**Agenda item: [27]**

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| **Title of report:** | IPC Board Assurance Framework update |
| **Presented to:** | WWL Board |
| **On:** | 2 February 2022 |
| **Presented by:** | [Rabina Tindale, Chief Nurse, Director IPC] |
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**Executive summary**

**Summary**

This report provides an update on progress with the IPC BAF. Ongoing gaps in assurance are also listed below before the main table.

**Gaps in Assurance and Mitigating Actions** – these are listed below with more detail in the table in the report.

* The use of FRSMs in non-clinical areas is not currently audited. All staff within NHS premises are required to wear face masks in line with current UKHSA Guidance. Last updated 17.1.2022
* WWL are not meeting the new National Cleaning Standards. New risk assessment drafted on cleaning scored 12 approved at IPC Committee. The Business case has been approved with the mitigating actions reflected within the narrative below.
* Compliance of inpatients wearing masks has improved but remains low. An action plan remains in place.
* Due to the number of patients with COVID-19, we are not always able to separate pathways. Tracking patients through the Bed management team, the number of transfers and outbreak occurrences to minimise risk. This is monitored and supported by IPC.
* There is a continued lack of side room capacity to enable the isolation of every patient requiring this measure. A Risk assessment has been completed with regards to the lack of side rooms capacity. IPC Team members attend bed meetings and support bed managers with decision making and are available 24/7 if required. A Datix is completed if staff are unable to isolate a patient requiring this measure – this includes patients with confirmed infections, suspected infections and CEV patients.
* Fit testing results are not reviewed regularly by the Board. A member of the Board had weekly oversight of a summary of the register during the first wave.

December 21: A status update was provided to the Board following discussion at the Occupational and Safety Health Group. Mitigation action: The Board needs to advise an agreed process of review.

**Link to strategy**

IPC is integral to WWL strategy and there is also an increased focus from regional and national teams.

**Risks associated with this report and proposed mitigations**

IPC risks are managed via the IPC Committee and the Corporate Risk Meeting.

Some IPC actions required may have adverse reactions in other areas of patient care e.g., not continually moving patient cohorts may lead to an increased number of closed beds.

**Financial implications**

Some actions will require significant financial resource to implement fully e.g., new cleaning standards.

**Legal implications**

The Code of Practice on the prevention and control of infection links directly to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

**People implications**

Additional resource will be required in some areas e.g., cleaning to fully comply with national guidance.

The current challenges associated with COVID-19 on top of the standard IPC workload continues to create additional ongoing pressure on the IPC team.

**Wider implications:**

IPC is fundamental to the way all staff work and requires a Trust-wide approach.

**Recommendation(s)**

Please acknowledge the key points in this paper and continue to support the implementation of actions required to enable compliance with national guidance and reduce hospital onset COVID-19 infection.

