropriate training are assigned to care for and treat patients in COVID-19 isolation or cohort areas	Estates and Facilities staff are split to work in designated areas based on the designation of the ward using the high risk and low risk pathways. These teams have received the appropriate training which is in-line with PHE guidance. Housekeeping staff have received training in cleaning techniques and have routinely completed these types of cleans. Additional training and guidance has been provided to all Estates and Facilities staff on PPE use. Staff training in the use of PPE and cleaning techniques is recorded centrally using ESR. Assurance is received through the CSU governance structures and the Infection Prevention and Control Committee. **Supporting Evidence/Documents:** - COVID-19 PHE IPC Guidance (updated 29 September 2021)		

		- - NHSE/I IPC Operational Framework - PAS5748 (2014) - LTHT Ward Nomenclature Guidance (PPE Guidelines - Ward Designation Posters)		
2.2	• Designated cleaning teams with appropriate training in required techniques and use of PPE, are assigned to COVID-19 isolation or cohort areas	There is an electronic process for requesting cleaning and decontamination of isolation or cohort areas. Estates and Facilities staff have had the appropriate training to carry out these duties including the required techniques and use of PPE.		
2.3	• Decontamination and terminal decontamination of isolation rooms or cohort areas is carried out in line with PHE and other national guidance	Both Estates and Facilities historical and current practices are in-line with PHE guidance for the decontamination and terminal decontamination of isolation rooms or cohort areas. The electronic cleaning request system records the level of cleaning requested for all terminal cleans.		
2.4	• 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	Facilities have a check list for terminal cleans prior to the COVID-19 pandemic. During the pandemic supervisors sign off the frequent touch point cleaning and patient shared equipment cleaning twice a day. Action cards to facilitate the cleaning of patient shared		

		equipment and strengthen the use of “I am clean green label” completed by the 31st March 2021.		
2.5	• Cleaning and decontamination is carried out with neutral detergent followed by a chlorine-based disinfectant, in the form of a solution at a minimum strength of 1,000ppm available chlorine as per national guidance. 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	In all areas, the Trust moved to using Chlorclean for daily cleaning; this was before the COVID-19 pandemic was declared and was requested by the IPC team. In 2019 chlorine-impregnated wipes were also made available across the Trust to complement the use of Chlorclean solution. A disinfectant guide has been produced to support the clinical teams in choosing the appropriate cleaning agent if the manufacturer’s guidance stipulates a chlorine releasing agent cannot be used on equipment. **Supporting Evidence/Documents:** Evidence - DISINFECTANT GUIDE A new wipe, currently being implemented, enables a single step process that utilizes >1,000ppm available chlorine and neutral detergent, this		

		negates the need for a two stage clean.		
2.6	• Manufacturers' guidance and recommended product 'contact time' must be followed for all cleaning/disinfectant solutions/products as per national guidance	Chlorclean is, in the main, used by Estates and Facilities staff, and they have been trained in its use, which includes following manufacture guidance and contact time. Nursing staff, who have access to both Chlorclean and chlorine-impregnated wipes, are also aware of the need to follow manufacturers' guidance and recommended contact times. Training on this is included during the Trust's IPC induction session and via mandatory training.		
2.7	• 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 and keyboards – Rooms/areas where PPE is removed must be decontaminated, ideally timed to coincide with periods	Estates and Facilities current operational processes conform to national guidance. The Trust's historical cleaning frequencies, as agreed by the IPC team, as part of PAS5748, meet this guidance and the required increased decontamination frequencies required for 'frequently touched' surfaces (minimum of four touch point cleans per area per day).Facilities supervisors sign off twice a day **Supporting Evidence/Documents:** Evidence - decontamination poster of Trust approved		

	immediately after PPE removal by groups of staff	cleaning agents DISINFECTANT GUIDE Non- clinical areas that use electronic equipment have implemented cleaning check lists to ensure there is a robust process for cleaning. Additional touch-point cleaning has been implemented in public areas since the start of the pandemic. Where specific areas are identified for the removal of PPE, for example on ITU, processes for cleaning and decontaminating the environment are put in place. Such areas are also cleaned and decontaminated as part of routine cleaning schedules. **Supporting Evidence/Documents:** - Staff guidance for putting on and removing PPE, accessible via Trust COVID-19 intranet site - PPE Guidelines - LTHT IPC Best Practice Video (Uploaded 03/03/2021)		

2.8	• Reusable non-invasive care equipment is decontaminated: – Between each use – After blood and/or body fluid contamination – At regular predefined intervals as part of an equipment cleaning protocol – Before inspection, servicing or repair equipment	Estates and Facilities current operational processes conform to national guidance. The Trust's historical cleaning frequencies, as agreed by the IPC team, as part of PAS5748, meet this guidance and the required increased decontamination frequencies required for 'frequently touched' surfaces (minimum of four touch point cleans per area per day).Facilities supervisors sign off twice a day Visual aid developed to support the decision on what product to use on individual patient shared equipment. **Supporting Evidence /document :** -Cleaning elements risk assessment 2020 -Cleaning schedule 2020 -PHE Checklist a Monitoring Tool for Reporting the Management of COVID-19 DISINFECTANT GUIDE		

