Royal United Hospitals Bath
NHS Foundation Trust

Report to:	**Public Board of Directors**	**Agenda item:**	**13.0**
Date of Meeting:	**29 July 2020**		

Title of Report:	**Annual Infection Prevention and Control Report 2019/20**
Status:	**For approval**
Board Sponsor:	**Lisa Cheek, Director of Nursing and Midwifery/Director of Infection Prevention and Control**
Author:	**Yvonne Pritchard, Senior Infection Prevention and Control Nurse**
Appendices	**None**

1. Executive Summary of the Report

The attached report provides a summary of the progress against the 2019/20 Annual Infection Prevention and Control Programme. Infection Prevention and Control is aligned to the priority objective of keeping patients safe and minimising harm, and the key standard of improving quality by reducing infections.

The report includes performance against national targets for MRSA, *Clostridium difficile*, Gram negative bloodstream infection reduction and mandatory surveillance of other infections.

Mandatory surveillance health care associated infection performance was as follows:

- MRSA bloodstream infections: 2 Trust apportioned cases
- MSSA bloodstream infections: there was a 22% decrease in these infections in comparison with last year however the Trust remains an outlier.
- *E coli* bloodstream infections: a total of 53 hospital onset cases were reported. This is a reduction of 13% on last year's performance.
- *Klebsiella spp.* bloodstream infections: 27 hospital onset cases were reported, an increase of 8 cases compared with the previous year.
- *Pseudomonas aeruginosa* bloodstream infections: 13 hospital onset cases reported, an increase in 2 cases compared with the previous year.
- *Clostridium difficile* infections: a revised Clostridium difficile objective was launched in 2019 where both hospital onset and community onset healthcare associated cases were apportioned to the Trust. 42 cases were reported, of these it was agreed that there were no lapses in care in 5 cases making the year-end total 37 against a trajectory of 59 cases.

The report also covers bed closures due to outbreaks of infection, COVID-19, antimicrobial stewardship, surgical site infection surveillance and environmental cleanliness.

2. Recommendations (Note, Approve, Discuss)

For approval.

3. Legal / Regulatory Implications

CQC Registration 2019/20
CQC Regulation 12: Safe Care and Treatment
CQC Regulation 15: Premises and Equipment

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

4.	Risk (Threats or opportunities, link to a risk on the Risk Register, Board Assurance Framework etc)
• 180 Insufficient isolation facilities (tolerated risk) • 1788 Loss of ICNet surveillance system	

5.	Resources Implications (Financial / staffing)
Potential financial penalty if *Clostridium difficile* objective is exceeded.	

6.	Equality and Diversity
None identified	

7.	References to previous reports
Annual Infection Prevention and Control Report 2018/19.	

8.	Freedom of Information
Public	

Royal United Hospitals Bath
NHS Foundation Trust

Infection Prevention and Control

Annual Report | 2019/20

Contents

Key:

Target met, Trust meeting standards, increase in performance from previous year

Target not met by narrow margins, Trust not meeting standards but evidence of improvement, slight reduction in performance from previous year

Target not met, Trust not meeting standards, significant reduction in performance from previous year

1 Executive Summary

Compliant
Health and Social Care Act 2008: Code of Practice on the prevention and control of infections

2
MRSA infections
Trajectory: 0

22%
Reduction in MSSA infections from 2018/19
30 cases

13%
Reduction in *E coli* infections from 2018/19
53 cases

8
More *Klebsiella spp.* infections than 2018/19
27 cases

2
More *Pseudomonas aeruginosa* infections than 2018/19
13 cases

22
Clostridium difficile cases less than the objective of 59 cases

2%
Fewer cases of Norovirus in closed areas compared to 2018/19
93 cases

182
Bed days lost as a result of Influenza closures
39 outbreaks

Antimicrobial Stewardship 2019/20 CQUIN Targets not met

1.7%
Above the national average for total knee replacement surgical site infections
National average: 0.6%

86.9%
Level 2 Infection Prevention & Control training compliance
Target: 90%

1.1 This is the annual report of the Director of Infection Prevention and Control (DIPC) and summarises the work undertaken at the Royal United Hospitals Bath NHS Foundation Trust to manage infections during the period 1 April 2019 to 31 March 2020.