**IPC BAF Framework (last updated 8 Dec 2021):**

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| --- | --- | --- | --- | --- |
| |  | | --- | | 1. **Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users** | | | | |
| **Key lines of enquiry** | **Evidence** | **Gaps in Assurance** | **Mitigating Actions** |
| Systems and processes are in place to ensure:   * local risk assessments are based on the measures as prioritised in the hierarchy of controls. The risk assessment needs to be documented and communicated to staff; | * A new COVID risk assessment has been drafted using this process titled ‘There is a risk that non-compliance with best practice guidance associated with sessional use of protective gowns by staff on Winstanley ward for the care of CPAP, BiPAP, NIV patients, could lead to lack of patient confidence and increased risk of infection’ to go to IPCC meeting in July. * A new COVID risk assessment has been drafted using this process ‘There is a risk that if appropriate measures are not adhered to regarding front-line staff who have been a contact of a confirmed COVID-19 positive individual, there is a risk of nosocomial infections to patients and of transmission of infection to staff and visitors’ * August 21: the new risk manager has reviewed and advised on all IPC risks. * **December 21:** A new risk assessment has been drafted which incorporates the hierarchy of controls. The risk assessment is titled ‘There is a risk that Fluid Resistant Surgical Masks (FRSM) may not provide an adequate level of protection to healthcare staff in certain situations due to COVID-19, which may result in the transmission of COVID-19 to healthcare workers” and sets out additional recommendations for the use of FFP3 masks (not just aerosol generating procedures). This was presented at the Corporate Risk Group in Nov 21. The recommended amendments have been incorporated and submitted for further review at the Corporate Risk Group in December 21. | None | NA |
| * 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. | See above | See above | See above |
| * triaging and SARS-CoV-2 testing is undertaken for all patients either at point of admission or as soon as possible/practical following admission across all the pathways; | * All patients attending AED are screened for COVID on registration with a risk assessment completed. Symptomatic and asymptomatic patients are segregated at this point. * All patients requiring admission undergo a LAMP test as well as PCR. * Flow chart is in place for ward allocation of symptomatic, asymptomatic, positive and negative patients. * All patients within the community are contacted to ensure a face-to-face visit is clinically required ensuring that staff do not mix visits for both symptomatic and asymptomatic patients. * Telephone advice lines are in place where visits are not required. * Patients who are admitted straight to wards e.g.; ASU are tested on admission. * **December 21:** New guidance has been issued on 23/11/2021 ‘UKHSA Guidance: Infection Prevention and control for seasonal respiratory infections in health and care settings (including SARS-CoV-2) for Winter 2021 to 2022’. This is currently being reviewed and Trust SOPs updated. * **December 21:** Flowcharts have been developed and shared with ECC Consultants with regards to the Travel arrangements following the multiple publication of UKHSA Guidance for the new variant of concern Omicron and Ending Isolation early (COVID-19 Positive and Exemption from self-isolation COVID-19 Contacts in line with the UKHSA updates communicated to all staff via Trust communications/ bulletins. | None | NA |
| * when an unacceptable risk of 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; | * Wording from the latest national guidance has been added to the SOP. Introduction of this would be in collaboration with the IPC Team. * Staff are currently able to wear FFP3 masks through choice if preferred. * 20/8/21: Staff on the outbreak ward were asked to wear FFP3 masks. * **December 2021:** Additional recommendations for the use of FFP3 masks (not just aerosol generating procedures and including outbreak and high-risk areas) included within the Trust COVID-19 SOP and communicated via Trust senior management teams and Trust communication forums. | There is no current risk assessment that extends the use of RPE | Sept 21: IPC and H&S are reviewing the use of FFP3 masks for high-risk areas - a new risk assessment has been drafted (Completed) |
| * there are pathways in place which support minimal or avoid patient bed/ward transfers for the duration of admission unless clinically imperative; | * Microbiology results are obtained and documented in HIS before patients are moved to designated COVID negative or positive wards. * If symptomatic but negative, patients are reassessed by medics. If COVID still suspected, patients stay on the ward and are retested which is all documented on HIS. * There is a Flowchart on Screening of admissions for COVID-19 infection’ and in the SOP. * There is an agreed process flow chart to limit the number of times patients who have been a contact of a positive case can be moved and re-cohorted. * IPC attend bed meetings each morning to support appropriate patient placement. | None | NA |
| * that on occasions when it is necessary to cohort COVID-19 or non-COVID-19 patients, reliable application of IPC measures is implemented and that any vacated areas are cleaned as per national guidance; | * Part of the COVID SOP. * Assurance obtained via regular audits including cleaning, hand hygiene and PPE in clinical areas. | None | NA |
| * 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 & 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 | * Monitoring of IPC practices against key policies (including COVID-19) is included within IPC audit programme and includes environmental checklists, hand hygiene (monthly) and PPE (RAEI wards audited at least every other month). * Monitoring of IPC practice is also included within matron’s mini audits. * Beds/trolleys are at least 2m apart. * Configuration ‘bed/chair/locker’ is used on ward when patients sit out. * COVID safety Champions audit non-clinical settings. * **November 21:** A new DDIPC seconded from the CCG and a new IPC Nurse have commenced in post. * **December 21:** New guidance has been issued on 23/11/2021 ‘UKHSA Guidance: Infection Prevention and control for seasonal respiratory infections in health and care settings (including SARS-CoV-2) for Winter 2021 to 2022’. This is currently being reviewed and Trust SOPs updated. * **December 2021:** The Agency IPC Nurse who had been supporting the IPC team left her post. | The use of FRSMs in non-clinical areas is not currently audited. | The need to wear FRSMs in non-clinical areas was discussed with the Exec Team and agreement to continue with the wearing of FRSM in all Healthcare settings across the Trust. |
| * that the role of PPE guardians/safety champions to embed and encourage best practice has been considered; | * COVID Safety Champions in place; complete audits of own areas. Results collated by IPC and reported via IPCC. | None | NA |
| * 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 | * Implemented as requested in 2020 but compliance has reduced since then. * Staff are encouraged to complete tests twice weekly, and report all results on-line – regular items/reminders in newsletter. * COVID positive staff are followed up by dedicated team and risk assessments completed and shared with IPC. * 20/8/21: LFT reporting data now available and was 6% for w/c 2/8/21. * 20/8/21: Staff in the outbreak ward have been asked to carry out daily lateral flow testing. * Sept 21: staff have been informed of the move to national ordering of LF kits. * **December 21:** The Trust has now streamlined the reporting process and provided resources and communications to support and encourage staff participation and engagement. | There is no data available on how many staff are carrying out twice weekly lateral flow tests. | 20/8/21: The Trust plan to simplify the reporting process to encourage staff participation. |
| * 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; | * Part of the outbreak SOP. * Introduction of this would be in collaboration with the IPC Team. | None | NA |
| * training in IPC standard infection control and transmission-based precautions is provided to all staff; | * Mandatory training via e-learning is provided for all staff and levels monitored and reported to the IPCC. | None | NA |
