The Leeds Teaching Hospitals NHS Trust

PUBLIC BOARD
30 July 2020

Infection Prevention and Control Board Assurance Framework

Presented for:	Assurance
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Previous Committees:	Quality Assurance Committee 2 July 2020

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	

Purpose/s	
1. To provide assurance to the Quality Assurance Committee (QAC) in relation to the infection prevention and control (IPC) Board Assurance Framework (BAF) published by NHS England and NHS Improvement (NHSE/I) on 4 May 2020, which requires the Trust to self-assess against Public Health England (PHE) and other COVID-19-related IPC guidance and identify risks.	Assurance
2. To provide the QAC with assurance regarding how the IPC BAF will be completed and monitored, including the Care Quality Commission's (CQC) approach to monitoring compliance.	Assurance

SUMMARY

This report provides a summary of information relating to the IPC BAF published by NHSE/I on 4 May 2020. This includes the steps the Trust has taken to date to implement the framework and the Trust's current position.
Appendix one - IPC BAF forward and introduction from Ruth May, Chief Nursing Officer for England.

(https://www.england.nhs.uk/coronavirus/publication/infection-prevention-and-control-supporting-documentation/)

BACKGROUND

The IPC BAF has been developed to support all healthcare providers to effectively self-assess their compliance with PHE and other COVID-19-related infection prevention and control guidance and to identify risks and mitigating actions. The first version was published on 4 May 2020 and includes 60 key lines of enquiry (KLOE). The BAF was updated on 22 May 2020 with an additional 12 specific KLOEs, including cleaning frequencies and hand hygiene.

Using the framework is not compulsory; however, NHSE/I recognise that its use as a source of internal assurance will support organisations to maintain quality standards. If the NHSE/I IPC BAF is not used, Trusts must ensure they have alternative appropriate internal assurance mechanisms in place.

Following publication of the IPC BAF, it was discussed at the Clinical Advisory Group on 11 May 2020. It was agreed that the Trust would implement the IPC BAF as the primary framework for assurance relating to infection prevention and control and COVID-19. The IPC BAF has also been presented at the Infection Prevention and Control Committee (IPCC) on 2 June 2020; the Committee supported its use and agreed on how it should be implemented, including the process for engaging CSUs and how they would be supported in this.

The framework itself is structured around the existing 10 criteria as set out in The Health and Social Care Act (2008) Code of Practice on the prevention and control of infection (appendix 2), which the infection prevention and control team update each year as an assurance document; this has been completed since 2015.

The IPC BAF published in May 2020 is focused on assurance relating to COVID-19 and PHE guidance. It links, in the main, to Regulations 12 and 15 of the Health and Social Care Act (2008), including: -

- Regulation 12h - assessing the risk of, and preventing, detecting and controlling the spread of infections, including those that are health care associated
- Regulation 15 1a - all premises and equipment used by the service provider must be clean.

In addition, the CQC are looking nationally at assurance regarding infection prevention and control in light of COVID-19 and, on 22 May 2020, asked the Trust to confirm its use of the IPC BAF as an assurance measure and to provide an update regarding progress, including whether it had been signed off at board, or the timescale by which the Trust expected this to have been done. The Trust confirmed that this would be presented to the QAC on 2 July 2020 following review at the IPCC; this was also discussed with the local CQC engagement lead in June 2020.

On 19 June 2020 the CQC stated that it had written to all NHS Trusts to update them that from Monday 22 June 2020, they will start to roll out a new approach to regulation during COVID-19, described as their Emergency Support Framework (ESF). The CQC recognise that having effective infection prevention and control measures in place remains of vital importance in providing patients with safe care.

Starting with NHS acute and mental health providers from 22 June 2020, the CQC's ESF conversations will focus on establishing whether Trusts have full assurance on infection prevention and control in the COVID-19 emergency and recovery period.

IMPLEMENTATION

The approach is to firstly build evidence and assurance by reviewing corporate processes, external to the CSUs, and then request that all CSUs complete their own internal self-assessments. At CSU level, self-assessments will be undertaken during July 2020 and be completed by 1 August 2020.

The CSUs will review the IPC BAF and populate the columns with the necessary evidence, which includes providing statements and linking evidence to documents, for example, policies, guidance notes, operating procedures. Completed CSU BAF self-assessments will be reviewed at the IPCC and Quality Management Group.