1.2 The Trust is compliant with the Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance which was revised in July 2015. Compliance with the Hygiene Code was reviewed on a rolling programme at the Infection Prevention and Control Committee. Each criterion was assessed during the year and overall compliance reported

1.3 During 2019/20 there were 2 Trust apportioned MRSA bloodstream infections against a trajectory of 0.

1.4 There were 104 cases of MSSA bloodstream infections reported, of which 2 were reported for community providers. There were 30 hospital onset cases; a decrease of 22% on last year's reported Trust apportioned cases however the Trust remains a national outlier for these infections. There is currently no national reduction target for MSSA bloodstream infections however the Trust has introduced a 10% reduction target for 2020/21.

1.5 A 10% year on year ambition to reduce healthcare associated Gram negative blood stream infections was launched in 2017. This target is shared with the CCGs. During 2019/20 the Trust reported 344 cases of *E coli* bloodstream infection, this includes both hospital, community onset and community provider cases. There were 53 hospital onset cases; a 13% reduction on the previous year. The lower urinary tract remains the most common source of infection.

1.6 There were 109 *Klebsiella spp*. bloodstream infections were reported in 2019/20. 27 hospital onset cases were recorded; an increase in 8 cases compared with last year's performance.

1.7 There were 36 cases of *Pseudomonas aeruginosa* bloodstream infections. 13 hospital onset cases were recorded; an increase in 2 cases compared with last year's performance.

1.8 A revised *Clostridium difficile* objective was launched for 2019/20, the trajectory of 59 cases included both hospital onset and community onset healthcare associated cases. There were 42 cases of Trust apportioned *Clostridium difficile* infection reported of which there were no lapses of care in 5 cases therefore the year-end total was 37 cases. The Trust has introduced a 10% reduction target for 2020/21.

1.9 There were a total of 39 wards/bays closed during the period due to norovirus outbreaks. 273 bed days were lost as a result of the closures. There was a 53% decrease in lost bed days compared with the previous year.

1.10 There were 39 outbreaks of influenza between April 2019 and March 2020 which resulted in 182 bed days lost. This is an increase of 5% compared with the same time frame during 2018/19.

1.11 The antimicrobial stewardship programme has continued throughout the year. The 2019/20 CQUIN targets were not met.

1.12 Surgical site infections have reduced in patients undergoing repair of fractured neck of femur and total hip replacements however the number of patient reported infections that are associated total knee replacement remains above the national average.

1.13 The target for compliance with infection prevention and control Level 2 training did not meet the target; there were 86.9% of staff trained by the end of March 2019.

2 Key progress against objectives 2019/20

2.1 The team provided Trust wide updates on healthcare associated performance through infection prevention and control summits and presentations to the divisions. The updates have provided staff with performance data and a focus on where improvements need to be made.

2.2 Mandatory surveillance of health care associated infections has continued alongside the Infection Prevention and Control Team's key involvement with the COVID-19 pandemic. All cases have been reported through the Public Health England data capture system.

2.3 The Infection Prevention and Control Team (IPCT) have worked with the senior sisters to implement improvement projects within their areas. The projects have been targeted specifically at reducing *Clostridium difficile* and MSSA/Gram negative bloodstream infections.

2.4 Doors have been installed on bays throughout the Trust to improve cohorting facilities.

2.5 IPCT participated in wave 4 of the Improving Together programme. The main focus was on achieving a 10% reduction in hospital onset MSSA and E coli bloodstream infections and *Clostridium difficile* infections. An A3 was produced and presented to the Board and adopted by the Trust as a breakthrough objective. The 10% reduction in these infections was achieved and the objective has been carried forward to 2020/21 with aim of achieving a further 10% reduction in cases.

2.6 Other wards and departments who took part in Improving Together have also focused on reducing infections and the IPCT has taken part in huddles and provided support to the teams to achieve their goals.

2.6 IPCT were involved in the planning and commissioning of a number of building and refurbishment projects including C30 and external consultation with NHS Wiltshire CCG regarding the design of the integrated care centres in Trowbridge and Devizes.

2.7 IPCT led on fit testing staff for FFP3 respirators during the influenza season and also in preparation for COVID-19.

2.8 New hand hygiene posters were produced working collaboratively with the Communications Team.

2.9 IPCT undertook a Trust-wide audit of peripheral cannula insertion and maintenance. The results have been used to influence changes to the cannula care record and a review of practice.

2.10 IPCT led on equipment cleanliness audits; undertaking these monthly or weekly as required. An escalation plan was devised for areas that have not met the standard. An overall improvement in equipment cleanliness has been noted.

