Oxford Health
NHS Foundation Trust

RR/App BOD 03/2021
(Agenda item: 22)

Infection Prevention and Control Board Assurance Framework 2020

V4 January 2021

1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems are in place to ensure:			
1.1 Infection risk is assessed at the front door and this is documented in patient notes	Carenotes, and use of inter healthcare transfer form Swabbing on admission in all wards and 5-7 later Single en-suite rooms where possible for all admissions into MH settings, for those without en-suite designated bathrooms Single room/ cohorting patients in community hospitals Trust Inpatient management pathway SOP, management of Covid patients and PPE requirements 13th March 2020.   SOP Oxford Health Inpatient_Care_Path from SB on covid ma Updated 27th April 2020 to include patient de-isolation requirements.  ISOLATION and De ISOLATION OF PATIE Management of Community Hospital admissions. This includes patient de isolation requirements and is based on the traffic light pathways from Public Health England, IPC guidance updated 28th August 2020.	Non-consenting patients in MH wards No robust recording for admission and follow up screening in place	Clear guidance (isolation and seclusion) produced for all staff within these settings -8th May 2020.  Isolation and seclusion_Covid 19_ 9/11/20 New screening form introduced on carenotes

	Management of admissions commu		
1.2 Patient's with possible or confirmed COVID-19 are not moved unless this is essential to their care or reduces the risk of transmission	Trust dashboard in order that Trust understands levels of infection, staffing and best capacity. The information is updated twice daily. COVID-19 Dashboard sample.c Isolation guidance (see 1.1 above)		
1.3 Compliance with the national guidance around discharge or transfer of COVID-19 positive patients	Carenotes, Discharge screening guidance issued 27.4.20 Updated national guidance shared below – Jan 2021 Discharge to care homes - 14 day plus c	Need to ensure audit in place for monitoring this	
1.4 Monitoring of IPC practices, ensuring resources are in place to enable compliance with IPC practice	IPC/ PPE audits in community hospitals and mental health wards CH IPC checklist UPDATED 061020.dc Completion of matron's checklists Reported to weekly HAI meeting Action plans in place following weekly matrons audits if low compliance. Reported via directorate governance meetings and SMT's and up to Trust wide IPC meeting.		Monitored by HoN and matrons

1.5 Monitoring of compliance with PPE, consider implementing the role of PPE guardians/safety champions to embed and encourage best practice	Introduction of PPE safety champions to all clinical areas  PPE Champions Responsibilities Oct  PPE competency assessment form Oc Completion of PPE competency assessments forms	Robust system to record competency assessments for staff	L&D are recording PPE competencies on staff training records. Local records are also being held.
1.6 Staff testing and self-isolation strategies are in place and a process to respond if transmission rates of COVID-19 increase	Process set up for staff testing using lateral flow testing- twice a week- positive test results are followed up with confirmation via PCR. Staff informed of self isolation process through HR process and awareness from comms	To review process when staff declare +ve results outside of a ward outbreak	Senior nurse to lead detailed timeline of all staff +ve cases in line with IPC and Chief Nurse to set up a panel to ensure all staff cases are reviewed.
1.7 Training in IPC standard infection control and transmission-based precautions are provided to all staff	IPC training provided via online, and team training and includes standard IPC practice, per national content recommendations		
1.8 IPC measures in relation to COVID-19 should be included in all staff Induction and mandatory training	As 1.7, plus PPE donning and doffing video included in mandatory IPC training		
1.9 All staff are regularly reminded of the importance of wearing face masks, hand hygiene and maintaining physical distance both in and out of work	Posters, intranet messages, local reinforcement messaging all in place. Chief nurse webinars, regular reminders on twice weekly comms bulletins PPE champions, matrons, Heads of nursing , PPE champions		
1.10 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 and context as per national guidance	PPE donning and doffing video included in mandatory IPC training PPE safety champions leading individual staff competency assessment as per 1.5  PPE competency assessment form Oc		