By implementing the IPC BAF in this way, the Trust will have broad oversight and assurance, both in terms of compliance and gaps, and have a clear focus of where improvements may need to be made in order to meet COVID-19 PHE requirements and mitigate known areas of increased risk.

CURRENT POSITION

At corporate level, evidence and assurance, including mitigating actions, are currently being gathered and populated in to the IPC BAF (appendix 3). This work is being supported by a Patient Safety and Quality Manager (PSQM) in conjunction with the infection prevention and control team. The 10 sections of the BAF have been shared with relevant service leads to provide the necessary evidence, gaps and mitigating actions for their areas. This evidence will be stored in a shared folder on G drive for assurance and to assist with preparations for inspection.

RECOMMENDATIONS

QAC is asked to note the decision taken by the Trust to use the NHSE/I IPC BAF to assess compliance against PHE COVID-19, and COVID-19-related infection prevention and control guidance, and acknowledge the steps being taken to monitor and achieve compliance and assess gaps in assurance.

Gillian Hodgson, Head Of Nursing/Deputy Director Infection Prevention
Nick Allen, Patient Safety and Quality Manager
June 2020

Appendix 1 - IPC BAF forward and introduction from Ruth May, Chief Nursing Officer for England

Appendix 2 - Existing IPC 10 criteria as set out in The Health and Social Care Act (2008) Code of Practice on the prevention and control of infection

Appendix 3 - IPC BAF (29.6.20)
February 2020

Appendix 1

Infection prevention and control board assurance framework

Foreword

NHS staff should be proud of the care being provided to patients and the way in which services have been rapidly adapted in response to the COVID-19 pandemic.

Effective infection prevention and control is fundamental to our efforts. We have developed this board assurance framework to support all healthcare providers to effectively self-assess their compliance with PHE and other COVID-19 related infection prevention and control guidance and to identify risks. The general principles can be applied across all settings; acute and specialist hospitals, community hospitals, mental health and learning disability, and locally adapted.

The framework can be used to assure directors of infection prevention and control, medical directors and directors of nursing by assessing the measures taken in line with current guidance. It can be used to provide evidence and also as an improvement tool to optimise actions and interventions. The framework can also be used to assure trust boards.

Using this framework is not compulsory; however its use as a source of internal assurance will help support organisations to maintain quality standards.

Ruth May
Chief Nursing Officer for England

Introduction

As our understanding of COVID-19 has developed, PHE and related guidance on required infection prevention and control measures has been published, updated and refined to reflect the learning. This continuous process will ensure organisations can respond in an evidence-based way to maintain the safety of patients, services users and staff.

We have developed this framework to help providers assess themselves against the guidance as a source of internal assurance that quality standards are being maintained. It will also help them identify any areas of risk and show the corrective actions taken in response. The tool therefore can also provide assurance to trust boards that organisational compliance has been systematically reviewed.

The framework is intended to be useful for directors of infection prevention and control, medical directors and directors of nursing rather than imposing an additional burden. This is a decision that will be taken locally although organisations must ensure they have alternative appropriate internal assurance mechanisms in place.

Legislative framework

The legislative framework is in place to protect service users and staff from avoidable harm in a healthcare setting. We have structured the framework around the existing 10 criteria set out in the Code of Practice on the prevention and control of infection which links directly to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Health and Safety at Work Act 1974 places wide-ranging duties on employers, who are required to protect the 'health, safety and welfare' at work of all their employees, as well as others on their premises, including temporary staff, casual workers, the self-employed, clients, visitors and the general public. The legislation also imposes a duty on staff to take reasonable care of health and safety at work for themselves and for others; and to co-operate with employers to ensure compliance with health and safety requirements.

Robust risk assessment processes are central to protecting the health, safety and welfare of patients, service users and staff under both pieces of legislation. Where it is not possible to eliminate risk, organisations must assess and mitigate risk and provide safe systems of work. In the context of COVID-19, there is an inherent level of risk for NHS staff who are treating and caring for patients and service users and for the patients and service users themselves in a healthcare setting. All organisations must therefore ensure that risks are identified, managed and mitigated effectively.