| * IPC measures in relation to COVID-19 are included in all staff Induction and mandatory training; | * IPC measures in relation to COVID-19 form part of the above * COVID-19 module launched Dec 20 and is mandatory for all staff. * COVID 19 Module to be reviewed and updated November/ December 2021 and will continue into 2022. * Jan 21: IPC level 1 and 2 and COVID-19 module reviewed and updated. | None | NA |
| * all staff (clinical and non-clinical) are trained in:   + putting on and removing PPE   + what PPE they should wear for each setting and context | * A PowerPoint Presentation on PPE (inclusive of a quiz to test learning) is included within the e-learning for all staff and is mandatory. * PPE modules reviewed and updated in Feb 21. * Monthly PPE audits in clinical areas. * **December 21:** COVID-19 module currently under review. | None | NA |
| * all staff (clinical and non-clinical) have access to the PPE that protects them for the appropriate setting and context as per [national guidance](https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control) | * PHE national guidance is in place across the Trust * There is a PPE Store at each main site: PPE is delivered daily to wards and additional stock is available 24/7 if required. * July 21: Agreed that the PPE store is to remain for the remainder of this financial year and to extend the temporary contracts of staff accordingly. | None | NA |
| * 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; | * Multi-modal communications strategy in place which includes posters, roller banners and newsletter campaign and regular reminders. * IPC COVID SOP updated in-line with updated. * Items from National UKHSA (formerly PHE) Toolkit being used in newsletters, websites and social media. * **December 21:** IPC COVID SOP to be updated in-line with updated UKHSA Guidance (last: 23.11.2021 and 30.11.2021). | None | NA |
| * IPC [national guidance](https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control) is regularly checked for updates and any changes are effectively communicated to staff in a timely way; | * DDIPC is on circulation list for updates from UKHSA and attends GM and NW IPC meetings and relevant webinars. * All new guidance is acted upon in a timely manner. Where necessary SOPs are updated. * Changes are communicated through the IPC team, newsletters and Divisional leads and meetings. | None | NA |
| * changes to [national guidance](https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control) are brought to the attention of boards and any risks and mitigating actions are highlighted; | * DIPC presents to the Board through the performance report or specific agenda items. * IPC Committee and Quality and Safety committee review quarterly IPC reports. | None | NA |
| * risks are reflected in risk registers and the board assurance framework where appropriate; | * Trust Risk register. * IPC BAF reviews by IPCC, Exec and Board. * August 21: the new risk manager has reviewed all IPC risks. | None | NA |
| * robust IPC risk assessment processes and practices are in place for non-COVID-19 infections and pathogens; | * Q&S sign off for IPC audit programme. * IPC Committee monitors progress and establishes mitigating actions to be taken. * RCAs/PIRs continue to be undertaken for all reported CDT cases and MRSA, MSSA and Gram-negative bloodstream infections post 48 hours admission. * **December 21:** Clinical and Nursing Staff are actively engaging with the CDT Review process. * **December 21:** RCAs/PIRs continue to be undertaken for all reported CDT cases and MRSA, MSSA and Gram-negative bloodstream infections. | None | NA |
| * 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 | * IPC check and validation of data for all HOCI cases downloaded from HIS before submission. CEO and DIPC are copied in so can check data. | None | NA |
| * the IPC Board Assurance Framework is reviewed, and evidence of assessments are made available and discussed at Trust board; | * New IPC BAF last presented to the Exec on 5/8/21 * IPC BAF document presented to the Board July 21 and Sept 21. * **December 21**: IPC BAF updated. | None | NA |
| * the Trust Board has oversight of ongoing outbreaks and action plans; | * Outbreaks that meet StEIS criteria are reported through Safety Committee. * IPC report through IPC Committee up to Q&S and monthly Performance report to Board. | None | NA |
| * there are check and challenge opportunities by the executive/senior leadership teams in both clinical and non-clinical areas. | * Senior Leadership Walkabouts take place each month. * Senior Nurses are establishing a rota and proforma for visiting all areas. * **December 21:** Supportive ward visits increased during December 21 by the IPC Team and DDIPC. | None | NA |
| 1. **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 nursing/medical teams with appropriate training are assigned to care for and treat patients in COVID-19 isolation or cohort areas | * All redeployed staff undertake additional training to meet their needs. * PPE training is mandatory. | None | NA |
| * designated cleaning teams with appropriate training in required techniques and use of PPE, are assigned to COVID-19 isolation or cohort areas; | * Domestic Response team and designated Domestics in place. * All Domestics are trained in the correct use of PPE and have been mask fit tested. | None | NA |
| * decontamination and terminal decontamination of isolation rooms or cohort areas is carried out in line with PHE and other [national guidance](https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control) | * Domestic provision for the cleaning of isolation rooms and cohort areas follows PHE and National Guidance. * SOP in place agreed in conjunction with IPC. * Rapid Response Domestic team cover terminal cleans and work out of hours. | None | NA |
| * 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; | * Document in supervisor’s office to show what terminal cleans have been undertaken. * New sign off form for Ward manager to complete introduced in July 21. | None | NA |
| * 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](https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control). If an alternative disinfectant is used, the local IPCT should be consulted on this to ensure that this is effective against enveloped viruses; | * SoChlor is used for the routine cleaning of the environment across all risk pathways and will continue. * SoChlor used at 1,000ppm is used for cleaning in all clinical areas. * Green disinfectant wipes are available in non-clinical areas. * IPC sign off any new business cases. | None | NA |
| * manufacturers’ guidance and recommended product ‘contact time’ is followed for all cleaning/disinfectant solutions/products as per [national guidance](https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control); | * Manufacturer’s guidance followed and available on the intranet and included in decontamination SOPs. | None | NA |
| * a minimum of twice daily cleaning of:   + areas that have higher environmental contamination rates as set out in the PHE and other [national guidance](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/881489/COVID-19_Infection_prevention_and_control_guidance_complete.pdf);   + ‘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 immediately after PPE removal by groups of staff; | * All clinical areas undergo decontamination of the environment at least twice daily. * IPC liaise with Facilities to highlight and agree high risk areas. * The wards have Housekeeping schedules outlining frequency of cleaning. * Compliance is audited via Matron and IPC Spot audits and reported to the IPC Committee. * Disinfectant wipes are used in non-clinical area PCs and phones. * SOPs in place for all Facilities staff. * There are limited designated PPE doffing areas. * **December 21:** The Business case with regards to compliance with the National Cleaning Standards was approved for clinical areas only, with a further consideration to non-clinical areas in 2022. * **December 21:** Domestic staff recruitment process is in operation. * **December 21:** Domestic staff have been recruited to support the high frequency cleaning requirements. * **December 21:** The Domestic Service provision has been increased in ward areas and Second Clean Teams. * **December 21:** Additional domestic support has been deployed within ECC and ITU. * **December 21:** A recruitment initiative is being held on 14.12.2021 for additional Domestic staff to meet the needs of the Business case. | Not meeting new National Cleaning Standards | New risk assessment drafted on cleaning scored 12 approved at IPCC.  David Evans is finalising the business case. |