1.11 National IPC guidance is regularly checked for updates and any changes are effectively communicated to staff in a timely way	Trust PPE guidance issued 31.3.20 and updated via designated PPE intranet page and updated as revised guidance is sent from PHE. Robust system for ensuring all guidance is collated and noted through emergency planning team  C0372-compendium-of-publications-and-c Chief Nurse and IPC nurse consultant on regular calls and webinars with CNO England/ regional NHSE/I calls Regular staff briefings and weekly CEO Webinar Weekly HAI meetings with DIPC, IPC and Heads of Nursing	Guidance at a weekend may be missed	Clear system for escalation Emergency planning team and director on call Guidance issued through Chief Nurse and CEO circulation lists
1.12 Changes to guidance are brought to the attention of boards and any risks and mitigating actions are highlighted	IPC was reported and discussed at the following senior/ board meetings; Executive Team GOLD command daily / twice weekly Silver tactical calls weekly Trust Board of Directors meetings on 30th April; 10th June; 22nd July; 30th September and 26th November 2020. Quality Committee with Board members on 13th May; 8th July; 9th September and 11th November 2020. Safety Quality Sub-Committee chaired by the Chief Nurse on 30th June; 13th August; 18th September; 20th October; 17th November and 15th December 2020. IPCD Committee attended by the Chief Nurse on 1st May and 16th July 2020, 29th October 2020.		
1.13 Risks are reflected in risk registers and the board assurance framework where appropriate	Risk register detailed PPE and IPC separately as potential risks. Latest risks reported to Quality Committee on 13th May; 8th July; 9th September and 11th November 2020. Monthly review of risk registers with Chief Nurse / IPC nurse consultant and Trust risk register lead. Risk registers reported at Trust Board and Quality Committee		

1.14 Robust IPC risk assessment processes and practices are in place for non COVID-19 infections and pathogens	IPC Committee reporting on all infections. Weekly review meeting (WRM) reviews all infections and pathogens- formal meeting chaired by Deputy Director of Nursing RCA for all other infections such as MRSA and CDiff as 'usual' mechanism for reporting and reviewing. Quarterly health economy review meetings for CDI/MSRA/MSSA cases		
1.15 Trust CEOs or the executive responsible for IPC approve and personally signs off, all data submissions via the daily nosocomial sitrep. This will ensure the correct and accurate measurement and testing of patient protocols are activated in a timely manner.	Process in place- IPCT-DIPC weekdays IPC nurse consultant reviews all cases daily with business and performance team Issues escalated to the Chief Nurse where necessary – Trust executive lead for IPC	Incorrect reporting at weekends of new Covid cases	SOP under review for out of hours use/reporting
1.16 Ensure Trust Board has oversight of ongoing outbreaks and action plans	Weekly review meetings, Reported by chief nurse to Gold command (x2 weekly and as required in response to events) Reported to Quality Committee		
1.17 Patients and staff are protected with PPE, as per the PHE national guidance	Trust followed PHE guidance at all times. Changes issued to staff in relation to PPE on 31st March, 2nd April, 14th April and 12th June 2020, 24th December 2020. Email from MC 31.03.20.docx PPE guidance for clinical staff v 1 020 PPE guidance for clinical staff v 2 140 IPC GUIDANCE AND USE OF FACE MASKS	Possible shortages of PPE in certain locations	Robust distribution of all PPE across Trust sites. Twice daily team sitrep reports introduced with central management. Trust dedicated PPE team working across BOB to secure supplies and products

	Guidance updated re RAG pathways re wearing of visors Management of admissions commu IPC intranet page developed so staff can find all information in one place with guidance on PPE, testing and hygiene. Updated regularly in line with national/ Trust guidance– screen shot embedded. Email sent daily to all staff highlighting any changes.  From 19th March 2020 the Trust introduced weekly and then twice daily sitrep reports from every clinical team. This included reviewing PPE stock levels, supplies and escalating any issues. Overseen by procurement team and discussed in daily escalation calls. COVID19 Pandemic Influenza Situation I		
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 are in place to ensure:			
2.1 Designated teams with appropriate training are assigned to care for and treat patients in COVID-19 isolation or cohort areas	Staff have all received IPC annual mandatory training. IPCT deliver training via inline teams, e-learning, videos and guidance. All patient facing staff asked to watch the PPE		PPE safety champions introduced in all inpatient areas