2.9	• Linen from possible and confirmed COVID-19 patients is managed in line with PHE and other national guidance and the appropriate precautions are taken	Linen management at the Trust conforms to PHE guidance relating to COVID-19. **Supporting Evidence/Documents:** - Synergy HMS Certificate 9001 - 24/10/2019 - Synergy HMS Conformity 14065 - 24/10/2019 - Choice Framework for Policy and Procedures 01 - 04 Decontamination of linen for health and social care		
2.10	• Single use items are used where possible and according to single use policy	The Trust conforms to this standard. For new COVID- 19-specific equipment staff might be unfamiliar with, the actions required are briefed at Silver Command and the CMO daily update. **Supporting Evidence/Documents:** - IPC Induction and Mandatory Training		
2.11	• Reusable equipment is appropriately decontaminated in line with local and PHE and other national guidance and that actions in place to mitigate any identified risk	The Trust has two decontamination hubs, national guidance is followed with regards to reprocessing of re-useable medical devices.		
2.12	• Cleaning standards and frequencies are monitored in non-clinical areas	Introduced cleaning monitoring forms for non-clinical areas to complete for frequent touch		

	with actions in place to resolve issues in maintaining a clean environment	points cleaning. All areas completed a covid-19 secure working environment risk assessment and submitted to H&S.		
2.13	• Where possible ventilation is maximized by opening windows where possible to assist the dilution of air	Air change rates have been reviewed across all LTHT clinical areas, and monitored. Few of the areas meet the 2007 HTM 03- 01 guidance which for example, requires six air changes per hour for general wards. Areas where ventilation has been ungraded: ARCU, Theatres- Jubilee hybrid, Geoffrey Giles (10 and 11), Clarendon wing, Maternity and Recovery Gledhow Wing, J44 & 45, and JAMA/HOBS at SJUH **Supporting Evidence/Documents:** - Ventilation Information for Clinical Areas (Pre Covid-19) December 2020 - Cleaning elements risk assessment 2020 - Cleaning schedule 2020 - PHE Checklist a Monitoring Tool for Reporting the Management of COVID-19	The age of the Trust estate varies greatly and there are buildings within the Trust that do not meet the current ventilation requirements.	Review through the OIPC group chaired by Assistance Director of Operations to explore alternative technology to enhance ventilation in an aging estate

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**
3.1	Systems and process are in place to ensure: • Arrangements for antimicrobial stewardship are maintained	The antimicrobial stewardship group continued to meet every month using MS Team. A clinical guideline was developed for COVID-19 pneumonia to optimise patient treatment whilst minimising unnecessary antibiotic use through the routine use of biomarkers (procalcitonin) to assist in guiding treatment. The guideline was update regularly to reflect learning and updates from NICE and PHE. Visits reflected COVID-19 cases in the hospital (March 2010, April 565). A daily report was developed that linked procalcitonin level to COVID-19 status and current antibiotics to maintain remote stewardship. Guidelines were kept up to date through on-going review. An Abdominal Medicine & Surgery (AMS) work plan has been written for this year that reflects the new ways of working. Targeted ward based AMS visits have been introduced in line with the recovery plan. **Evidence:** Meetings where antimicrobial stewardship is discussed continue, albeit in a less frequent manner and		

		through the use of MS Teams. Monthly surveillance of antimicrobial consumption and antimicrobial prescribing and review continued at a Trust level and reviewed through the CSU governance structures, at the HCAI Action Team and IPCC.		
3.2	Mandatory reporting requirements are adhered to and boards continue to maintain oversight	The mandatory antimicrobial stewardship audit took place by all patient facing specialties in Quarter 2. CSU triumvirate provides assurance that a monthly review of data occurs and an action is put in place where improvements is required through the CSU governance structure. Ongoing of monthly audit of antibiotic prescribing and day 3 review is ongoing and data is made available via the LHP Infection Performance pages and reports data at CSU, specialty and ward level.	Nationally mandated quality improvement programmes on AMS remain suspended.	Mitigating factors: CQUINs and NHS Contract reduction in antibacterial usage was suspended by NHS England.

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**
4.1	Systems and processes are in place to ensure: • National guidance on visiting patients in a care setting is implemented	Trust visiting guidance is accessible through the Trust's internet page. This sets out the changes to visiting due to COVID-19 precautions required and is updated in line with national guidance.		
4.2	• Areas where suspected or confirmed COVID-19 patients are being treated have appropriate signage and have restricted access	Across the Trust, there is clear signage and marked areas where there are suspected or confirmed COVID- 19 patients, this includes restricted access where appropriate. **Supporting Evidence/Documents:** - LTHT Ward Nomenclature Guidance (PPE Guidelines - Ward Designation Posters)		
4.3	• Information and guidance on COVID-19 is available on all trust websites with easy read versions	On the Trust's internet page information and guidance on COVID-19 is available. This includes leaflets on COVID-19. These are available in different languages and easy-read versions. **Supporting Evidence/Leaflets:** - Coronavirus (COVID-19) leaflet LN004800 04/2020 V1		

		- COVID-19 patient rehabilitation booklet LN004864 06/2020 V2 - Going to Outpatient Clinic during Coronavirus Pandemic LN004856 06/2020 V1 - Having a diagnostic test during the Coronavirus Pandemic LN004857 06/2020 V1 - Having an endoscopic procedure during the Coronavirus Pandemic LN004855 06/2020 V1 - Having surgery during the Coronavirus Pandemic LN004851 05/2020 V1 - Important information regarding your planned procedure during the Coronavirus Pandemic LN004847 05/2020 V5 - UTalking to Loved Ones (JusTalk and		