Appendix Two

The table below is the 'Code of Practice' for all providers of healthcare and adult social care on the prevention of infections under The Health and Social Care Act 2008. This sets out the 10 criteria against which a registered provider will be judged on how it complies with the registration requirements related to infection prevention. Not all criteria will apply to every regulated activity. Parts 3 and 4 of this document will help registered providers interpret the criteria and develop their own risk assessments.

Compliance criterion	What the registered provider will need to demonstrate
1	Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks that their environment and other users may pose to them.
2	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.
3	Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.
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.
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.
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.
7	Provide or secure adequate isolation facilities.
8	Secure adequate access to laboratory support as appropriate.
9	Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections.
10	Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection.

The Health and Social Care Act 2008, Code of Practice on the prevention and control of infections and related guidance (2015) p.13

APPENDIX 3

LEEDS TEACHING HOSPITALS NHS TRUST INFECTION PREVENTION AND CONTROL BOARD ASSURANCE FRAMEWORK

V1.7 14 July 2020

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: • infection risk is assessed at the front door and this is documented in patient notes	- 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 - Every adult patient admitted to LTHT has an assessment against a range of risks including infection risks. These risks are in the Nursing Specialist Assessment (NSA) which is on PPM+; this is the Trust's integrated electronic patient record system - If a patient is suspected or known to have an infection risk the electronic form will trigger nursing teams to complete more robust infection risk assessments - In the Emergency Department (ED), there are specific COVID-19 pathways for patients arriving via ambulance and walk-in patients. There is an IPC risk assessment tool on the ED's IT system (Symphony) that support judgements relating to infection risk - all admitted patients are swabbed to test for COVID-19 and managed accordingly depending on the result - GP patient triage process in place, managed via the Trust's Patient Call Advice Line (PCAL)		

• patients with possible or confirmed COVID-19 are not moved unless this is essential to their care or reduces the risk of transmission	**Supporting evidence / documents**: - IPC Policy - Managing the risks associated with infection prevention and control - Adult Nursing Specialist Assessment IPC Section - 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 Ambulance arrival flow chart - COVID-19 Patient Flow 1.2 - LTHT COVID-19 Resus Pathway V4 - Management of adult patients with suspected COVID-19 (excluding ICU) 13.7.20 - For patients with possible or confirmed COVID-19 infection, each potential 'move' is carefully considered. The arrangements for the management of patients with possible or confirmed COVID-19 is set out in a Standard Operating Procedure (SOP) and associated clinical guidelines that have been developed by microbiology and IPC teams. This includes the establishment of hot and cold patient pathways to minimise patient movement; these are in-line with the NHSE/I Operational Framework **Supporting evidence / documents:** - Operating framework for urgent and planned services in hospital settings during COVID-19 - IPC Step-down & Discharge Guidance (26.5.20) - COVID-19 Patient Flow 1.6 - Operational Weekly Bed Plan Example - Patient Placement Plan (Example, 26 June 2020) - SOP (COVID-19) 17 April 2020		
• compliance with the national guidance relating to discharge or transfer of COVID-19 positive patients	- Tactical lead for discharge reviews all guidance with specialty leads and attends the city-wide Silver Command care homes meeting. This is to ensure consistency of approach. Communications issued to	- Supply of FFP3 mask types is variable, which means fit testing sessions need to be continually provided	- Fit testing sessions are currently being led by Organisational Learning and will be devolved to CSUs in July. This will ensure staff

	staff to advise on changes to guidance relating to patient discharge/transfer. Assurance provided to Quality Assurance Committee 2 July 2020. **Supporting evidence / documents:** - IPC Step-down & Discharge Guidance (26.5.20) - Report to Quality Assurance Committee 2 July 2020		have continued access to fit testing support sessions
• all staff (clinical and non-clinical) are trained in putting on and removing PPE; know what PPE they should wear for each setting and context; and have access to the PPE that protects them for the appropriate setting as per national guidance	- 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 - Re respirator masks (FFP3), 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 - 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) - 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:** - Recommended PPE for healthcare workers (2.4.20) - Recommended PPE for outpatients (2.4.20) - A visual guide to PPE poster (7.4.20) - Re-use of eye protection guidance (8.4.20) - PPE requirements for surgery (8.4.20) - PPE posters; entering a ward, whilst on a ward, single aerosol generating procedure (AGP), high risk acute care area - Fit Test totals by mask type		