	guidance for health and social care- which is now part of mandatory IPC training. All staff / ward areas issued with: Approved PPE training package (including PHE videos' posters, donning and doffing guidance, flow charts)  Using PPE.pdf All staff issued with robust IPC guidance on intranet (see 1.5 above) and through HoN and Matrons. On 29th April 2020 Trust issued SOP and video on resuscitation during covid-19 for inpatient settings. Level 2 PPE recommended. This was in line with PHE guidance. Emailed to every manager of team with resus equipment.  2020-04-29 CPR During COVID-19 In In early May 2020 the community hospital wards completed an audit to look at how IPC guidance is being implemented within routine practices. 92 shifts were observed across 8 wards. The results across all wards were positive and helped to identify where further actions were needed. In May 2020 "Clinell time" was introduced at each shift handover, with staff taking a minute to clean common touch points at every handover and more frequency during outbreaks		Additional IPC training and resources provided and over 100 staff undertaking this role above PPE audit taken place in all inpatient settings

	All actions in place for community hospitals following audit- high percentage compliance All areas including MH and secure settings also now regularly completing audits		
2.2 Designated cleaning teams with appropriate training in required techniques and use of PPE, are assigned to COVID-19 isolation or cohort areas.	Cleaning staff have had all appropriate IPC training – increased cleaning schedules now in place. Guidance for domestics issued.  Guidance for housekeepers using Mandatory training records/content of IPC training. In addition, approved training package includes: PHE videos; posters, guidance, flowcharts		
2.3 Decontamination and terminal decontamination of isolation rooms or cohort areas is carried out in line with PHE and other national guidance	Environmental cleaning, linen and laundry procedure in place from March 2020.  CLEANING ISOLATION ROOM B		
2.4 Increased frequency at least twice daily of cleaning in areas that have higher environmental contamination rates as set out in the PHE and other national guidance	Enhanced cleaning and records introduced Environmental cleaning, linen and laundry procedure in place		
2.5 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	Chlorclean standard environmental agent, with clinell wipes for equipment https://gamahealthcare.com/latest/clinell-efficacy-against-coronavirus-covid-19		

guidance. If an alternative disinfectant is used, the local infection prevention and control team (IPCT) should be consulted on this to ensure that this is effective against enveloped viruses			
2.6 Manufacturers' guidance and recommended product 'contact time' must be followed for all cleaning/disinfectant solutions/products as per national guidance	As per 2.5 Included in mandatory training		
2.7 'Frequently touched' surfaces e.g. door/toilet handles, patient call bells, over bed tables and bed rails should be decontaminated more than twice daily and when known to be contaminated with secretions, excretions or body fluids	Clinell time introduced three times a day (handovers) in clinical areas. Increased to hourly when outbreaks on wards.		
2.8 Electronic equipment e.g. mobile phones, desk phones, tablets, desktops & keyboards should be cleaned a minimum of twice daily	Frequently used items/equipment are included in regular 'clinell' time cleaning on all wards at every handover and hourly when necessary. On handover sheet to remind shift coordinator		
2.9 Rooms/areas where PPE is removed must be decontaminated, ideally timed to coincide with periods immediately after PPE removal by groups of staff (at least twice daily)	Designated doffing rooms are included in the cleaning schedule	This may not coincide with all shift handovers	
2.10 Linen from possible and confirmed COVID-19 patients is managed in line with PHE and other	Environmental cleaning, linen and laundry procedure in place		

national guidance and the appropriate precautions are taken			
2.11 Single use items are used where possible and according to Single Use Policy	PPE guidance (see 1.5 above) and medical devices policy in place		
2.12 Reusable equipment is appropriately decontaminated in line with local and PHE and other national policy	Decontamination procedure in place Clear Trust guidance for staff for re-using any PPE - goggles/visors only (see 1.5 above)		
2.13 Ensure cleaning standards and frequencies are monitored in non-clinical areas with actions in place to resolve issues in maintaining a clean environment	Cleaning schedules are established for all areas including non-clinical		
2.14 Ensure the dilution of air with good ventilation e.g. open windows, in admission and waiting areas to assist the dilution of air	Guidance issued  Resuming services IPCT prinicples v2 02  Instructions for Safe use of spaces v		
2.15 There is evidence organisations have reviewed the low risk COVID-19 pathway, before choosing and decision made to revert to general purpose detergents for cleaning, as opposed to widespread use of disinfectants	 Management of admissions commu Same cleaning regime in place- chlorclean		
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 are in place to ensure:			