		Facebook Messenger) - use of iphones/ipads to support patient communication with friends and families		
4.4	• Infection status is communicated to the receiving organisation or department when a possible or confirmed COVID-19 patient needs to be moved	The Trust's electronic patient record system contains a high priority infection alert and a red flag shows for positive COVID-19 patients both via swab, and patients' positive on radiological findings. In addition there is also a high priority alert for shielding patients (extremely clinically vulnerable). Wards and departments are informed by telephone and there is also an automated flag on the electronic patient record.		
4.5	• There is clearly displayed, written information available to prompt patients' visitors and staff to comply with hands, face and space advice	Trust has implemented PHE guidance on advice to patients, visitors and staff to comply with hands, face, space Stations at the entrance to hospital providing hand decontamination and surgical face masks to visitors. Posters displaying hands, face, space in clinical areas. **Supporting**		

		Evidence/Documents: – Posters, resources and links		

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**
5.1	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 isundertaken to enable early recognition of COVID-19 cases	Trust follows PHE guidance on screening and triaging all patients via emergency or elective routes. This also includes outpatients. Triage questions are recorded on PPM+. Updated 23rd March to support latest national guidance **Supporting Evidence/Documents:** – PHE COVID-19: Guidance for maintaining services within health and care settings (last updated 1 June 2021)		
5.2	• Front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed COVID-19 symptoms and to segregate from non COVID-19 cases to minimise the risk of cross-infection as per national guidance	Within ED and Outpatients, there are arrangements in place for cohorting patients with COVID-19 symptoms. There is a high level of vigilance regarding COVID-19, and IPC in general, due to the COVID-19 pandemic and the Trust command and control response. All Outpatient areas under the responsibility of Outpatient CSU have screening at arrival. Every patient or visitor is screened using PHE triage questions, which are		

		documented on PPM+.. Process in place for managing anybody who does not pass questions through a separate clinic room. The principle of 2m social distancing, face mask and hand hygiene is a central requirement in all reception areas and where needed additional screening has been added to protect reception staff.		
5.3	• Staff are aware of agreed template for triage questions to ask	Implemented the PHE triage questions, which are documented on PPM+.		
5.4	• Triage undertaken by clinical staff who are trained and competent in the clinical case definition and patient is allocated appropriate pathway as soon as possible	Implemented the PHE triage questions, and system in place to escalate to the appropriate healthcare worker.		
5.5	• Face coverings are used by all outpatients and visitors	All patients and visitors are encouraged to wear a surgical mask if clinically appropriate. All hospital entrances have a station with hand sanitizer, and face masks **Supporting Evidence/Documents:** COVID-19: Guidance for maintaining services within health and care settings	Not all patients comply with the requirement to wear a face covering either because of choice or clinical exemption. Increased awareness of IPC requirements.	If a patient declines to wear a face mask rather than clinically unable to wear a mask. They are placed in screening room and discussion with expecting clinician regarding clinical risk of not seeing. If clinically urgent patient is then seen maintaining social distancing by clinician wearing full PPE again in screening room which is cleaned at end of appointment. If not clinically urgent patient, patient is advised the clinician is unable to review them and they are sent home with a repeat appointment made and given option to reconsider. If unable to wear a

				mask the patient is kept in a different part of waiting area or is placed straight into a clinic room on arrival. Daily hand hygiene and room cleaning recorded and uploaded daily onto Trust or local database. Regular reminders at Sisters' meetings. Assurance walk rounds by Matron and HoN. Support given if other professionals are not compliant with PPE. Escalation through HoN if regular breach by same individuals to other staff group managers. Any patients who are admitted to wards from Outpatients are swabbed as part of admission from Outpatient nursing staff on day of admission. This data is available on ICE and PPM+.
5.6	• Individuals who are clinically extremely vulnerable from COVID-19 receive protective IPC measures depending on their medical condition and treatment whilst receiving healthcare e.g. priority for single room isolation	All patients are risk assessed on their vulnerability to Covid-19 and managed accordingly All patients are tested for COVID-19 on admission (Day 0) and then Days 1, 3, and 5. From Day 7 of inpatient stay patients are tested twice weekly depending on ward Supporting Evidence/Documents: COVID-19: Guidance for maintaining services within health and care settings		

5.7	• Clear advice on use of face masks is provided to patients and all inpatients are encouraged and supported to use surgical face masks (particularly when moving around the ward) providing it is tolerated and is not detrimental to their (physical or mental) care needs	Posters on ward demonstrating the requirement to wear a face mask when leaving their bed space and using communal spaces. Matrons regularly walk round the wards discussing with patients the importance of wearing a face mask and listening to any concerns. Loop and ties masks are offered to support comfort.		
5.8	• 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	Daily ward check list monitors the compliance of wearing face masks. In addition weekly COVID-19 assurance visits by Matrons and corporate teams. **Supporting Evidence/Documents:**		
5.9	• Patients, visitors and staff are able to maintain 2 metre social and 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	Wards have plastic curtain to segregate bed spaces along with 2 meters distance between bed spaces. The plastic curtain is drawn at the head end to reduce droplet transmission between beds, Reception areas and none clinical areas have utilised protective Perspex sheets. Some areas such as ED have had new walls built to achieve segregation.		
5.10	• Isolation, testing and instigation			