• national IPC guidance is regularly checked for updates and any changes are effectively communicated to staff in a timely way	- The Emergency Preparedness Team reviews all national guidance that is issued daily and liaises with the Incident Command Centre (ICC). Royal College/Professional Body and speciality-specific guidance is reviewed by speciality teams. Guidance is reviewed at Silver Command and the designated Tactical Group through the incident response structure and disseminated to all relevant staff by Bronze Commanders - Key messages from the guidance are disseminated to all staff via the daily CMO COVID-19 staff bulletin - The Tactical Groups led by Clinical Directors and specific advice is provided by the Clinical Advisory Group, chaired by CMO **Supporting evidence / documents:** - Notes from Tactical Group - Notes and actions from Clinical Advisory Group		
• changes to guidance are brought to the attention of boards and any risks and mitigating actions are highlighted	The operational response to COVID-19 and associated guidance is brought to the attention of the Board at the monthly meeting that has been held April-July. Further assurance is provided to Quality Assurance Committee. A weekly briefing is provided to the Board, setting our key updates, including changes to national guidance. **Supporting evidence / documents:** - Minutes of Trust Board - Minutes of Quality Assurance Committee		
• 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 (COVID-19) Two additional risks were added to the Corporate Risk Register in June 2020: CRSS16 - Risk of secondary harms due to reduced capacity (COVID-19) CRSS17 - Staff Health, Safety and Wellbeing During the COVID-19 Pandemic	- CSU level risks relating to COVID-19 are not fully completed, as this is changing frequently in line with national guidance	- To review CSU risk registers in July 2020 to ensure all COVID-19 risks are reflected, in line with national guidance.

	Supporting evidence / documents: - Trust Corporate Risk Register, Sections CRSS6, CRSS16 and CRSS17: - **- 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 because of delayed treatment due to a reduction in inpatient and outpatient capacity. This follows the suspension of some cancer pathways based on individualised clinical risk/benefit assessment, and all routine and planned procedures, including diagnostics and outpatient referrals, in-line with NHSE/I/PHE guidance issued 17 March 2020. This was to provide capacity to meet the admission demand relating to COVID-19, and implementation of the phase 2 recovery plan **- 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 **Supporting evidence / documents:** - Minutes of Risk Management Committee		
• 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 and at the Infection Prevention and Control Committee. A new weekly IPC meeting has been introduced and includes virology, infectious	- In response to the COVID-19 Pandemic national guidance to enable clinicians and managers to focus on the operational	- The IPC leadership team continued to review the HCAI performance at Trust level and the Consultant Microbiologists provided CSU-level review and feedback. HCAI

	diseases and microbiology. There is a healthcare-associated infection (HCAI) action team meeting which is held monthly **Supporting evidence / documents:** - HCAI action team meeting minutes - Infection Prevention and Control Committee Assurance Reports	response (phase 1), routine HCAI meetings were not held in April and May 2020	assurance continued to be provided via Ward Health Check data
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: • designated 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 hot and cold areas. These teams have received the appropriate training which is in-line with PHE guidance	- Completeness of training records	- Estates and facilities team currently gathering this evidence, confirmation regarding training figures to be sent by 17 July 2020
• designated cleaning teams with appropriate training in required techniques and use of PPE are assigned to COVID-19 isolation or cohort areas	- Housekeeping staff have received training in cleaning techniques and have routinely completed this. Additional training and guidance has been provided to all Estates and Facilities staff on PPE use. Staff training in the use of PPE aand cleaning techniques is recorded centrally using ESR		
• decontamination and terminal decontamination of isolation rooms or cohort areas is carried out in line with PHE and other national guidance	- 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 - Both Estates and Facilities practices are in-line with PHE guidance for the decontamination and terminal		