3 MRSA bloodstream infections

The reporting of MRSA bloodstream infections is mandatory for all NHS trusts. The Trust had a target of zero infections for the year 2019/20.

There were a total of 10 cases reported by the Trust during 2019/20. Eight cases were community acquired infections and two cases were recorded as 'Trust apportioned' as the blood cultures were taken more than 2 days after admission.

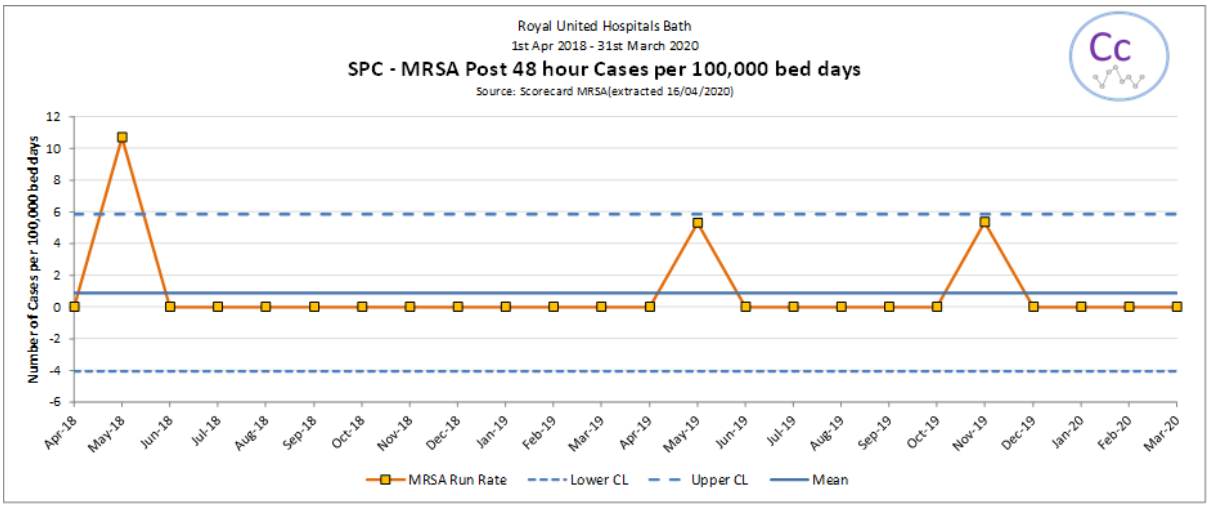


Figure 3: Trust apportioned MRSA bloodstream infection run rate

Actions taken

Post infection reviews were led by the IPCT for both hospital onset cases. The cases were also reported as Serious Incidents; these were investigated and reported through the Operational Clinical Governance Committee. Action plans were developed and these have been monitored by the relevant divisions through their governance structures.

See Appendix 14.2 for further information on these investigations and regional MRSA rates.

The IPCT worked collaboratively with the CCGs to investigate community onset cases and have shared action plans where required.

4 MSSA bloodstream infections

The mandatory reporting of MSSA bloodstream infections commenced on 1 January 2011. There are currently no reduction targets set for this infection; Public Health England (PHE) are collating data which may act as a baseline for trajectory setting in the future.

There has been an overall decrease in the number of MSSA bloodstream infections reported during 2019/20 compared with the previous year. There were 104 cases of MSSA bloodstream

infection reported; 2 were reported for community providers, 72 taken within 2 days of admission and 30 cases where the blood cultures were taken after 2 days. There has been a 22% decrease in hospital onset cases in comparison with last year.