	of contact tracing is achieved for all patients with new-onset symptoms, until proven negative	All patients are tested for COVID-19 on admission (Day 0) and then Days 1, 3, and 5. From Day 7 of inpatient stay patients are tested weekly depending on ward nomenclature (odd/even). This change came into effect on 10 May 2021. For inpatients, clinical investigations are requested as appropriate by the clinical team. Guidance is accessible to all staff and this includes advice regarding necessary clinical investigations. Contact tracing is instigated and completed by members of the IPC team. For such patients, who display clinical symptoms, they remain segregated and re-tested.		
5.11	• Patients that test negative but display or go on to develop symptoms of COVID-19 are segregated and promptly re-tested and contacts traced promptly	Covered in the Trust's COVID-19 testing guidance. For patient swabbing - this is done by a variety of staff that undergo local training; guidance for this is also provided on the Trust's COVID-19 website resource page. All patient contact tracing is initiated by the clinical team supported by the CSMs and followed up by the IPCT		
5.12	• There is evidence of compliance with routine patient testing protocols	There are daily ward level testing reports supported with		

	in line with Key actions: infection prevention and control and testing document	weekly compliance reports by Trust and CSU. These are reviewed at CSU and Trust level.		
5.13	• Patients that attend for routine appointments who display symptoms of COVID-19 are managed appropriately	For such appointments, and for patients who display symptoms, pathways have been designed and implemented to ensure safe patient flow and reduce risk **Supporting Evidence/Documents:** - COVID-19 testing for adult patients before surgery / treatment/ attendance at LTHT SOP [v8 - 18/01/2020] - COVID-19 testing of elective paediatric admissions (including resident parent) SOP [27/05/2020] - COVID-19 testing of non-elective paediatric admission - parent/carer SOP [27/05/2020] - Covid-19 testing for patients with Learning Disabilities and/ or Autism before surgery/ treatment/ attendance [19/06/2020] - Pre-treatment COVID-19 Patient Testing v.4.1 - 6341 Remdesivir - Elective admission swabbing SOP v.3		

		- Swabbing guidance - Patient Placement Plan (Example 26 June 2020) - NHSE/I Healthcare associated COVID-19 infections - further action (24 June, 2020)		

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**
6.1	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	PHE guidance on the low, medium and high risk pathways implemented. All clinical areas have signage indicating which pathway Signage throughout the hospital showing one way systems **Supporting Evidence/Documents:** - LTHT Ward Nomenclature Guidance (PPE Guidelines - Ward Designation Posters)		
6.2	• All staff (clinical and non- clinical) have appropriate training, in line with latest PHE and other national guidance to ensure their personal safety and working environment is safe	A tactical work-stream group reviews PPE suitability, availability and forecast requirements. In addition FFP3 fit testing pass rates by model and make are reported weekly and monitored centrally to allow prompt re-provision of resources if required.		
6.3	All staff providing patient care and working within the clinical environment are trained in the selection and use of PPE appropriate for the clinical situation	COVID secure work place assessments include ensuring that the correct PPE is available and staff have been trained in the correct		

	and on how to safely put it on and remove it	selection and donning and doffing. Trust staff are regularly updated regarding PPE via the COVID-19 (CMO) Trust-wide operational update , these updates include links to guidance for staff to follow on how to put on and remove PPE With respirator masks, namely FFP3 masks, staff are trained in their use via the fit testing process. During fit testing, staff are shown how to use respirator masks, including fit checking, the situations in which they are required and safe removal/disposal On the Trust's COVID-19 intranet resource page, there is clear guidance on the appropriate use of PPE and this follows PHE guidance. This includes details on how staff should select PPE appropriate for the clinical situation, including how to put on and take off PPE Every clinical area has been provided with pictorial guides and training videos are accessible to all staff Staff working in high risk areas receive additional PPE training		

		due to the extra PPE required in such areas, this includes how to put on the PPE, remove the PPE and where this should be done **Supporting Evidence/Documents:** – A visual guide to PPE poster (7.4.20) – Re-use of eye protection guidance [14/08/2020] – PPE requirements for surgery [15/05/2020] – LTHT Ward Nomenclature Guidance (PPE Guidelines - Ward Designation Posters) – Staff FFP3 Respirator Fit Testing Records In relation to respirator masks, training is managed via the clinical service units (CSU) and staff attendance is recorded and populated in to the Trust's electronic staff record system (ESR). FFP3 testing records are held on ESR.		
6.4	• A record of staff training is maintained.	In terms of decisions made around the re-use of PPE, the CAS alert followed the Trusts Gold Command structure. Sessional use of PPE is in line with national guidance. **Supporting Evidence/Documents:**	PPE training records are held locally; not monitored and managed centrally.	All CSUs have completed a CSU specific IPC BAF and monitor assurance through their local governance process. Additionally they are invited annually to provide assurance at the IPCSC.