3.1 Arrangements around antimicrobial stewardship are maintained	Antimicrobial stewardship programme in place alongside all providers led by CCG IPCDC minutes DIPC annual report 2019/20 presented to Quality Committee on 7th July and presented at Trust Board on 22nd July 2020. 34(ii)_QC_OH DIPC annual report 2019-		
3.2 Mandatory reporting requirements are adhered to and boards continue to maintain oversight	Weekly Review Meeting, escalation to Executive Team weekly. Quality committee and Trust Board oversight.		
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 are in place to ensure:			
4.1 Implementation of national guidance on visiting patients in a care setting	18th March 2020 Trust suspended visitors/ contractors apart from in exceptional circumstances. On mental health wards visits were individually risk assessed (no blanket bans) and on community hospital wards we followed the national guidance issued on 25th March allowing exceptions for EOL patients. Visiting recommenced 1st July, under 1 patient/1 visit process- Visitor guidance issued and risk assessment introduced Visitor protocol agreement 14 Aug 2 Visiting in community hospitals was suspended on 23rd December 2020 due to increased cases of community		

	Covid-19. This was not blanket as there were exceptions for End of Life care Specific guidance was issued Mental health wards visiting and leave have continued on a risk assessment basis. https://ohft365.sharepoint.com/sites/COVID-19/SitePages/Guidance-for-leave-from-Adult-and-Older-Adult-wards.aspx Owing to the national lockdown the Trust has reverted to measures in line with national requirements in relation to visitors to all services (excluding extenuating circumstances)		
4.2 Areas in which suspected or confirmed COVID-19 patients are where possible being treated in areas clearly marked with appropriate signage and have restricted access	Signage on wards Trust standard isolation posters Information on all community hospital sites Information clearly marked on all MH wards		
4.3 Information and guidance on COVID-19 is available on all Trust websites with easy read versions	Trust intranet- designated covid page. https://ohft365.sharepoint.com/sites/COVID-19 Trust website has dedicated covid section and advice for the general public/ patients. https://www.oxfordhealth.nhs.uk/publication/coronavirus/ Easy read versions/ videos of all types of information available on Trust website developed by LD service		
4.4 Infection status is communicated to the receiving organisation or department when a possible or confirmed COVID-19 patient needs to be moved	Inter healthcare transfer form Referral letter Swabbing on discharge to care homes		
4.5 There is clearly displayed and written information available to prompt patients' visitors and staff to	Posters and patient information provided		

comply with hands, face and space advice.	Covid 19 Patient leaflet Dec 2020.pdf		
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:			
5.1 Screening and triaging of all patients as per IPC and NICE Guidance within all health and other care facilities must be undertaken to enable early recognition of COVID-19 cases	Processes in place for all admissions – screening on Day 1; Day 3 and Day 5-7 plus weekly screening of all inpatients across all inpatient services Outpatients are screened before attending and appointment letters include advice to contact team via phone if symptomatic or in contact with confirmed cases in the past 14 days As per 1.1		
5.2 Front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed COVID-19 symptoms to minimise the risk of cross-infection	Triage system with screening and designated areas Cohorting in community hospitals in place as per IPC team guidance (and other infection management) MH settings which have en-suite rooms can isolate patients Trust guidance on patient management/ cohorting/ testing (see 1.1. above) Isolation and seclusion guidance issued for MH and secure settings (see 1.1 above).	Concerns regarding non-consenting patients in MH and Secure settings	Clear Trust guidance in place for isolation and seclusion (see 1.1 above)
5.3 Staff are aware of agreed template for triage questions to ask	Embedded in guidance and SOP for admission / assessment		
5.4 Triage undertaken by clinical staff who are trained and competent in the clinical case definition and patient is allocated appropriate pathway as soon as possible	All inpatient areas and EMU's and urgent care pathways follow guidance re RAG pathways Management of admissions commur		