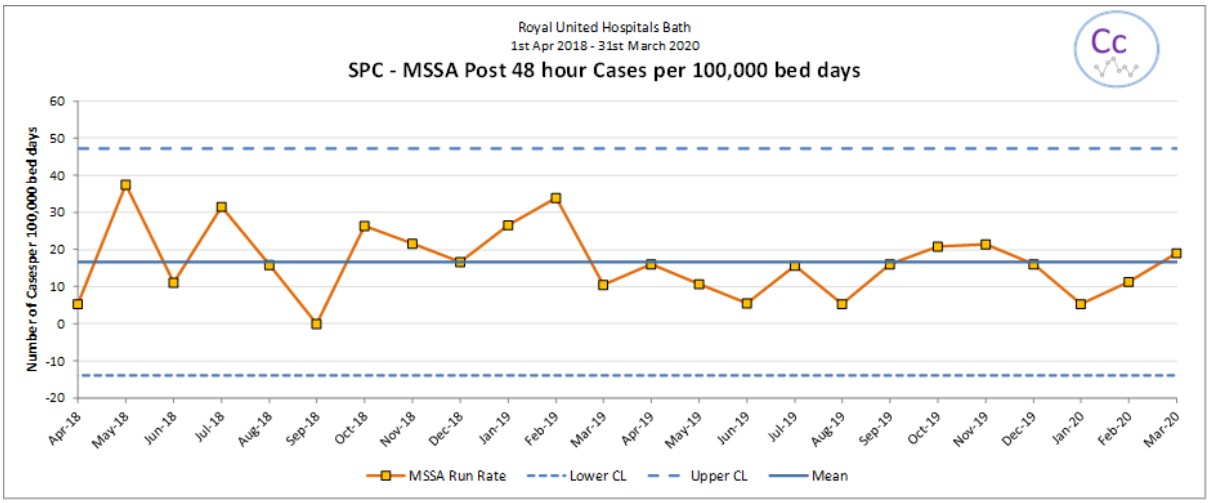


Figure 4: Trust apportioned MSSA bloodstream infection run rate

Actions taken

All cases of MSSA blood stream infection are assessed by the microbiologists or the Infection Prevention and Control Nurses who identify the potential source of infection. The microbiologists advise the clinical teams on treatment of the infection and follow these cases whilst they remain inpatients.

During 2019/20 a high proportion of Trust attributed MSSA infections were associated with vascular access devices. Infections associated with vascular access devices are almost always preventable; as a result a number of actions are being undertaken to reduce further infections:

- Only sterile gauze is used for line removal.
- All cannulation equipment stored in a clean location.
- Amended peripheral venous cannulation care record to include observation of site following removal.
- Refresher training for dressing application and skin decontamination.
- Revision of the Aseptic Non-Touch Technique workbook: staff assessment and sign-off by senior sisters.
- Cannulation audit pre and post implementation of the revised care record.
- Sharing of data at Infection Prevention and Control summits and divisional meetings.

See Appendix 14.3 for further information on these investigations and regional MSSA rates.

5 Gram negative bloodstream infections

5.1 *Escherichia coli* (E coli) bloodstream infections

During 2019/20 the Trust reported a total of 344 E coli bloodstream infections. This includes 3 cases that were reported on behalf of community providers. The 10% reduction target was achieved for hospital onset cases.