		- Re-use of eye protection guidance [14/08/2020] – PPE requirements for surgery [15/05/2020] Incidents relating to the use of re-usable PPE are monitored via the Trust's incident reporting system (DATIX). Within Datix, a specific field has been added for incidents linked to COVID. Such incidents are periodically reviewed and monitored by the risk management team and CSU teams to ensure any necessary, and appropriate action, is taken. **Supporting Evidence/Documents:** - LTHT Risk Management Policy (Version 3.0)		
6.5	• Adherence to PHE national guidance on the use of PPE is regularly audited with actions in place to mitigate any identified risk	Adherence to PHE guidance and use of PPE is monitored via daily ward check lists and weekly Matron COVID-19 ward assurance visits. Peer assurance visits by the corporate nursing team are conducted for all areas where nosocomial transmission has occurred. IPC team conduct daily reviews of areas with suspected or confirmed		

		COVID-19 patients where there is an incidents or outbreak and assess adherence to PHE guidance including use of PPE **Supporting Evidence/Documents:** - Daily ward assurance check list - Weekly COVID-19 ward assurance document (JR) Monthly ward metrics audit covers hand hygiene and IPC precautions Central electronic data base for hand hygiene compliance now established by insights and informatics. Weekly metrics scores and hand hygiene performance data emailed to Heads of Nursing and Matrons (SP). Weekly meeting with HoNs (on a rotational basis) with Chief Nurse/Deputy Chief Nurse for verbal update on compliance to IPC standards and hand hygiene (SP). Outcome of Corporate Nursing COVID-19 ward visits to CSUs in		

		real time and to Chief Nurse and Chief Medical officer at Weekly Quality Meeting (SP). Weekly Covid assurance audits include IPC/PPE precautions completed by Matrons (JR).		
6.6	• 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 maintain physical and social distancing of 2 metres wherever possible in the workplace unless wearing PPE as part of direct care - staff are maintaining 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	All hand wash basins have pictorial guides to washing hands. Posters provided and on display in clinical and non-clinical areas. Matron walk rounds to gain assurance on guidance implemented for pandemic. Bulletins from the CMO are shared with all staff to promote PHE guidance on travelling to and from work. A new wipe, currently being implemented ,enables a single step process that utilizes >1,000ppm available chlorine and neutral detergent, this negates the need for a two stage clean. Evidence - link to poster displaying the quick guide to decontamination products Implementation of PHE guidance		

	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	on advice to patients/visitors/staff on the use of face coverings.		
6.7	• Staff regularly undertake hand hygiene and observe standard infection control precautions	Matron walk rounds Corporate Nursing Team COVID-19 ward visits Daily hand hygiene audits Weekly HH performance reports Weekly assurance meeting with Chief Nurse and HoNs		
6.8	• 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 WC areas have been surveyed and where hand driers are installed these have been electrically isolated to prevent use Paper towels in suitable dispensers are provided in all WCs.		
6.9	• Guidance on hand hygiene, including drying should be clearly displayed in all public toilet areas as well as staff areas	A mixture of posters and proprietary stickers on soap dispensers are in place.		
6.10	• Staff understand the requirements for uniform laundering where this is not provided for onsite	Clear messages have been regularly sent to all staff via the CMO bulletins regarding uniforms including laundering.		

		Other than scrubs, staff have laundered their own uniforms for some time. **Supporting Evidence/Documents:** - CMO bulletins		
6.11	• All staff understand the symptoms of COVID-19 and take appropriate action (even if experiencing mild symptoms) in line with PHE and other national guidance if they or a member of their household display any of the symptoms COVID-19: management of staff and exposed patients or residents in health and social care settings (23 August 2021)	Regular information has been sent out to all staff, with links to the necessary guidance, via the CMO COVID-19 Trust wide bulletins regarding the latest advice on steps required to be taken if a staff member, or a member of their household displays any the recognised COVID. The Trust has a local risk assessment which CSU's can submit to a dedicate panel for review. The panel consists of Clincial directors, General Managers, Head of Nursing and Infection Prevention and Control. The panel is held daily (Monday to Friday)		
6.12	• 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)	Implementation of monitoring infection rates, separating community and hospital acquisition. Implementation of PHE guidance on community or hospital acquired Covid-19 RCA process triggered on case that are 8 days		

		plus. Meetings triggered in accordance with the PHE definition of an Outbreak.		
6.13	• 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	Trust policy on Outbreak management is followed. Outbreak reports and minutes recorded. RCA and Outbreak Performance tool shared with CSU's on a weekly basis. The Chief Nurse meets with CSU heads of Nursing weekly for assurance.		
6.14	• Robust policies and procedures are in place for the identification of and management of outbreaks of infection. This includes the documented recording of outbreak meetings	Trust policy on Outbreak management is followed. Outbreak reports and minutes recorded.		

7. Provide or secure adequate isolation facilities				
Key Lines of Enquiry		**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
7.1	Systems and processes are in place to ensure: • Restricted access between pathways if possible, (depending on size of the facility, prevalence/incidence rate low/high) by other patients/individuals, visitors or staff	The Trust has implemented the PHE guidance on low, medium and high risk pathways. **Supporting Evidence/Documents:** – LTHT Ward Nomenclature Guidance (PPE Guidelines - Ward Designation Posters)		
7.2	• Areas/wards are clearly signposted, using physical barriers as appropriate to patients/individuals and staff understand the different risk areas	– LTHT Ward Nomenclature Guidance (PPE Guidelines - Ward Designation Posters)		
7.3	• Patients with suspected or confirmed COVID-19 are isolated in appropriate facilities or designated areas where appropriate	The Trust adopted the PHE NHSE/I IPC three patient pathways of low, medium and high to support safe patient placement during the COVID-19 Pandemic and remobilisation of services. The designation of all these areas is updated weekly in line with the current COVID-19 prevalence and Trust recovery plans. Signage is displayed on the entrance to wards/bays/side rooms to show designated areas.		