| * 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 | * Decontamination SOP in place. * SOP on Medical Equipment Management Procedure for Decontamination Cleaning of Devices – reminder sent out in June 21 newsletter. * Departmental and divisional SOPs for more specialised equipment e.g., ultrasound probes. | None | NA |
| * linen from possible and confirmed COVID-19 patients is managed in line with PHE and other [national guidance](https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control) and the appropriate precautions are taken; | * Linen system managed in line with National guidance. * SOP available on the Intranet. * External contractor performance is monitored against the contractual requirements. | None | NA |
| * single use items are used where possible and according to single use policy; | * Single Use SOP in place. * Single Use is included in mandatory level 2 IPC training. * Patient Safety Alerts communicated through internal Newsletters, Governance Team and changes to individual policies. | None | NA |
| * reusable equipment is appropriately decontaminated in line with local and PHE and other [national guidance](https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control) and that actions in place to mitigate any identified risk; | * There is a Decontamination Lead at Executive level. * Decontamination is covered at the IPCC. * Decontamination SOP both WWL wide and at department levels in place. * All reusable equipment is decontaminated in line with national guidance. * Audit programme in place. * Risk assessment process in place to minimise risk. * Deputy DIPC must sign off new business cases. | There is no separate Decontamination group now. | Decontamination is covered at the IPC Committee. |
| * cleaning standards and frequencies are monitored in non-clinical areas with actions in place to resolve issues in maintaining a clean environment; | * Kitchens and toilets are cleaned in non-clinical areas. * With current resources the focus remains on clinical areas. * Monitoring only occurs annually in non-clinical areas. * **December 2021:** Business case agreed. | Additional resource is required to meet new cleaning standards | New risk assessment drafted on cleaning – Nick Bastow.  David Evans is finalising the business case |
| * where possible ventilation is maximised by opening windows where possible to assist the dilution of air. | * Mechanical ventilation available in some admission and waiting areas. * Where mechanical ventilation is not available, managers have been advised to encourage the dilution of air by opening windows. * Window restrictors are in place for all windows. * Estates are completing a review of ventilation on all sites – to be discussed at the IPC Committees. * **December 21:** Estates have completed a review of ventilation at all sites with the exception of a small area at the Leigh site. The report has highlighted there is a heavy reliance on natural ventilation particularly at the RAEI site. * **December 21:** Window opening capacity has been increased at the Wigan site within safety limitations. | None | Window open capacity has been increased at the Wigan site within safety limitations. |
| 1. **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 | * Regular remote antimicrobial ward rounds are performed by the Consultant Microbiologist. * Daily Antimicrobial ward rounds undertaken within Critical Care by Consultant Microbiologist * Data collected on each intervention and feedback given. * Antimicrobial Pharmacist continues to review prescribing and new guidance as appropriate. * Antimicrobial audit programme. * Antibiotic audits done on wards following each new CDT case in line with Saving lives guidance and repeated if <95% scored. | None | N/A |
| * mandatory reporting requirements is adhered to, and boards continue to maintain oversight | * Mandatory reporting through the Board performance report. * Mandatory reporting through the quarterly IPC paper to Quality and Safety Committee. * Monthly reporting through Divisional Quality Assurance Groups. | None | N/A |
| 1. **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:   * [national guidance](https://www.england.nhs.uk/coronavirus/publication/visitor-guidance/) on visiting patients in a care setting is implemented | * National guidance in place - policy and SOP. * Changes communicated through Divisional Teams and via COVID Newsletter. * Visitor disclaimer in use. * Visiting is still subject to restrictions, but Exec have agreed visitors can attend in exceptional circumstances. Decision tree drawn up and agreed by Exec for special circumstances which includes IPC requirements. * July 21: New guidance drawn up for a pilot scheme for when visiting can be re-introduced. * December 21: Patient visiting reinstated in Green areas 23/11/21. Trust Visiting SOP and resources (e.g., patient information leaflet) developed. * **December 21:** Visiting suspended for 14 days due to Outbreak and Bay closures. Reviewed and the decision taken to continued suspended visiting with exception of patient’s groups, End of Life, Paediatrics and Maternity. * **December 21:** Ward visits to review practice undertaken during November and December 2021. Identified learning actioned as appropriate and will be shared wider. * **December 21:** COVID-19 Quick Tips resources in draft process for proposed communication to staff. | None | 4 December 21: Visiting suspended for 14 days due to Outbreak and Bay closures. For review in 14 days. |
| * areas where suspected or confirmed COVID-19 patients are being treated have appropriate signage and have restricted access; | * Blue, yellow, green and cohort bay system in place with supporting SOP. * Entry to wards is via swipe which restricts unauthorised access. * Colour coded signs for all wards in place. * Signs include key instructions e.g., PPE required * Clear signage in AED indicating symptomatic and asymptomatic patient areas. | None | NA |
| * information and guidance on COVID-19 is available on all trust websites with easy read versions; | * Dedicated COVID tab on landing page of Trust Intranet with divided sections including PPE and IPC. * External website has clear information and advice. | None | NA |
| * infection status is communicated to the receiving organisation or department when a possible or confirmed COVID-19 patient needs to be moved; | * Infection status is communicated verbally before the patient is transferred and then in writing via a transfer form when the patient is moved. * Discharge to assess process works to rapidly discharge patients to the most appropriate setting with a philosophy of home wherever possible reducing contact with others. * Patients swabbed 48 hours before discharge to nursing or care home. | None | NA |
| * there is clearly displayed, written information available to prompt patients’ visitors and staff to comply with hands, face and space advice. | * Roller banners are displayed at each entrance to prompt patients, visitors and staff to comply with hands, face, space. * Alcohol hand gel mask stations are available at entrances. * Patient leaflets includes information on masks, hand hygiene and social distancing. | None | NA |
| * Implementation of the Supporting excellence in infection prevention and control behaviours Implementation Toolkit has been considered [C1116-supporting-excellence-in-ipc-behaviours-imp-toolkit.pdf (england.nhs.uk)](https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2021/03/C1116-supporting-excellence-in-ipc-behaviours-imp-toolkit.pdf) | * Review of all resources by IPC and Comms. * Several items have been used in internal and external comms. * Toolkit also shared with HR staff. | None | NA |
| 1. **Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people** | | | |
| **Key lines of enquiry** | **Evidence** | **Gaps in Assurance** | **Mitigating Actions** |
| Systems and processes are in place to ensure:   * screening and triaging of all patients as per IPC and [NICE](https://www.nice.org.uk/news/article/nice-publishes-new-covid-19-rapid-guideline-on-arranging-planned-care-in-hospitals-and-diagnostic-services) guidance within all health and other care facilities is undertaken to enable early recognition of COVID-19 cases; | * Patients are assessed on admission and admitted to the most appropriate area. * All patients attending A/E are screened for COVID-19 symptoms on registration. * Patients are swabbed on day of admission (day 1; PCR and LAMP tests), day 4, day 6 and then weekly thereafter. * Reminders on HIS tracking board to alert staff when swabs are due. * Telephone screening is in place for all elective patients; they are swabbed 3 days prior to admission and asked to self-isolate prior to coming in. * SOPs are in place to support guidance. * App in place to show compliance with swabbing. * Sept 21: Audit shows compliance with inpatient swabbing was 89% overall. | None | NA |