5.5 Face coverings are used by all outpatients and visitors	Guidance issued via posters for patients and included in appointment information	Patients may not wear face coverings	NHSE/I to develop national patient's information leaflet on using face coverings/masks
5.6 Face masks are available for patients with respiratory symptoms	Available in community services i.e. wards/EMU and risk assessed for safe use	Patients may not be able to wear	To record in patient notes if refused or cannot for clinical reasons wear face masks
5.7 Provide clear advice to patients on use of face masks to encourage use of surgical facemasks by all inpatients in the medium and high-risk pathways if this can be tolerated and does not compromise their clinical care	Guidance issued an available in all service areas.	In MH settings patients may not be able to wear face masks owing to safety and clinical risk reasons (Issued risk note in relation to this- must be risk assessed)	Reinforce importance of self-isolation and maintaining 2m distance, hand hygiene etc. Record in patient notes – rationale and risk assessment
5.8 Ideally segregation should be with separate spaces, but there is potential to use screens, e.g. to protect reception staff.	Screens installed in outpatients, EMU reception areas. Installed in psychological therapies / CAMHS neurodevelopmental pathway services where clinical assessment may indicate patients cannot wear masks		
5.9 For patients with new-onset symptoms, isolation, testing and instigation of contact tracing is achieved until proven negative	All patients are isolated and tested on admission and tested on Day 3 and Day 5 -7 days and if symptomatic or +ve - as per Trust IPC guidance Alert on Carenotes if COVID +ve Any patients returning from overnight leave in MH settings tested are tested as per guidance	Ensure we understand compliance	Record screening compliance
5.10 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	Alert on Carenotes if +ve MH guidance issued Screening guidance – see 5.9		
5.11 Patients that attend for routine appointments who display symptoms of COVID-19 are managed appropriately	All services prioritised in line with national community services guidance and MH guidance. Clear protocol for staff		

	Notices/signage in all areas telling public not to enter if displaying symptoms. Where possible appointments digital. PPE worn on all home and face to face visits / appointments – specific guidance for community staff regarding PPE, embedded is the general guidance, there was also specific guidance created with certain services ie dental team, school nurses for immunisations.  SOP Covid-19_OH_Carryi		
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:			
6.1 Separation of patient pathways and staff flow to minimise contact between pathways. For example, this could include provision of separate entrances/exits (if available) or use of one-way entrance/exit systems, clear signage, and restricted access to communal areas	All areas reviewed to ensure one way systems can be implemented in outpatients areas/urgent care, and where possible in community outpatient areas. In inpatient areas one way systems cannot be maintained given delivery of clinical care. All staff wear level 1 PPE.		
6.2 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	See evidence in 2.1 above for clinical staff. Non-clinical staff – IPC and mask guidance issued.   IPC GUIDANCE AND USE OF FACE MASKS Non Clinical staff USING A SURGICAL I Clear process for contractors led by estates		IPC/PPE safety champions introduced; training via webinars with another trust using this system- around 130 in place now across the Trust Community hospital wards decided the shift coordinator would be responsible for leading on PPE – ensuring it was being worn and used correctly.

	HoN and estates reviewing each inpatient area to ensure all IPC measures to prevent Hospital Acquired COVID are in place such as: social distancing in communal areas; use of paper towels; use of appropriate ventilation systems; frequent cleaning of all non-clinical devices such as PC; 'clinell time'		 To all CH wards from SB on covid ma
6.3 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	Approved PPE Training; Donning and doffing PHE videos; PHE posters, clear trust guidance, training presentations, community hospital audit. PPE competencies for every member of staff in inpatient care See 2.1 above.  PHE_COVID-19_visua l_guide_poster_PPE.pc		
6.4 A record of staff training is maintained	IPC annual mandatory training – (1.7) teams training, and e-learning in place. Local records held of mask fit testing training for aerosol generating procedures/ resuscitation. Training records held for all staff who have completed e-learning and L and D hold records for all those fit tested cross refenced with the mask tested		
6.5 Appropriate arrangements are in place that any reuse of PPE in line with the MHRA CAS Alert is properly monitored and managed	Trust guidance on re-usable PPE – googles and visors only (not gowns) to be cleaned with Clinell wipes  Management of eye protection 050121 v.		Audit of compliance in community hospitals and MH and secure settings
6.6 Any incidents relating to the re-use of PPE are monitored and appropriate action taken	All incidents related to PPE are reported on Ulysses system and monitored by governance team		