		Supporting Evidence/Documents: - NHSE/I Operational Plan - LTHT Ward Nomenclature Guidance (PPE Guidelines - Ward Designation Posters)		
7.4	• 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	All clinical and non-clinical areas have been reviewed in line with IPC PHE guidance. Trust wide review of ventilation systems completed. Installation of a new ventilation plant for the respiratory ward completed. Areas where ventilation has been ungraded: ARCU, Theatres - Jubilee hybrid, Geoffrey Giles (10&11).Clarendon wing, Maternity and Recovery Gledhow Wing, J44 & 45, and JAMA/HOBS at SJUH Review or side room capacity in all High risk pathways undertaken expansion of SJUH ED SR capacity being undertaken. Isolation pods purchased to support high risk pathway in surgery.		
7.5	• Patients with resistant/alert organisms are managed according to local IPC guidance, including ensuring appropriate patient placement	IPC Policy - Managing the risks associated with infection prevention and control Trust-wide side room risk		

		assessment tool. **Supporting Evidence/Documents:** – IPC Policy - Managing the risks associated with infection prevention and control v. 6 – Trust-wide side room risk assessment tool – Patient Placement Plan (Example 26 June 2020)		

8. Secure adequate access to laboratory support as appropriate				
Key lines of enquiry		**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
8.1	There are systems and processes in place to ensure: • Testing is undertaken by competent and trained individuals.	All laboratory testing is only undertaken by staff who have received the relevant training and successfully completed the relevant competency assessment(s) within a defined interval for re-assessment (procedures can only be performed when competency is in date). Records are monitored centrally by section leads and through departmental training and governance forums. All disciplines are subject to regulatory and accreditation body external assessment provides assurance that all testing is performed in accordance with international standards for medical laboratories. Assessments are performed annually and when testing arrangements change (e.g. new test added to scope). **Supporting Evidence/Documents:** UKAS accreditation references and on-going review of current		

		accreditation status (CSU level and Trust QG team): G:\Clinical Governance\Pathology\8. BestPracticeGuidanceActionTracker&AuditSchd\BestPractGuid&ActTrack Departmental training and competency matrices stored within G drive folders (real time assurance). E.g. G:\Blood Sciences\Training & Development\Competency Assessment\COMPETENCY Spreadsheets -		
8.2	• Patient and staff COVID-19 testing is undertaken promptly and in line with PHE and other national guidance	Trust provides regular undated guidance for when staff & patient testing is required. Covid-19 testing has an average of around 8hr TAT from receipt in Laboratory compared to a national standard of 15hrs. Introduction of Covid-19 Point of Care Testing has resulted in a decreasing of turnaround time of result where rapid clinical decision making is required.		

		Microbiology testing is provided until midnight 5 days per week with a 24 hours service 3 days per week to ensure all samples received for testing are dealt with promptly. Point of care testing is available on the Roche LIAT and Abbott ID NOW for urgent testing within the hospital and rapid staff testing where there is a potential for service disruption. The turnaround time for testing provides evidence that the systems for testing are adequate with >95% of results available within 24 hours. Table taken from KPI reporting for Quality Assurance purposes: **Supporting Evidence/Documents:** - COVID-19 Staff Testing (21.5.20) 003 - COVID-19 testing for adult patients before surgery / treatment/ attendance at LTHT SOP [v8 - 18/01/2020] - COVID-19 testing of		

		non-elective paediatric admission - parent/carer SOP [27/05/2020] - COVID-19 testing of elective paediatric admissions (including resident parent) SOP [27/05/2020]		
8.3	• Regular monitoring and reporting of the testing turnaround times with focus on the time taken from the patient to time result is available	Reporting suite of: 1. Daily Nosomical results. 2. Daily report of patients requiring testing. 3. Positive patients by location.		
8.4	• Regular monitoring and reporting that identifies cases that have been tested and reported in line with the testing protocols (correctly recorded data)	Bench marking data from region Pathology produces reports that are fed into the command and control structure during the pandemic		
8.5	• Screening for other potential infections takes place	Business as usual for all other infectious diseases and microbiology and virology tests. Microbiology consultants provide on call and specialist advice to Trust on the provision of testing for other infections **Supporting Evidence/Documents:** - On-call and specialist responsibilities for		

		LTHT consultants.		
8.6	• That all emergency patients are tested for COVID-19 on admission.	Systems (point of care testing) now in place in ED to test all admissions. Testing in place in all admission units to test all acute admission.		
8.7	• That those inpatients who go on to develop symptoms of COVID-19 after admission are retested at the point symptoms arise.	All patients are tested on day of admission and then on day 1,3, and 5.Then weekly for duration of the patients stay. Patients who become symptomatic during their hospital stay are tested.		
8.8	• That those emergency admissions who test negative on admission are retested on day 3 of admission, and again between 5-7 days post admission.	All patients are tested on day of admission and then on day 1,3, and 5.Then weekly for duration of the patients stay In an outbreak situation the test regime increases to daily for 10 days		
8.9	• That sites with high nosocomial rates should consider testing COVID negative patients daily.	All patients are tested on day of admission and then on day 1,3, and 5.Then weekly for duration of the patients stay		
8.10	• That those being discharged to a care home are tested for COVID-19 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	Testing system in place to test all patients to care home facilities, unless positive within the prior 90 days, in accordance with PHE discharge guidance. **Supporting Evidence/Documents:** PHE - Guidance for stepdown of infection control precautions and		

		discharging COVID-19 patients (Updated 16 August 2021)		
8.11	• 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	Discharge coordinators within the clinical areas communication with care homes to enable safe discharge to care home and reduce risk of transmission.		
8.12	• 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	All CSU's have a system in place to screen elective patient 3 days prior to admission, with instruction for the patient to self-isolate from time of screening to admission date.		