| * 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](https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control); | * Patients are further assessed at triage and segregated appropriately to different areas/wards. | None | NA |
| * staff are aware of agreed template for triage questions to ask; | * COVID-19 risk assessment questions included within COVID SOP. * HIS core assessment questions are included in the COVID-19 checklist. | None | NA |
| * triage is undertaken by clinical staff who are trained and competent in the clinical case definition and patient is allocated appropriate pathway as soon as possible; | * Staff within AED have received specific training in relation to COVID-19 clinical case definition. * Pathways of care are defined within the Trust COVID-19 SOP. * Triage questions and COVID-19 checklist assessment within HIS further supports staff in clinical care definition and patient allocation. | None | NA |
| * face coverings are used by all outpatients and visitors; | * FRSMs are available in all clinical areas and at all entrances. Outpatients and visitors are requested to wear at all times. * COVID SOP includes information on mask wearing. | None | NA |
| * 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; | * CEV patients are priority for side rooms. * Included in SOP. * IPC attend bed meetings and are available 24/7 to support patient placement decisions. | None | NA |
| * clear advice on the use of face masks is provided to patients and all inpatients are encouraged and supported to use surgical facemasks (particularly when moving around the ward) providing it is tolerated and is not detrimental to their (physical or mental) care needs; | * FRSMs are available in all clinical areas and at all entrances; staff and visitors are requested to wear masks as they enter hospital. * The COVID SOP includes sections on mask wearing. * Patients are asked to wear a mask unless clinically impossible or medically exempt. * There is an information leaflet for patients on masks approved at IPC Committee. | None | NA |
| * 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; | * Compliance audited in April and June and reported through SIRI and IPCC. Action plan in progress. | Compliance of inpatients wearing masks has improved but remains low | Action plan in place – Rabina Tindale |
| * patients, visitors and staff are able to maintain 2 metre social & physical distancing in all patient care areas; ideally segregation should be with separate spaces, but there is potential to use screens, e.g., to protect reception staff. | * Seating rearranged or areas blocked off to ensure segregation. * Floor markings where required. * Hot clinic areas in the community have reduced and have clear signage. * Staff are not utilising patient entrances in order to reduce footfall. * Perspex screens in place at receptions. | None | NA |
| * isolation, testing and instigation of contact tracing is achieved for patients with new-onset symptoms, until proven negative; | * COVID SOP in place. * Symptomatic patients moved to symptomatic ward while awaiting swab result and then moved to either negative or positive wards depending on results (and a medical review if still positive). * Patient incident forms completed for all HOCI >8days that includes test and trace requirements. * IPC carry out daily tracking to monitor patient moves. * IPC attend bed manager meetings each day. * Bay closure spreadsheet maintained by IPC. | None | NA |
| * 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; | * See above | None | NA |
| * there is evidence of compliance with routine patient testing protocols in line with [Key actions: infection prevention and control and testing document](https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/11/key-actions-boards-and-systems-on-infection-prevention-control-testing-23-december-2020.pdf); | * App available to report on compliance with swabbing and data reported to IPCC and in quarterly IPC report. | None | NA |
| * patients that attend for routine appointments who display symptoms of COVID-19 are managed appropriately. | * In line with departmental SOPs, should patients attend who are symptomatic a risk assessment is undertaken. * All COVID departmental SOPs are signed off by IPC. | None | NA |
| 1. **Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection** | | | |
| **Key lines of enquiry** | **Evidence** | **Gaps in Assurance** | **Mitigating Actions** |
| Systems and processes are in place to ensure:   * patient pathways and staff flow are separated to minimise contact between pathways. For example, this could include provision of separate entrances/exits (if available) or use of one-way entrance/exit systems, clear signage and restricted access to communal areas; | * Patient pathways have been risk-stratification and included within the Trust COVID-19 SOP. * Display posters and updates on the Trust intranet also available. * One way system in place in Leigh hospital. * **December 21:** Patient pathways to be reviewed in line with ‘UKHSA Guidance: Infection Prevention and control for seasonal respiratory infections in health and care settings (including SARS-CoV-2) for Winter 2021 to 2022’ and Trust SOPs updated. | Due to constrictions on the Estate and the number of patients with COVID 19, we are not currently able to separate pathways at all times, in all places. | Environmental risk assessments have been completed at ward and department level. |
| * all staff (clinical and non-clinical) have appropriate training, in line with latest PHE and other [national guidance](https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control) to ensure their personal safety and working environment is safe; | * Mandatory e-learning for all staff. * Environmental risk assessments have been completed at ward and department level. * Where concerns are raised additional bespoke training is undertaken by the relevant individual to ensure staff comply. * A detailed IPC Checklist was used to assess areas for the safe return of CEV staff. | None | N/A |
| * 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 and on how to safely [put it on and remove it;](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/911313/PHE_quick_guide_to_donning_doffing_PPE_standard_health_and_social_care_settings.pdf) | * Don and doff posters are displayed in all wards and departments. * IPC check posters are present on ward visits. * IPC advice is available 24/7. * The Professional Practice Team support IPC to carry out classroom training on donning and doffing. * Don and doff guidance is included in the PPE e-learning module. | None | N/A |
| * a record of staff training is maintained; | * All mandatory training is recorded through personal passports and electronically through the Trust mandatory training system. * FFP3 mask fit training is organised by H&S and records held centrally and shared with divisions. | None | NA |
| * adherence to PHE [national guidance](https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control) on the use of PPE is regularly audited with actions in place to mitigate any identified risk; | * IPC visit wards regularly. * All key wards PPE compliance is audited at least every 2 months. Results fed back to clinicians, reported to IPCC and to Q and S via the quarterly report. * **December 21:** The compliance with PPE was reiterated to the IPCC group members for cascade within all Divisions (November IPCC). | None | NA |