See Appendix 14.4.1 for more information

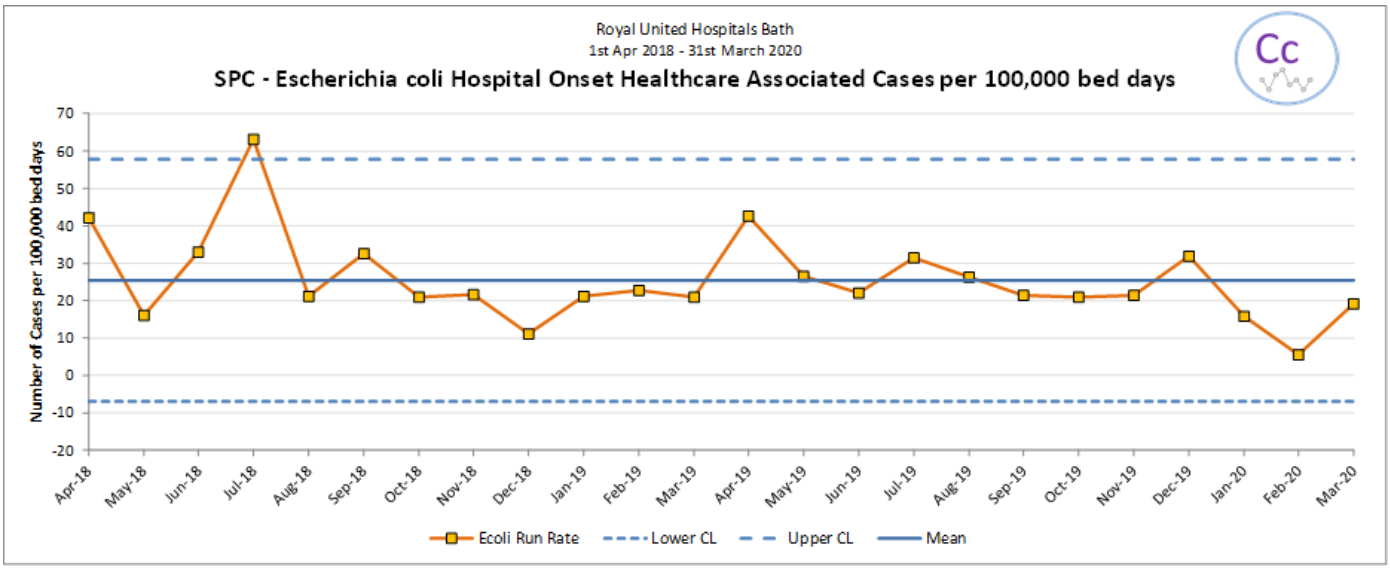


Figure 5.1: Hospital onset healthcare associated E coli bloodstream infections

Actions taken

The lower urinary tract is the most common source of these infections and it has been identified that dehydration is often an underlying issue. The Trust Nutrition and Hydration group have undertaken a spot check audit of hydration within inpatient settings and this demonstrated that there were areas where patients had a negative fluid balance and were therefore likely to develop adverse effects due to dehydration.

A number of actions were undertaken following the audit, these included:

- Trial of a hydration station for patients
- Purchase of larger cups for patients
- 'Droplet' trial: an electronic reminder to patients to drink more frequently

The actions have not been fully evaluated at the time of writing this report due to COVID activity however there has been feedback that all of the actions were received positively by patients or staff. There is a plan to re-audit in the next few months.

Actions taken to reduce E coli bloodstream infections should also have a positive impact on reducing infections from *Klebsiella spp.* and *Pseudomonas aeruginosa*.

5.2 *Klebsiella spp.* bloodstream infections

There were a total of 109 cases of *Klebsiella spp.* bloodstream infections reported during 2019/20. This includes two infections that were reported for community providers.

There were 27 hospital onset healthcare associated cases, 26 community onset healthcare associated cases and 54 community onset non-healthcare associated cases. There has been an increase in all of these categories in comparison with last year's performance.

See Appendix 14.4.2 for more information.

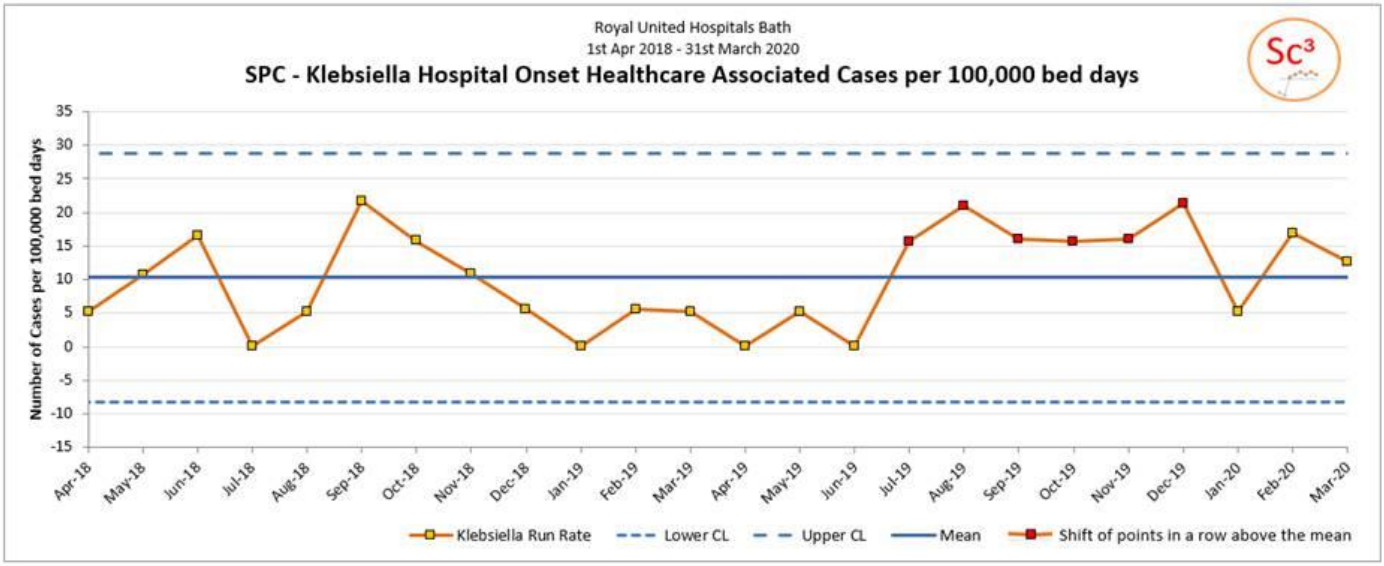


Figure 5.2: Hospital onset healthcare associated Klebsiella spp. bloodstream infections