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**
9.1	Systems and processes are in place to ensure that: • Staff are supported in adhering to all IPC policies, including those for other alert organisms	There are processes in place to support staff in adhering to IPC policies including staff induction, IPC mandatory training, competency assessments and appraisal. Other processes include ward visits and training by infection control nurses and clinical educators. There is also specific guidance and SOPs for staff to follow that have been developed in-line with PHE guidance and LTHT. Induction, training, audit, competency packages, risk assessments, guidance, SOPs.		
9.2	• Any changes to the PHE national guidance on PPE are quickly identified and effectively communicated to staff	PPE is delivered into the Trust to a central location based at SJUH. James's Hospital. The team at SJUH then provide stock to a central store at LGI and to the Materials Management teams at each of the peripheral sites. Areas request stock they require via the Trust e- mail leedsth-tr.clinicalprocurement@nhs.net		

		Weekly meeting lead by a Trust executive established to monitor stock IPC operational group established to review any guidance published and recommend a course to implement the changes. As long as all the information required to identify what is required, who is making the request and where it should be delivered is included in the e-mail then the stock is sent out; delivery is normally made no later than two hours after the initial request is made. If, when orders are received, they are for excessive amounts of stock compared to previously then they are questioned.		
9.3	• All clinical waste and linen/laundry related to confirmed or suspected COVID-19 cases is handled, stored and managed in accordance with current national guidance	PHE guidance at the start of the pandemic identified waste should be treated as infectious in accordance with Health Technical Memorandum 07-01 Safe management of healthcare waste. **Supporting Evidence/Documents:** – COVID-19 waste guidance [08/04/2020]		
9.4	• PPE stock is appropriately stored and accessible to staff who require it	PPE is stored in a central location at SJUH and distributed to peripheral site PPE stores. From here, stock is distributed to ward		

		and departments areas and appropriately stored to allow easy access for staff who require it. **Supporting Evidence/Documents:** – COVID-19 waste guidance [08/04/2020]		

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**
10.1	Appropriate systems and processes are in place to ensure: • Staff in 'at-risk' groups are identified using an appropriate risk assessment tool and managed appropriately including ensuring their physical and wellbeing is supported	Occupational Health (OH) guidance for staff and managers is available and kept updated on the Trust's 'Internal Updates – COVID-19 site' HR work closely with OH supporting the staff identified at risk Dedicated OH clinicians provide telephone advice to staff and managers on the day of request. This includes advice on fitness for work and adjustments for 'at-risk' staff to safeguard their health. It also includes providing support for physical and psychological wellbeing, and includes signposting to internal and external resources Appointments for full consultations, if needed, can be arranged. Such consultations can include appointments with an OH doctor, OH psychologist or psychiatrist OH signpost staff to IPC and their managers for advice on correct use of PPE in their workplaces, and for training and mask fit testing		

		OH reiterates to staff the importance of robust compliance with PPE and provides support and advice to staff that have problems with their health in connection with using PPE.		
10.2	• 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	A comprehensive suite of guidance and policies are provided by HR to support the risk assessments. Line managers undertake assessment on secure COVID-19 working environment along with BAME risk assessment. These are then placed in the individual's personal file.		
10.3	• 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 • NPSA alert circulated in August : Infection risk when using FFP3 respirators with valves or	The Trust now has access to reusable respirators. Information is provided to relevant staff who use re-usable respirators and includes guidance on checking, putting on, taking off, maintenance and storage of the masks. The staff member receives their own named respirator and they are held within each CSU. Currently, the CSUs which have staff using reusable respirators includes critical care, ENT and children's. all staff are supported to ensure they are tested on the 7 different types of FFPE3 masks initially to find the best FFP3 mask for each individual. All valved FFP3 face masks were removed from use in the Trust on the publication of the latest	Replacement for powered hoods removed for staff that remain to fail fit testing on	

	Powered Air Purifying Respirators (PAPRs) during surgical and invasive procedures.	guidance: COVID-19: Guidance for maintaining services within health and care settings Infection prevention and control recommendations Version 1.2 All FFP 3 respirators and powered hoods have been removed from key areas.	available masks	
10.4	• Staff who carry out fit test training are trained and competent to do so	Fit training is provided via registered companies on both the qualitative and quantitative method and the clinical service units (CSU) keep records of fit testers once trained. A stock level tracker provides the ability to monitor PPE usage centrally and forecast requirements for the next four weeks.		
10.5	• 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	Fit testing is provided via the clinical service units (CSU) and the pass rates for each FFP3 mask are centrally logged to ensure stock levels for all types of FFP3 masks match the CSU need. A stock level tracker provides the ability to monitor PPE usage centrally and forecast requirements for the next four weeks.		