| * hygiene facilities (IPC measures) and messaging are available for all patients/individuals, staff and visitors to minimise COVID-19 transmission such as:   + hand hygiene facilities including instructional posters   + good respiratory hygiene measures   + staff maintaining physical and social distancing of 2 metres wherever possible in the workplace unless wearing PPE as part of direct care   + staff are maintaining physical and social distancing of 2 metres when travelling to work (including avoiding car sharing) and remind staff to follow public health guidance outside of the workplace   + frequent decontamination of equipment and environment in both clinical and non-clinical areas   + clear visually displayed advice on use of face coverings and facemasks by patients/individuals, visitors and by staff in non-patient facing areas. | * Instructional posters available at all sinks. * Instructional posters at hand gel stations throughout the hospital and ward/ department entrances. * Guidance is given to all elective patients within the patient information booklet. * Patient information leaflet has information on hands, face and space. * Facemasks are available at all hospital and ward/ department entrances. * Roller banners and posters are used to promote mask use, good respiratory hygiene and social distancing. * Trust SOPs clearly define the need to maintain 2 metres distance unless wearing PPE as part of patient care. * There are signs on doors to indicate the maximum number of people who should be in the room at any one point. * Floor markings are present in many outpatient areas and ‘keep left’ signs in corridors. * Staff asked to avoid car sharing via SOP, newsletters etc. * Comms highlight key messages internally and externally through variety of medias. | None | NA |
| * staff regularly undertake hand hygiene and observe standard infection control precautions; | * Hand hygiene training is mandatory. * Hand hygiene audits take place monthly in all clinical areas and the results are monitored by IPCC. * There is an annual programme of CQC Spot audits for clinical areas monitoring the environment and practice. | None | NA |
| * 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](https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control); | * There are no hand dryers in any clinical areas at WWL. Where hand dryers were available for the public these have been deactivated and replaced with paper towels. | None | NA |
| * guidance on hand hygiene, including drying should be clearly displayed in all public toilet areas as well as staff areas; | * Hand hygiene posters are available from IPC and on the intranet. * Laminated posters are displayed in all areas – checked by COVID Safety Champions. * **December 21:** COVID-19 Quick Tips resources in draft process for proposed communication to staff. | None | NA |
| * staff understand the requirements for uniform laundering where this is not provided for onsite; | * National guidance has been followed with information for staff on laundering their uniforms. * Staff have been updated through the COVID Newsletters. | None | NA |
| * 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](https://www.gov.uk/government/publications/wuhan-novel-coronavirus-initial-investigation-of-possible-cases/investigation-and-initial-clinical-management-of-possible-cases-of-wuhan-novel-coronavirus-wn-cov-infection) if they or a member of their household display any of the symptoms; | * National guidance is being followed and available on the intranet. * Updates are included in the COVID Newsletters. * There is a drive through facility for staff testing at Leigh and Wrightington. * IPC liaise closely with H&S and Occupational Health as required. * Staff now have lateral flow kits for twice weekly testing. * Advice is available 24/7. | None | NA |
| * 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); | * An electronic laboratory reporting process (Queue) provides the IPCT with timely COVID results. * Positive results from elsewhere come via PHE emails to the IPC inbox and are acted upon. * An in-house COVID-19 App has been developed that supports the collation, evaluation and summary of COVID cases. * HOCI are reported via the daily nosocomial sitrep. * Local UKHSA information on population transmission is circulated to IPC. | None | NA |
| * 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; | * Patient investigation templates are completed for patients who test positive for COVID 8 or more days after admission. * If the criteria for outbreak is met this is declared and acted upon   and reported to DIPC and NHSE/I.   * SOP in place that is updated and monitored through IPCC. | None | NA |
| * 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. | * SOP for the identification and management of COVID-19 outbreaks that incorporates national guidance. This has been approved by the IPCC. * Daily outbreak meetings are held when necessary and minutes recorded. * Outbreaks reported to StEIS where relevant. | None | NA |
| 1. **Provide or secure adequate isolation facilities** | | | |
| **Key lines of enquiry** | **Evidence** | **Gaps in Assurance** | **Mitigating Actions** |
| Systems and processes are in place to ensure:   * restricted access between pathways, if possible, (depending on size of the facility, prevalence/incidence rate low/high) by other patients/individuals, visitors or staff; | * Patient pathways according to risk stratification have been defined and included within the Trust COVID-19 SOP which has been disseminated to all clinical teams. * Environmental risk assessments have been completed by wards and departments to establish safe flow of patients and staff. * Visiting policy and SOP based on national guidance. * **December 21:** ‘UKHSA Guidance: Infection Prevention and control for seasonal respiratory infections in health and care settings (including SARS-CoV-2) for Winter 2021 to 2022’. This is currently being reviewed and Trust SOPs to be updated. | Due to the number of patients with COVID 19, currently we are not always able to separate pathways. | Tracking patients through the Bed management team, the number of transfers and outbreak occurrences to minimise risk. This is monitored and supported by IPC |
| * areas/wards are clearly signposted, using physical barriers as appropriate to patients/individuals and staff understand the different risk areas; | * ‘Zone’ display posters developed and updates on the Trust intranet provided. * Entry to wards is via swipe which restricts unauthorised access. | None | NA |
| * patients with suspected or confirmed COVID-19 are isolated in appropriate facilities or designated areas where appropriate; | * Patients are currently cohorted on admission into symptomatic or non-symptomatic areas then wards. * Where a designated side room is available this would be used. * Once the COVID result is known they are moved to either positive or negative wards. * There is an Operational flowchart and COVID SOP. | There is a lack of side rooms to isolate every patient who should be. | There is a risk assessment on lack of side rooms.  IPC attend bed meetings and support bed managers with decision making and are available 24/7 if required.  A Datix is completed if unable to isolate a patient who should be – this includes those who have infections, those suspected to have an infection and CEV patients. |
| * 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](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/910885/COVID-19_Infection_prevention_and_control_guidance_FINAL_PDF_20082020.pdf); | * All bed spaces have been reviewed * Ward staff are requested to use privacy curtains between beds to minimise close contact where safe to do so; reminder in Newsletters and in COVID SOP. * IPC guidance on blue, green and yellow wards has been implemented and circulated to all wards; reinforced through Newsletter and meetings. * SOP covering all actions required. * IPC environmental checklists are reviewed every time an outbreak is declared. | None | N/A |
| * patients with resistant/alert organisms are managed according to local IPC guidance, including ensuring appropriate patient placement. | * All previous IPC policies, SOPs and patient information leaflets are in place and up to date to identify and appropriately place patients. * Side rooms on non-COVID wards are used for patients requiring isolation for other reasons e.g., MRSA. * C.*diff* patients are managed on Pemberton ward if possible. * COVID positive CPAP ward has a separate SOP. * Mandatory surveillance data is reported to IPCC and Trust Board. | None | NA |
| 1. **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; | * The Laboratories used are UKAS accredited. | None | N/A |
| * patient and staff COVID-19 testing is undertaken promptly and in line with PHE and other [national guidance](https://www.gov.uk/guidance/coronavirus-covid-19-getting-tested); | * Testing is performed in line with national guidance. It is provided by Northern Care Alliance, monitoring of compliance is through contractual discussions. * Trust guidance is in line with national guidance on testing for suspected COVID cases and for other infections. * The HIS tracking board highlights when patients need re-swabbing. * System established for antibody testing. * March 21: System established for carrying out additional testing on vaccinated patients and for identifying patients who may have new variants. * **December 21:** Identification of the new variant of concern Omicron will be notified via Regional UKHSA. | The Omicron variant is not easily identified via routine testing process. | Identification of the new variant will be reported/ notified via Regional UKHSA process. |