Actions taken

All cases were reviewed by the microbiologists or the infection prevention and control nurses and the potential source identified. Lower urinary tract infections were the most common source (30%) of which 44% were urinary catheter associated. A notes review of the catheter associated cases has been undertaken and dehydration was identified as the most common theme.

5.3 *Pseudomonas aeruginosa* bloodstream infections

There were a total of 36 cases reported during 2019/20. There were 13 hospital onset healthcare associated cases, 6 community onset healthcare associated cases and 17 community onset non-healthcare associated cases. There has been an overall increase of 6 cases (20%) compared with last year.

See Appendix 14.4.3 for more information.

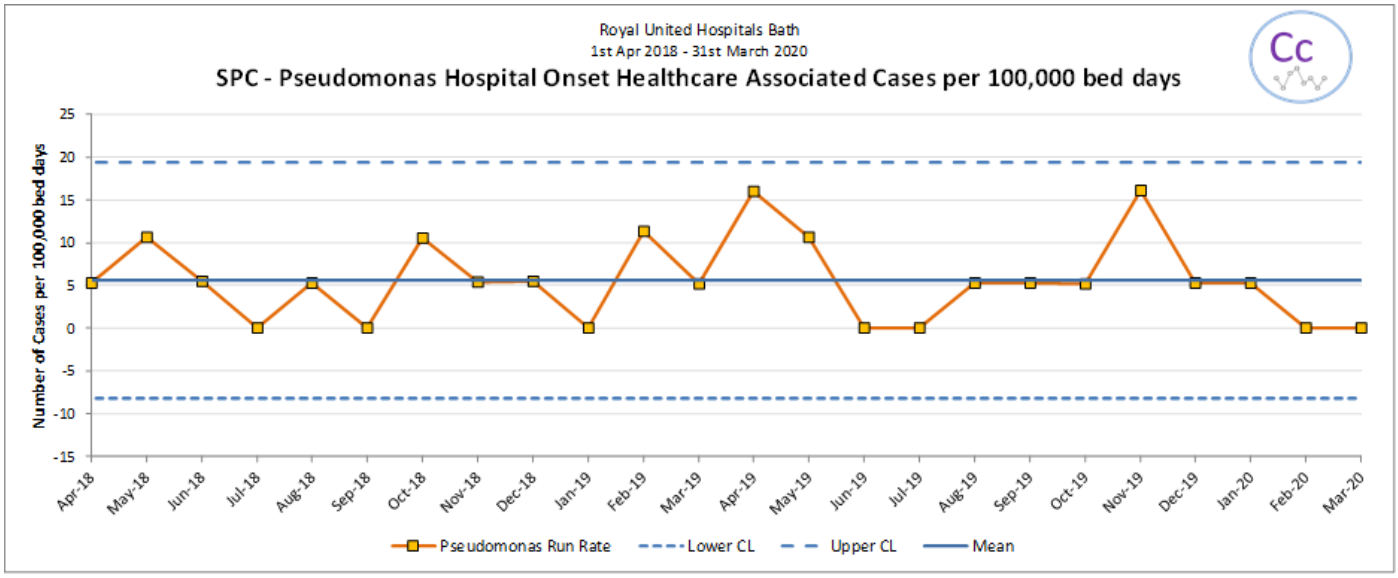


Figure 5.3: Hospital onset healthcare associated Pseudomonas aeruginosa bloodstream infections

Actions taken

Many of the patients with *Pseudomonas aeruginosa* bloodstream infections have other underlying conditions and it has been difficult to identify a source of infection in a large number of these cases. For those where the source has been identified the lower urinary tract remains the most commonly identified and more than half of these patients has urinary catheters. Notes reviews of the patients with catheters have been undertaken however due to the small numbers no significant trend has been identified.