	decontamination of isolation rooms or cohort areas		
• 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	- Estates and Facilities frequencies, as agreed by the IPC team, as part of PAS5748, meet the requirement for two cleans per day; this includes areas that have higher rates of environmental contamination, for example, intensive care units. Reviewed at the HCAI action team meetings.		
• attention to the cleaning of toilets/bathrooms, as COVID-19 has frequently been found to contaminate surfaces in these areas	- Estates and Facilities cleaning frequencies, as agreed by the IPC team, as part of PAS5748, meet this standard, which includes cleaning of toilets/bathrooms		
• 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	- In all areas, the Trust moved to using Chlorclean for daily cleaning; this was before the COVID-19 Pandemic and was requested by the IPC team. In 2019, chlorine-impregnated wipes were also made available across the Trust, mainly for non-domestic staff to use, to complement the use of Chlorclean solution		
• manufacturers' guidance and recommended product 'contact time' must be followed for all cleaning/disinfectant solutions/products	- 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 manufacture guidance and recommended contact times. Training on this is included during the Trust's IPC induction session and via mandatory training		
• as per national guidance: - – 'frequently touched' surfaces e.g. 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,	- 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		

excretions or body fluids	increased decontamination frequencies required for 'frequently touched' surfaces		
– electronic equipment, e.g. mobile phones, desk phones, tablets, desktops and keyboards should be cleaned at least twice daily	- Additional touch-point cleaning (at least twice daily) has been implemented which includes electronic equipment		
– rooms/areas where PPE is removed must be decontaminated, timed to coincide with periods immediately after PPE removal by groups of staff (at least twice daily)	- Where specific areas are identified for the removal of PPE, for example on the ITU, processes for cleaning and decontaminating the environment is put in to place. Such areas are also cleaned and decontaminated as part of routine cleaning schedules		
• 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 - Synergy HMS Conformity 14065 - Choice Framework for Policy and Procedures 01 - 04 Decontamination of linen for health and social care		
• 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:** **-** Mandatory Training and Induction latest figures July 2020		
• reusable equipment is appropriately decontaminated in line with local and PHE and other national policy	The Trust has two decontamination hubs, national guidance is followed with regarding to reprocessing of re-useable medical devices **Supporting evidence / documents:**		

• review and ensure good ventilation in admission and waiting areas to minimise opportunistic airborne transmission	- decontamination procedure (add date of approval) - Minutes to decontamination group Air change rates have been reviewed across all LTHT clinical areas, few of the areas meet the 2007 HTM 03-01 guidance which for example, requires 6 air changes per hour for general wards. The risk, controls and mitigating actions were reviewed at Risk Management Committee (July 2020) **Supporting evidence / documents:** - Ventilation Information for Clinical Areas (Pre Covid-19) June 2020 - Cleaning elements risk assessment 2020 - Cleaning schedule 2020 - Minutes of Risk Management Committee (July 2020)	- The age of the Trust estate varies greatly and there are buildings within the Trust that do not meet the current ventilation requirements	- - Task and finish group set up, chaired by the Deputy CMO, to review the opportunities available to upgrade ventilation from new plant to refurbishment of localised air conditioning. Risk reviewed with Estates & facilities team at Risk Management Committee 2 July 2020
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	- The antimicrobial stewardship group continued to meet every month using MS Teams. 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 updated 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 antimicrobial stewardship work plan has been written for 2020/21 that reflects the new ways of working	- Ward-based antimicrobial stewardship visits paused in-line with national guidance, to enable clinicians and managers to prioritise the operational response to COVID-19 (phase 1). Audit programs were suspended from March to May 2020, in-line with national guidance	- Antimicrobial stewardship staff redeployed to focus on COVID-19 operational response

• mandatory reporting requirements are adhered to and boards continue to maintain oversight	**Supporting evidence:** - Antimicrobial resistance and HCAI annual programme 2020/21 Meetings where antimicrobial stewardship was discussed were continued, albeit in a less frequent manner and using Microsoft Teams. Monthly surveillance of antimicrobial consumption continued at a Trust level. National CQUIN relating to antimicrobial stewardship suspended Q1 -4 2020/2 **Supporting evidence** - Improving antimicrobial prescribing group meeting, June 2020, Operational Meeting - Improving antimicrobial prescribing group meeting, May 2020, Strategy Meeting - Improving antimicrobial prescribing group meeting, April 2020, Operational Meeting - Improving antimicrobial prescribing group meeting, January 2020, Strategy Meeting - Improving antimicrobial prescribing group meeting, March 2020, Operational Meeting - Improving antimicrobial prescribing group meeting, February 2020, Strategy Meeting	- Nationally mandated quality improvement programmes in antimicrobial stewardship were suspended as directed by national guidance.	- 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**
Systems and processes are in place to ensure: • implementation of national guidance on visiting patients in a care setting	- Trust visiting guidance is clearly set out on the Trust's internet page. This sets out the changes to visiting due to COVID-19		