| * regular monitoring and reporting of the testing turnaround times with focus on the time taken from the patient to time result is available; | * App shows turnaround times. * HIS alert if takes longer than 24 hours. | None | N/A |
| * regular monitoring and reporting that identified cases have been tested and reported in line with the testing protocols (correctly recorded data); | * National policy is followed. * Patient incident reviews are carried out on all probable and definite hospital onset COVID patients. | None | N/A |
| * screening for other potential infections takes place; | * National policy is followed. * Alert organisms are reported as required on national database and at IPCC and investigated according to national guidance. | None | N/A |
| * that all emergency patients are tested for COVID-19 on admission; | * All patients tested on admission via LAMP and PCR. | None | NA |
| * that those inpatients who go on to develop symptoms of COVID-19 after admission are retested at the point symptoms arise; | * COVID SOP. * Patients re-swabbed if symptoms occur in line with national guidance and moved to a symptomatic ward. | None | NA |
| * that emergency admissions who test negative on admission are retested on day 3 of admission, and again between 5-7 days post admission | * National policy is followed. * An App is in place to monitor compliance. * There are electronic reminders on the HIS tracking board to highlight when swabs are due. * Sept 21: Audit shows compliance with inpatient swabbing was 89% overall. | None | NA |
| * that sites with high nosocomial rates should consider testing COVID negative patients daily; | * In COVID SOP for IPC to consider if nosocomial rates high. Usually swab all patients 3 times per week in any outbreak. | None | NA |
| * 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; | * National policy followed. * In COVID SOP. | None | NA |
| * that patients being discharged to a care facility within their 14 day isolation period are discharged to a [designated care setting](https://www.gov.uk/government/publications/designated-settings-for-people-discharged-to-a-care-home/discharge-into-care-homes-designated-settings), where they should complete their remaining isolation; | * National policy followed. * In COVID SOP. | None | NA |
| * 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. | * National policy followed. * In COVID SOP. | None | NA |
| 1. **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:   * staff are supported in adhering to all IPC policies, including those for other alert organisms; | * IPC Policies and SOPs are approved at IPCC and are on the Intranet and kept up to date. * IPC and microbiology advice is available 24/7. * IPC level 1 and 2 e-learning is mandatory in line with national guidance. | None | N/A |
| * any changes to the PHE [national guidance](https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control/covid-19-personal-protective-equipment-ppe) on PPE are quickly identified and effectively communicated to staff; | * All new guidance is acted upon in a timely manner. * Where necessary SOPs are updated. * Changes are communicated through the IPC team, newsletters and Divisional leads. | None | N/A |
| * 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;](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/881489/COVID-19_Infection_prevention_and_control_guidance_complete.pdf) | * Trust adheres to national guidance and Waste Legislation. This is evidenced within the Trust’s Waste Management Policy and Procedures under Category waste. Community staff also follow the Trust’s Policies including the national guidance regarding the disposal of COVID-19 PPE within a patient’s home environment. * The Clinical Waste Management Module is mandatory for all staff. | None | N/A |
| * PPE stock is appropriately stored and accessible to staff who require it. | * PPE is distributed to the wards on a daily basis. The main PPE store is on the RAEI site and is accessible 24/7. Opening times are highlighted in COVID Newsletters. * PPE stores also at Leigh and Wrightington. * In Community, PPE store is well stocked and accessible to all teams. |  |  |
| 1. **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 using an appropriate risk assessment tool and managed appropriately including ensuring their physical and wellbeing is supported; | * All staff requested to complete a self-declaration form confirming if they fall within the extremely vulnerable or high-risk categories as defined by PHE. Where staff have been determined to fall within these groups, personal risk assessments have been completed by line managers with the support of Occupational Health. Records of the outcomes from the self-declaration’s forms logged and maintained within HR. * A comprehensive programme of support has been developed for all staff, including Access to rest spaces with trained volunteers to provide a listening ear; in-reach support for teams when requested (e.g., at times of higher stress), training for managers in supporting staff; a 24/7 telephone helpline; staff counselling (including remotely); development of roles as clinical wellbeing leads and wellbeing champions; communications and information about self-care and sources of support. This is accessible by all staff, including those who are at-risk. Regarding those staff that are shielding, developing tailored support in addition to the above, in terms of accessing support remotely, and having access to information about supporting positive mental health when shielding. * Regular communications have been sent via senior managers; the HR team continue to be proactive and engaged with managers and individuals to obtain this information. * Home working supported for all staff where possible. * Staff vaccination programme began 23/12/20. * March 21: Working areas for vaccinated high-risk staff has been extended. * April 21: CEV staff returned to work in lower risk areas. * **December 21:** COVID-19 Booster programme in operation | None | N/A |
| * 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; | * Personal risk assessments have been completed by line managers with the support of Occupational Health. * Records of the outcomes from the self-declaration forms are logged and maintained within HR. | None | NA |
| * staff required to wear FFP3 reusable respirators undergo training that is compliant with PHE [national guidance](https://www.hse.gov.uk/coronavirus/ppe-face-masks/index.htm) and a record of this training is maintained and held centrally; | * Face fit testing is available across all acute sites and at one location in the community on rotation every 2-3 weeks and is run by the H&S team. * All mask fit testers have been trained in line with national legislation. * A SOP has been developed and shared with all Testers. * Some staff cannot wear a close fitting FFP3 mask e.g., due to facial hair. Air powered hoods are available if required and issued to Wards and Departments with instructions for use. * Reusable FFP3 half masks have been withdrawn from use. * **December 21:** A list of registered users of Powered air purifying respirators (PARP) is being compiled, retained and made available to Divisions for regular review so new starters can be captured. * **December 21:** Divisions have been provided with a list of compliant staff to review. Divisions have also undertaken Fit testing of staff to improve local compliance. | Fit testing training records are not fully complete for staff who wear air purifying respirators (PAPR) (mechanical respirators with hood). | Health and Safety are working with Divisions to identify staff who rely on or choose to wear PAPR to ensure they have all been fully trained. |
| * staff who carry out fit test training are trained and competent to do so; | * Fit test training is overseen by the Trust H&S team and conducted by staff who have been trained in line with national legislation and competent to do so. * 20.8.21: The business case for sourcing a permanent face fit testing service has been approved. * **December 21:** One of the two posts has been recruited, with interviews for the second post mid December 21. * **December 21:** There are 64 actively trained local mask fit testers in key clinical areas across the Trust. | There is a temporary solution for mask fit testing in place | The JD for the substantive post is being banded.  One of the two posts has been recruited, with interviews for the second post mid December 21. |