6 *Clostridium difficile* infection (CDI)

For 2019/20 the Trust was set an objective (target) of 59 cases. New categories for assigning Trust apportioned cases were introduced in April 2019: cases where the sample has been taken 2 or more days after admission (hospital onset) and those where the sample has been taken within 28 days of discharge from hospital (community onset healthcare associated). The total number of Trust apportioned cases reported at the end of March 2020 was 42. Five cases were presented to NHS Wiltshire CCG who confirmed no lapse of care and there was agreement that these cases would not count against the trajectory although they remain as recorded cases. With these cases deducted the total number that counted against the objective was 37.

There were 24 hospital onset and 18 community onset healthcare associated cases. Two of the hospital onset and three community onset healthcare associated cases were found to have no lapses in care on investigation.

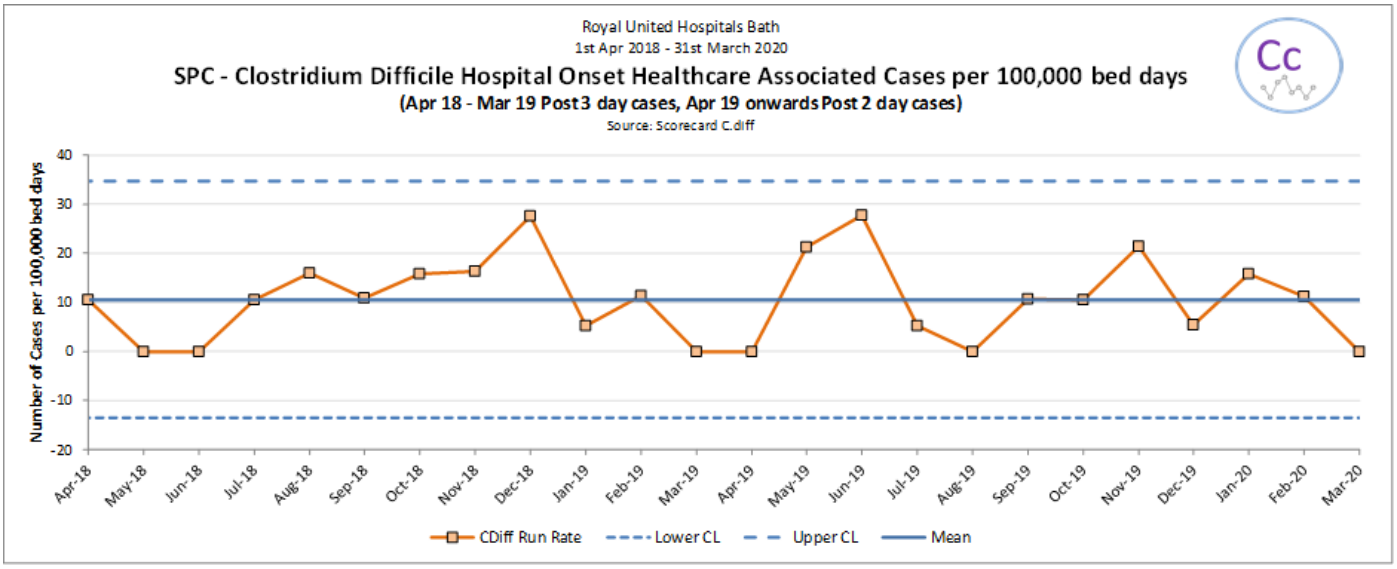


Figure 6: Hospital onset CDI run rate

Actions taken

The *Clostridium difficile* improvement plan has been amalgamated into an overarching healthcare associated infection improvement plan. Actions to reduce the incidence of *Clostridium difficile* infection include:

- Fortnightly senior sisters meetings to share data and review improvement strategies
- Weekly walkabouts by the DIPC and IPC Team to review cleanliness, condition of the environment and to speak with staff regarding infection prevention and control issues
- Revision of the RCA process to improve attendance at meetings
- Continued rollout of the antibiotic review kit (ARK)
- Introduction of a new cleaning auditing programme to meet with the revised National Standards of Cleanliness
- Trust wide focus on cleanliness of patient equipment with regular audits undertaken

The Trust requested a supportive visit for management of *Clostridium difficile* from NHSE/I early in 2019 however this was delayed due to availability of the visiting team. The visit took place in July 2019 and a feedback report was received. All issues identified within the report have been addressed and were included in the healthcare associated infection improvement plan.

See Appendix 14.5 for further information and regional CDI rates.