	Escalated when appropriate through to Clinical Director and then the weekly review meeting every Monday chaired by the Deputy Director of Nursing Report to Quality Committee on safety issues including all covid related incidents on 13th May; 8th July; 9th September and 11th November 2020.		
6.7 Adherence to PHE national guidance on the use of PPE is regularly audited	Trust guidance in place in line with national guidance. Audits of mental health and community hospitals in place and reviewed by directorates and heads of nursing- led by the PPE safety officers/ Matrons		
6.8 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 • maintaining physical distancing of 2 metres wherever possible unless wearing PPE as part of direct care • frequent decontamination of equipment and environment in both clinical and non-clinical areas • clear advice on use of face coverings and facemasks by	Posters in place  Resuming services IPCT prinicples v2 02  IPC GUIDANCE AND USE OF FACE MASKS  Back to Basics Poster v1 28 4 20.pdf  Covid-19 - Staff meeting guidance v2.  Covid-19 - Staff meeting signing in for  USING A SURGICAL MASK.pdf  123562-Oxford NHS Social Distancing Post		

patients/individuals, visitors and by staff in non-patient facing areas	As above 5.5		
6.9 Staff regularly undertake hand hygiene and observe standard infection control precautions	Trust issued basic IPC principles in form of an infographic for display on all wards and areas  Back to Basics Poster.pdf Posters relating to hand hygiene in place- demonstrating technique Trust guidance on all IPC measures on intranet. All Matrons and HoNs take lead role in ensuring adherence to basic hand hygiene and IPC measures Audits in place for compliance monitoring All measures reviewed weekly at HAC meeting chaired by Chief nurse		
6.10 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	No hand driers in place in clinical areas		

6.11 Guidance on hand hygiene, including drying should be clearly displayed in all public toilet areas as well as staff areas	Posters in place		
6.12 Staff understand the requirements for uniform laundering where this is not provided for on site	Trust guidance issued re uniforms as per PHE guidance All Staff working on MH and Secure wards issued with scrubs at start of pandemic  Keep your home a covid-free zone poste		
6.13 All staff understand the symptoms of COVID-19 and take appropriate action (even if experiencing mild symptoms) in line with PHE national guidance and other if they or a member of their household display any of the symptoms	Trust guidance on intranet. Central absence line to manage sickness. Daily briefing emails to all staff. Cascading information through Service Directors and Clinical Directors Visits from Senior nurses, matrons HoN leading on IPC measures Testing for symptomatic staff and members of their household in place.	Regular routine 2 weekly swab testing and 6 weekly antigen testing suspended due to availability	All staff now have access to the LFT kits to monitor twice weekly
6.14 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)	Attendance at Public Health Protection boards Weekly DIPC meetings Weekly NHSE/I regional DoN meetings Daily PHE alerts Weekly HAC meetings		
6.15 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	Process in place Single cases are reviewed and transmission investigation completed		

an outbreak investigation and are reported.	In cases of possible outbreaks the Trust reports via online system and manages via daily reviews and twice weekly outbreak meetings RCA's and SI's are completed for all outbreaks		
6.16 Robust policies and procedures are in place for the identification of and management of outbreaks of infection	 Outbreak Management proce Procedure in place		
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:			
7.1 Restricted access between pathways if possible, (depending on size of the facility, prevalence/incidence rate low/high) by other patients/individuals, visitors or staff	Process in place		
7.2 Areas/wards are clearly signposted, using physical barriers as appropriate to patients/individuals and staff understand the different risk areas	Signage in place (red, amber, green) in community hospitals Amber for mental health wards 2m distancing between beds, in bays		
7.3 Patients with suspected or confirmed COVID-19 are isolated in appropriate facilities or designated areas where appropriate	See evidence in 1.1 above. Confirmed +ve cases alerted via Carenotes Isolation guidance for MH		
7.4 Areas used to cohort patients with suspected or confirmed COVID-19 are compliant with the environmental requirements set out in the current PHE national guidance	See evidence in 1.1 above. Cohorting in community hospitals (as per other infection management)	Not possible to completely cohort in our MH settings	Using en-suite facilities to isolate +ve patients