• 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 • information and guidance on COVID-19 is available on all Trust websites with easy read versions	- 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. - 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:** - LTHT Visiting Guidance July 2020 - Coronavirus (COVID-19) leaflet - COVID-19 patient rehabilitation booklet - Going to Outpatient Clinic during Coronavirus Pandemic - Having a diagnostic test during Coronavirus Pandemic - Having an endoscopic procedure during the Coronavirus Pandemic - Having surgery during the Coronavirus Pandemic - Important information regarding your planned procedure during the Coronavirus Pandemic		
• infection status is communicated to the receiving organisation or department when a possible or confirmed COVID-19 patient needs to be moved	- On the Trusts electronic patient record system contains an infection alert and a red flag shows for positive COVID-19 patients and shielding patients. Wards and departs are informed by telephone and there is also an automated flag on the automated electronic patient record.		
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: • front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed COVID-19 symptoms and to segregate them from non COVID-19 cases to minimise the risk of cross-infection, 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 relating COVID-19, and IPC in general, due to the COVID-19 Pandemic and the Trust command and control response **Supporting evidence / documents:** - COVID-19 Admission SOP (v2.0)		
• mask usage is emphasised for suspected individuals	- Staff encourage suspected patients to wear a surgical mask if tolerated. PHE guidance appendix tables are followed across the Trust		
• ideally segregation should be with separate spaces, but there is potential to use screens, e.g. to protect reception staff	- Each clinical area is risk assessing their ability to deliver two metre social distancing. Where this is not possible, areas are utilising screens. In some cases, temporary walls are being constructed		
• for patients with new-onset symptoms, it is important to achieve isolation and instigation of contact tracing as soon as possible	- For in-patients, 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		
• patients who test negative but display or go on to develop symptoms of COVID-19 are segregated and promptly re-tested and contacts traced	- For such patients, who display clinical symptoms, they remain segregated and re-tested - Contact tracing is instigated and completed by members of the IPC team		
• patients with suspected COVID-19 are tested promptly	- This is covered in the Trust's COVID-19 testing guidance, a clear process is in place for referring staff with suspected COVID-19 for testing, results provided within 24 hours. This is monitored daily via the		

• patients who attend for routine appointments who display symptoms of COVID-19 are managed appropriately	performance dashboard. Patient swabbing is done by a range of staff that have undergone local training; guidance for this is also provided on the Trust's COVID-19 website resource page. - For such appointments, and for patients who display symptoms, pathways have been designed and implemented to ensure safe patient flow and reduce risk, including a risk assessment that is undertaken to identify whether a patient has symptoms of COVID-19 **Supporting evidence / documents:** - COVID-19 testing for adult patients before surgery / treatment / attendance at LTHT SOP 2.6.20 - COVID-19 testing of elective paediatric admissions (including resident parent) SOP 27.5.20 - COVID-19 testing of non-elective paediatric admission - parent/carer SOP - Swabbing guidance - Patient Placement Plan (Example 26 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**
Systems and processes are in place to ensure: • all staff (clinical and non- clinical) have appropriate training, in line with latest PHE and other guidance, to ensure their personal safety and working environment is safe • all staff providing patient care are trained in the selection and use of PPE appropriate for the clinical situation and on how to safely don and doff it	- There is a tactical work-stream that has been set up to support this work. There has been Trust-wide communication to all staff requesting they complete a risk assessment of their working environment to ensure staff safety and compliance with national guidance - 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 - 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, as defined by PHE, receive additional PPE training; this includes how to put on the PPE, remove the PPE and where this should be done **Supporting evidence / documents:** - Recommended PPE for healthcare workers (2.4.20) - Recommended PPE for outpatients (2.4.20) - PPE FAQs (7.4.20) - A visual guide to PPE poster (7.4.20) - Re-use of eye protection guidance (8.4.20) - PPE requirements for surgery (8.4.20) - PPE posters; entering a ward, whilst on a ward, single aerosol generating procedure (AGP), high risk acute care area - Staff FFP3 Respirator Fit Testing Records		
• a record of staff training is maintained	- 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)	- PPE training records are held locally; these are not monitored and managed centrally	- The IPC BAF will be integrated in to the Trust's IPC Annual Programme for 2020/21 and CSUs will be asked to provide assurance against this key line of enquiry
• appropriate arrangements are in place that any reuse of PPE in line with the CAS alert is properly monitored and managed	- The Trust utilises a PPE tracker tool which predicts the potential use of PPE three days in advance. There is an escalation trigger; this is where PPE supplies may only last a further 24 hours. In such a circumstance, escalation is via the Incident Command Structure so that mitigating actions are agreed and implemented.		