10.6	• A record of the fit test and result is given to and kept by the trainee and centrally within the organisation	Staff working in high risk areas receive additional PPE training due to the extra PPE required in such areas, this includes how to put on the PPE, remove the PPE and where this should be done.	Central register is not fully established to record FFP3 users and fit test results in ESR	CSU send weekly FFP3 records to the OIPC team
10.7	• 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	SOP developed for fit testing and donning and doffing respirator hoods with PPE, decontamination instructions have been incorporated into this. Hoods have been distributed to those who have failed all available FFP 3 masks. **Supporting Evidence/Documents:** FFP3 Mask Fit Testing SOP [04/03/2021 - Hayley Lancaster] Donning, doffing, cleaning and maintenance of powered respirator hoods SOP [04/03/2021 - Hayley Lancaster]		
10.8	• Members of staff who fail to be adequately fit tested a discussion should be had, regarding redeployment opportunities and options commensurate with the staff members skills and experience and in line with nationally agreed algorithm	All CSU's are responsible for maintaining a record of individuals who have failed fit testing and undertake a covid-19 secure working environment assessment and re purpose the identified individuals if an alternative cannot be found.		
10.9	• A documented record of this discussion should be available for the staff member and held centrally within the organisation, as part of	All CSU's are responsible for maintaining a record of individuals who have failed fit testing and line managers discuss and record the		

	employment record including occupational health	opportunities with individuals.		
10.10	• Following consideration of reasonable adjustments e.g. respiratory hoods, personal reusable 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	Discussions within CSU and adjustments made to support the individual to work safely following national guidance		
10.11	• Boards have a system in place that demonstrates how, regarding fit testing, the organisation maintains staff safety and provides safe care across all care settings. This system should include a centrally held record of results which is regularly reviewed by the board	All staff fit test trainer records are held on a central system (ESR) .	All staff fit testing is not recorded centrally. It is held locally.	
10.12	• Consistency in staff allocation should be maintained, reducing movement of staff and the crossover of care pathways between planned/elective care pathways and urgent/emergency care pathways, as per national guidance	Bed-holding CSUs review and reconfigure clinical rotas to ensure as far as possible, staff only provide care for patients within specific categories (confirmed positive patients, non-elective, planned elective) per shift, recognising an individual member of staff may provide care in a different category on their subsequent shift Staff cohorting; dedicated teams of staff are assigned to care for patients in isolation/cohort rooms/areas for their entire shift		

		There is consistency in staff allocation, reducing movement of staff and the crossover of care pathways between elective care pathways and urgent and emergency care pathways; reducing movement of staff between different areas Safer staffing guidance is always adhered to. **Supporting Evidence/Documents:** - Weekly operational bed plans - Principles to support staff cohorting - NHSE/I Healthcare associated COVID-19 infections – further action (24 June, 2020) - Pathway specific guidance found at https://www.leedsth.nhs.uk/covid19/clinical-guidelines/#SOPS19 A working group has been set up to specifically review social distancing, for staff and patients, to ensure people's safety. The work has been divided in to separate work-streams including		

		staff environment and patient flow / appointments. **Supporting Evidence/Documents:** - LTHT Non Clinical Risk Assessment for Working Safely with COVID-19 (June 2020) - LTHT Risk Assessment Tool for Working Safely with COVID-10 (June 2020)		
10.13	• All staff should adhere to national guidance and are able to maintain 2 metre social and physical distancing in all patient care areas if not wearing a facemask and in non-clinical areas	Social distancing working group has been established to specifically review social distancing, for staff and patients, and advise and oversee the implementation of the COVID-secure workplace Risk assessments, guidance and more. We continue to follow national guidelines relating to visitors Visiting is supported only in the following circumstances: • The patient is at the end of their life • Patients who need help with communication and/or health and social care needs • Carers are permitted to visit where there is an individual need, for example, to provide support at mealtimes or support a vulnerable patient such as a patient with a learning disability		

		• Children can have one parent visiting / resident with them at any time • Women will continue to be able to be accompanied by one birthing partner This approach continues to prove to be the most effective way of limiting the risks of COVID-19 within our services, and helps to keep our patients and colleagues safe. We continually review our visiting arrangements and will update them as soon as we are able to do so. me to pop in regular covid work place assessment		
10.14	• Health and care settings are COVID-19 secure workplaces as far as practical, that is, that any workplace risk(s) are mitigated maximally for everyone	Covid-19 secure working environment assessments undertaken and reviewed through the social distancing group. H&S team have supported all areas that identified a risk and worked with them to mitigate this.		
10.15	• Staff are aware of the need to wear facemask when moving through COVID-19 secure areas	PHE guidance implemented on the wearing of facemasks. **Supporting Evidence/Documents:** - LTHT Ward Nomenclature Guidance (PPE Guidelines - Ward Designation Posters) - CMO bulletin		

10.16	• Staff absence and well-being are monitored and staff who are self-isolating are supported and able to access testing	Ensure people's safety. Consideration has been given to staff working patterns, including during breaks. Staff absence is recorded on ESR by managers. Staff testing is available in the Trust accessed through Health and Wellbeing Leads, who monitor absence, self-isolation and shielding using ESR.		
10.17	• Staff who test positive have adequate information and support to aid their recovery and return to work	OH provides advice and signpost staff for testing, and provide advice and support to staff and managers on self-isolation and shielding OH provides telephone assessment and support for staff and manager as needed during absence and on fitness and adjustments to support their return to work. If needed a full OH consultation on manager's request (currently provided by telephone) **Supporting Evidence/Documents:** - Occupational Health COVID-19 Guidance LTHT (19.5.20) - Staff COVID-19 Risk Assessment for Vulnerable Pregnant Staff (19.5.20)		