	Management of admissions commur De-isolation flowchart		
7.5 Patients with resistant/alert organisms are managed according to local IPC guidance, including ensuring appropriate patient placement	Alerts of +ve patients on Carenotes Managed locally Multi Drug Resistant Organisms policy in place RCA of mandatory reportable bacteraemia's undertaken		
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:			
8.1 Ensure screens taken on admission given priority and reported within 24hrs	Results are checked daily by staff		
8.2 Regular monitoring and reporting of the testing turnaround times with focus on the time taken from the patient to time result is available	Results are checked daily by staff		
8.3 Testing is undertaken by competent and trained individuals	Specific testing team initially with appropriate training. Trust SOP issued when regular swab and antigen testing clinics introduced across the Trust. Covid surveillance SOP v2.docx Clear robust links with OUH Clinical Director overseeing testing system and process		
8.4 Patient and staff COVID-19 testing is undertaken promptly and in line with PHE and other national guidance	Clear trust guidance for staff and patient testing in line with national guidance.		

	Patient test results provided in Carenotes. Central absence line to manage staff sickness. Trust dashboard updated twice daily in order that Trust understands levels of infection daily for patients and staff.		
8.5 Regular monitoring and reporting that identified cases have been tested and reported in line with the testing protocols (correctly recorded data)	Process in place to validate positive result with exec oversight, as per PHE guidance		
8.6 Screening for other potential infections takes place	Process in place and results provided in Carenotes		
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:			
9.1 Staff are supported in adhering to all IPC policies, including those for other alert organisms	Trust IPC policy in place. IPC committee continued to meet on 1st May and 16th July 2020, 29th October 2020 and every quarter IPC agenda item on monthly Quality sub committee Weekly Review Meeting which captures all infections and associated RCA's. IPC team advice / IPC link nurses/PPE safety champions		
9.2 Any changes to the PHE national guidance on PPE are quickly identified and effectively communicated to staff	Chief Nurse, CEO and emergency planning team have alerts directly to their inbox. Changes identified and updated guidance issued on intranet and put in daily briefing to all staff. Communication via HON's and Clinical directors Chief nurse weekly meeting with HoN's and IPC nurse consultant Twice weekly communications bulletin for all staff via Chief Nurse and Medical Director in place		
9.3 All clinical waste related to confirmed or suspected COVID-19 cases is handled, stored and managed	Trust IPC policy and guidance. Comms/ designated intranet pages		

in accordance with current national guidance	National guidance issued and segregating waste guide provided.  C0140-covid-19-waste-management-gui  SEGREGATING WASTE in COVID.do		
9.4 PPE stock is appropriately stored and accessible to staff who require it	Procurement and distribution led by DoF and team. Clear process in place, central PPE coordination centre and PPE hubs. Daily teleconferencing and sit reps. See evidence under 1.4 above. Daily escalation process in place.		
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:			
10.1 Staff in 'at-risk' groups are identified using an appropriate risk assessment tool and managed appropriately including ensuring their physical and wellbeing is supported	Workplace screening assessment introduced for all staff. Trust introduced an electronic three-step process for rapidly implementing a comprehensive risk assessment and response strategy for our workforce: • Screening for all workers - new and existing • Personalised risk assessment and planning for those at higher risk • Actions and support for higher risk individuals and groups We have identified 'vulnerable' and 'at risk' groups and detailed risk assessment process in place. Local	Possible backlog of risk assessments causing delays for staff	Process in place with additional capacity if necessary