| * all staff required to wear an FFP3 respirator have been fit tested for the model being used and this should be repeated each time a different model is used; | * Face fit testing sessions are continuing a regular basis to ensure staff can receive fit test training in the FFP3 masks currently available * Data to end of August: 1262 staff fit tested to a current model. Pass rate from 01/07/2021-31/08/2021 is 89%. * **December 21:** There are 1560 staff fit tested to a current model. | Face fit testing continues but the Central Register of staff tested indicates that not all staff are tested to a model that is currently in stock. | Fit test sessions continue to be advertised.  Divisions have been provided with a list of compliant staff to review – Lynne Bushell. |
| * a record of the fit test and result is given to and kept by the trainee and centrally within the organisation; | * Record of the fit test and result is given to the staff member and mask fit training records are held centrally by the H&S team. * The Health and Safety Team are working with Payroll to ensure results can be uploaded onto ESR.   All results should eventually be available on ESR. | None | NA |
| * 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; | * Individuals that fail a fit test are tested on an alternative model until options are exhausted. If a secure fit cannot be achieved staff are advised to use a mechanical respirator and hood. Records are kept by the individual and held centrally by the H&S team | None | NA |
| * members of staff who fail to be adequately fit tested a discussion should be had, regarding re deployment opportunities and options commensurate with the staff members skills and experience and in line with nationally agreed algorithm; | * Included within the Respiratory Protective Equipment- Training Guidance SOP * Individuals that continue to fail fit tests and are unable to be provided with alternative respirators and hoods are provided with the opportunity for redeployment in line with Occupational Health and HR policies. * The Trust has a designated Redeployment team who oversee staff skill mix, knowledge and experience. | None | NA |
| * a documented record of this discussion should be available for the staff member and held centrally within the organisation, as part of employment record including Occupational health; | * Documented records of staff redeployment are kept in line with Occupational Health and HR policies. | None | NA |
| * following consideration of reasonable adjustments e.g., respiratory hoods, personal re-usable FFP3, staff who are unable to pass a fit test for an FFP3 respirator are redeployed using the nationally agreed algorithm and a record kept in staff members personal record and Occupational health service record; | * Documented records of staff redeployment are kept in line with Occupational Health and HR policies. | None | NA |
| * 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; | * A centrally held mask fit register is maintained and is available. | Fit testing results are not reviewed regularly by the Board | A member of the Board had weekly oversight of a summary of the register during the first wave. |
| * 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](https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control); | * Healthroster system used for nurses which includes Staff risk status. * Medical rotas for medical staff. * Where safe and practicable staff are only moved between similar colour coded areas in response to acuity and dependency of patients. There has also been a reduction in the volume of temporary staff working across the Trust. | Head of E&F has reviewed non-clinical staff allocation, but it was not possible to achieve everywhere. | Some staff do have to move between different areas on a daily basis. This includes circulating staff such as porters and phlebotomists. |
| * all staff to adhere to [national guidance](https://www.gov.uk/government/publications/staying-alert-and-safe-social-distancing) and are able to maintain 2 metre social & physical distancing in all patient care areas if not wearing a facemask and in non-clinical areas; | * National guidance has been adopted and promoted. Staff reminded regularly via Newsletters and Posters. Also, in COVID SOP. * Office space has been redesigned to ensure social distancing. * All community premises have been reviewed for social distancing and a number of work areas have been designated as no longer in use. * Wards asked to include minimum numbers at staff handovers. | None | NA |
| * 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; | * Space planning exercise undertaken at the start of the pandemic. * Maximum staff allowance per room assessments completed and supportive guidance provided to Departmental managers. * Environmental risk assessments completed. * COVID Safety Champions promote and support compliance in own areas – supported by IPC. | None | NA |
| * staff are aware of the need to wear facemask when moving through COVID-19 secure areas; | * Trust SOP for Masks in place and circulated to all departments. Regular reminders given at senior nursing and medical meetings for cascade, provided within Trust Newsletters and by the use of posters and roller banners. * July 21: As guidance changed externally, staff were reminded of the IPC measures required in healthcare via a global email and at Silver command and at divisional meetings. | None | NA |
| * staff absence and well-being are monitored and staff who are self-isolating are supported and able to access testing; | * Staff absence is recorded for payroll purposes through e-roster and through e-SVLs. This means that data taken from ESR can be 4/6 weeks in arrears. In order to comply with the daily SITREP requirements, absence data is recorded either in spreadsheets submitted by Divisional representatives or from the e-roster. * E-roster is currently rolled out to the majority of nurses and some AHPs. * Well-being offers are widely available to staff members, with pro-active holistic well-being provision through our Steps 4 Wellness and occupational health services. Psychological support programmes are in place including access to well-being apps, EAP, SOS rooms with trained facilitators, critical incident debriefing and departmental support programmes. There are nursing, AHP and medical well-being leads identified along with over 70 well-being champions within wards and departments. * The Trust continues to actively manage and support staff through attendance management procedures. The Strategic HR lead completes a monthly review of all long-term sickness absence cases with HR Business Partners. * Staff have access to COVID swab tests via a Trust drive through facility and home testing. * Sept 21: All staff continue to be able to access lateral flow testing and are asked to complete tests twice per week.  Results are reported through a local WWL system which is in the process of being simplified to make recording easier and quicker. * Sept 21: The Central Unplanned Absence Team continues to contact staff on first day of absence and support managers through the attendance management process.  This has been rolled out to add staff groups on e-roster. | Workforce data flows and the lack of accurate real time workforce data is on the corporate risk register. | Project underway to roll out Trust wide.  The Empactis absence management systems was launched in Specialist Services in Sept 21.  It will be rolled out service by service across the Trust.  All departments are expected to be supported by Empactis by April 2022.  Sept 21: ESR project commenced to centralise establishment control and vacancy management and improve the availability of accurate, real time workforce data. |
| * staff who test positive have adequate information and support to aid their recovery and return to work. | * Flow charts based on national guidance outline the processes and time periods to follow and are on intranet. Staff are supported via managers during absence in accordance with all sickness absence. * HR advisors are available to staff and managers to seek advice and support where any individuals are concerned or have questions around returning to work or being absent due to COVID. | None | NA |