	Supporting evidence / documents: - Re-use of eye protection guidance (8.4.20)		
• any incidents relating to the re-use of PPE are monitored and appropriate action taken	- 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-19. Such incidents are reviewed and monitored by the risk management team and CSU teams to ensure any necessary, and appropriate action, is taken. A report is provided to Quality Management Group. **Supporting evidence / documents:** Quality Management Group minutes and report regarding incident reporting		
• adherence to PHE national guidance on the use of PPE is regularly audited	- Adherence to PHE guidance and use of PPE is observed via Matron daily ward visits and IPC team visits	- Adherence to use of PPE being in-line with national guidance is not part of a formal audit process	- The IPC BAF will be integrated in to the Trust's IPC Annual Programme for 2020/21 and CSUs will be asked to provide assurance against this key line of enquiry
• staff regularly undertake hand hygiene and observe standard infection control precautions	- The Trust advocates strict adherence to hand hygiene guidance and standard infection control precautions. Trust guidance, including CMO bulletins and ward / department posters, clearly highlight the expected standards. Hand hygiene is audited via the ward metrics process. **Supporting evidence / documents:** - IPC team daily COVID-19 ward visit record sheets - Weekly / monthly ward metrics audit covers hand hygiene and IPC precautions		
• hand dryers in toilets are associated with greater risk of droplet spread than paper towels. 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		

• 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		
• staff understand the requirements for uniform laundering where this is not provided for on site	- 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		
• all staff understand the symptoms of COVID-19 and take appropriate action in line with PHE and other national guidance if they or a member of their household display any of the symptoms	- 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 steps required to be taken if a staff member, or a member of their household displays any the recognised COVID		
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: • patients with suspected or confirmed COVID-19 are isolated in appropriate facilities or designated areas where appropriate	- The Trust developed a comprehensive operational plan, based on hot and cold patient pathways to support safe patient placement during the COVID-19 pandemic. The designation of all these areas is updated weekly in-line with the current COVID-19 prevalence and Trust recovery plans	- Demand for side rooms in the Trust is greater than the capacity available on some days.	- There is a task and finish group set up to considering any enhancements that can improve ventilation at LTHT in designated areas
• areas used to cohort patients with suspected or confirmed COVID-19 are compliant with the environmental requirements set out in the current PHE	- Signage is displayed on the entrance to wards / bays / side rooms to show designated areas - Bed spacing has been assessed across the Trust to ensure compliance with PHE guidance	- Ventilation; systems are	- High risk areas exploring the

national guidance • patients with resistant/alert organisms are managed according to local IPC guidance, including ensuring appropriate patient placement	- Air change rates have been reviewed across all LTHT clinical areas, few of the areas meet the 2007 HTM 03-01 guidance - Such patients are managed according to Trust IPC guidance. Members of the IPC team discuss placement of patients with resistant/alert organisms to ensure patient placement is risk assessed and safe. **Supporting evidence / documents:** - NHSE/I Operational Plan - example of weekly operational surge plan - All clinical and non-clinical areas have been reviewed in-line with IPC PHE guidance - IPC Policy - Managing the risks associated with infection prevention and control - Trust-wide side room risk assessment tool - Patient Placement Plan (Example 26 June 2020)	not available in all clinical areas	feasibility for increasing side room capacity, including the option to use isolation pods. Side-room capacity is monitored daily through the command structure
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: • testing is undertaken by competent and trained individuals	- Microbiology holds UKAS accreditation, which requires all staff to be trained and competent in testing procedures. The document MBB9TM06 Microbiology Training Manual (attached) is the management procedure in place - There is a comprehensive range of training and competency documents in place for all aspects of the testing process **Supporting evidence / documents:** - MBB9TM06 Microbiology Training		