	bespoke interventions and plans developed for each individual involving Occupational Health where appropriate. Compliance monitored by executive team on a weekly basis BAME engagement / listening events in place to support specific issues Trust wide Psycho-social response group in place led by Associate Director of Psychological Therapies. Well being lead in place and supporting staff with a wide range of MH and well being support.  HWB poster.pdf  Psychosocial Response Group Staff  teams during COVID.c Recovery Days provided by pastoral team accessible to all staff		
10.2 The risk assessment(s) is (are) undertaken and documented for any staff members in an at risk or shielding groups, including Black, Asian and Minority Ethnic (BAME) and pregnant staff	All staff have completed a risk assessment. This risk assessment takes account of all risk factors and all staff in high risk group have an individual risk management plan which includes re-deployment where appropriate  COVID-19 Risk Reduction Plan for All		
10.3 Staff required to wear FFP reusable respirators undergo training that is compliant with PHE national	N/A		

guidance and a record of this training is maintained and held centrally			
10.4 Staff who carry out fit test training are trained and competent to do so	Train the trainer process in place with completion of sign off form Additional trainers have been provided by national PPE service to support training staff on the available FFP3 masks Trainer records are held with L&D External trainers providing extra training Trust lead for fit testing identified, providing weekly updates		
10.5 All staff required to wear an FFP respirator have been fit tested for the model being used and this should be repeated each time a different model is used	Full fit testing register in now in place. Capturing who needs to be fit tested for their role and when they have been fit tested with which mask. Training continuing for each specific mask	Difficulty in securing acceptable supplies	PPE orders working to secure stable supply of 2-3 mask models to enable fit testing of this models to take place in a timely way
10.6 A record of the fit test and result is given to and kept by the trainee and centrally within the organisation	Local records held and also collated centrally via L&D and linked to individual staff records- this includes fail rates and types of masks successfully fitted for each individual staff member	Gaps in training identified	Prioritisation of staff in higher risk areas i.e. undertaking AGP's
10.7 For 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	As 10.6		
10.8 For 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	As 10.6 Discussions with all staff who need re-deployment for a variety of reasons is taking place. A personalised action plan is then developed. See form below.  FORM 2 - personalised action pl		
10.9 A documented record of this discussion should be available for the	This is held within the staff risk assessment documentation		

staff member and held centrally within the organisation, as part of employment record including Occupational health			
10.10 Following consideration of reasonable adjustments e.g. respiratory hoods, personal re-usable FFP3, staff who are unable to pass a fit test for an FFP respirator are redeployed using the nationally agreed algorithm and a record kept in staff members personal record and Occupational health service record	This is part of the staff risk assessment process and records kept following any decision making	Review of process needs to take place to give full assurance	
10.11 Boards have a system in place that demonstrates how, regarding fit testing, the organisation maintains staff safety and provides safe care across all care settings. This system should include a centrally held record of results which is regularly reviewed by the board	SBAR produced identifying current situation with fit testing Report escalated to Quality committee if appropriate As above 10.6	 SBAR FFP3 fit testing update 161(	SBAR completed and discussed at IPCDC.
10.12 Consistency in staff allocation should be maintained, reducing movement of staff and the crossover of care pathways between planned/elective care pathways and urgent/emergency care pathways as per national guidance	System in place Wards closed when outbreaks occur in line with guidance Staffing solutions informed of any outbreaks and bank and agency workers movement minimised where possible Introduction of LFT for agency staff		
10.13 All staff should adhere to national guidance on social distancing (2 metres) if not wearing a facemask and in non-clinical areas	 123562-Oxford NHS Social Distancing Po		
10.14 Health and care settings are COVID-19 secure workplaces as far as	Recovery /estates guidance		

practical, that is, that any workplace risk(s) are mitigated maximally for everyone	COVID - Office V1 13-5-20.doc		
10.15 Staff are aware of the need to wear facemask when moving through COVID-19 secure areas.	Non Clinical staff USING A SURGICAL I		
10.16 Staff absence and well-being are monitored and staff who are self-isolating are supported and able to access testing	Central absence line to manage sickness established. Occupational health referrals where needed Personalised risk assessments for all staff. Employee Assistant Scheme (EAP) in place for all staff and their families to access Psycho-social group in place offering many wellbeing opportunities of support Testing guidance issued and staff self testing with lateral flow devices twice weekly		
10.5 Staff that test positive have adequate information and support to aid their recovery and return to work.	Trust guidance in place. Occupational health support if required Local manager support Bespoke local arrangements for phased return if needed COVID -19 WHAT TO DO IF YOU ARE A		