• patient and staff COVID-19 testing is undertaken promptly and in line with PHE and other national guidance • screening for other potential infections takes place	- Molecular Extraction for COVID-19 - Reporting of COVID-19 Samples - Receipt and Pre-processing of COVID-19 Samples for PCR - Trust provides the guidance for when staff and patient testing is required - Microbiology team have extended the working day to ensure all samples received for testing are dealt with promptly. 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 reporting to NHSEI Quality Assurance **Supporting evidence / documents:** - COVID-19 Staff Testing (21.5.20) 003 - Elective admissions swabbing SOP v.3 - Non-elective paediatric admission, parent / carer June 2020 - COVID-10 testing for adult patients before surgery / treatment, attendance at LTHT, SOP v.4 (2.6.20) - Workload figures for other infectious diseases throughout the pandemic evidence that screening for other potential infections takes place - 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		

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: • 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 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 - IPC induction and mandatory training - Changes to PPE national guidance are reviewed through the Incident Command Structure and communicated to staff through the daily CMO Bulletin **Supporting evidence / documents:** - COVID-19 testing for adult patients before surgery / treatment/ attendance at LTHT - LTHT-PPE-step-down-and-Discharge-guidance_19.pdf - Management of adult patients with suspected COVID-19 (excluding ICU) 13.7.20		
• any changes to the PHE national guidance on PPE are quickly identified and effectively communicated to staff	Changes to PHE guidance re PPE are overseen and co-ordinated by the Trust supplies and procurement team. 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. Delivery is normally made no later than two hours after the initial request is made.		
• all clinical waste related to confirmed or suspected COVID-19 cases is handled, stored and managed in accordance with	National guidance confirms that large volumes of waste may be generated by frequent use of PPE and disposal of all waste related to possible or confirmed cases should be classified as infectious clinical waste suitable for alternative treatment, unless the waste has		

current national guidance • PPE stock is appropriately stored and accessible to staff who require it	other properties that would require it to be incinerated. The Trust has complied with the requirements detailed in national guidance (section 4.10) and all waste related to possible or confirmed cases is classified as infectious clinical waste and has been sent for alternative treatment. - 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. CSU teams use an innovative PPE Tracker which enables them to monitor their PPE usage **Supporting evidence / documents:** - COVID-19 waste management guidance SOP version 2 - PPE ordering tool - COVID-19 Waste Guidance		
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 and managed appropriately including ensuring their physical and psychological 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' - 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 **Supporting evidence / documents:** - Supporting staff to work safely letter 3.7.20 - Risk Reduction Checklist 3.7.20 - BAME risk assessment proforma - BAME staff network		
• staff required to wear FFP reusable respirators undergo training that is compliant with PHE national guidance and a record of this training is maintained	- The Trust has 15 reusable respirators and there is a specific group that reviews the use of them. 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	- Supply route inconsistent and no re-usable respirators received in June 2020	All requests for reusable respirators go through the clinical director for each CSU and every individual is tested on each SPU mask. If staff member still fails, they go on a waiting list. Re-usable respirators held for emergency allocation
• 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	- 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	- It is recognised staff may mix when in non-clinical areas, for example base offices, rest areas	- Guidance has been issued to staff when undertaking duties on a cold planned elective area if they have already visited a hot area during the same shift - Guidance has been issued to all staff regarding use of surgical masks and social distancing principles

		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 **Supporting evidence / documents:** - Weekly operational bed plans		- Guidance has been issued to staff regarding social distancing
•	all staff adhere to national guidance on social distancing (2 metres) wherever possible, particularly if not wearing a facemask and in non-clinical areas	- 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)		
•	consideration is given to staggering staff breaks to limit the density of healthcare workers in specific areas	- A working group has been set up to specifically review social distancing, for staff and patients, to ensure people's safety. Consideration has been given to staff working patterns, including during breaks		
•	staff absence and well-being are monitored and staff who are self-isolating are supported and able to access testing	- 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. This is monitored via the daily dashboard.		
•	staff that 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)		