7 Norovirus

During 2019/20 there were a total of 39 closures due to outbreaks of diarrhoea and vomiting. These comprised of 9 full wards and 30 bay/partial ward closures. There were a total of 273 bed days lost as a result of these closures and a total of 93 confirmed cases of norovirus. There was a 53% decrease in the number of bed days lost compared with the previous year however there were only 2% fewer confirmed cases of norovirus on the closed areas.

The majority of infections occurred during November 2019 and February 2020. There were no closures due to norovirus in August and October 2019.

See Appendix 14.6 for further information and a breakdown by ward of closures.

Actions taken

The Trust takes part in voluntary surveillance of norovirus outbreaks; these are reported to Public Health England via a database. This information is used to show regional trends in norovirus infection and helps with predicting when major outbreaks are likely to occur. Norovirus often occurs in cycles and it is recognised that there will be peaks of infection every few years.

When a ward or bay is closed due to an outbreak the IPCT visit the area twice a day to document and monitor the severity of symptoms. During the winter months the team provide an on-call service for weekends and bank holidays so that closed wards can continue to be monitored and decisions to reopen areas can be made without having to delay until the next working day. Outbreak meetings are held at least once a day during the week if there are areas closed; plans for reopening the areas are made in consultation with divisional staff, the Site Team and Hotel Services (now Facilities).

8 HCAI associated deaths

All deaths where HCAI is recorded on the death certificate in part I, the primary cause, are reported as Serious Incidents (SIs) by the Trust. For each SI a root cause analysis investigation is carried out in order to identify possible causes and actions to be taken to prevent similar incidents. These incidents are also reported on the Strategic Executive Information System (StEIS).

During 2019/20 there was one HCAI associated death reported. MSSA bloodstream infection was reported as the joint cause of death along with pneumonia in part 1a of the patient's death certificate, see 13.8. The death has been investigated and it was identified that the probable source of the MSSA infection was an infected peripheral venous cannula site. The root cause analysis was reviewed at the Infection Prevention Control Committee and via the divisional governance structure and an action plan has been completed.

9 Influenza

Influenza A was the predominant strain during the influenza season of 2019/20; there were no ward closures due to Influenza B. The influenza season started earlier than in previous years however the majority of bed closures happened in December 2019 and January 2020. There were 182 bed days lost due to influenza bed closures; a 5% increase in closures in comparison with the previous year however the figures include outbreaks that occurred in April and May 2019 which were part of the previous season.

The use of the cohort ward (Parry) commenced in December 2019 and remained in use for 6 weeks. The beds on Parry were held for patients who were admitted with influenza and this helped to free up side rooms that could be used for patients with other infections across the Trust.

See Appendix 14.7 for further information and a breakdown by ward of closures.

Actions taken

On site testing for influenza continued throughout the winter and the laboratory offered extended opening hours when required. A total of 2564 rapid influenza tests were carried out in the RUH Microbiology laboratory: 419 tested positive for Influenza A and only 23 tested positive for Influenza B.

Testing for other respiratory viruses has continued to be available via the laboratory at Southmead Hospital.

10 Antimicrobial stewardship (AMS)

10.1 Staff update

Antimicrobial Stewardship Microbiologist – The post holder will be on Maternity Leave from June 2020. Whilst microbiologists offer some AMS work through their MDTs, ward rounds and clinical advice there will be no lead for AMS until September 2021. There was a business case submitted in February for a 5th microbiologist to increase infection control, AMS and general microbiology capacity. In relation to AMS, the RUH currently provides 1.5 Pas for the AMS lead. Benchmarking shows that most Trusts of equal size have 4 – 5 Pas for this role. In order to support AMS fully and activities such as the anti-fungal stewardship CQUINS the time dedicated to an AMS lead needs to increase. The business case was not successful but has been re-submitted in May 2020 due to Covid highlighting the high pressures on this department.

Antimicrobial Stewardship Pharmacist – The post holder is on Maternity Leave until August 2020. Interim cover has been provided on a part-time basis however the cover will cease on 31 May 2020.

If both roles were covered the Trust would still remain below regional/national average for staffing for AMS activity per 100 beds.

Actions taken

An action plan has been drafted alongside the board assurance framework which highlights the need for the 5th consultant post and the business case is currently being reviewed.

The Chief Pharmacist and lead for pathology are planning to review AMS using an A3 with support from the coach house with a view to producing a 5 year plan and framework for the Trust AMS. There may be a resource implication for this but the initial aim is to identify the need better.

The Chief Pharmacist has agreed to fund the current interim AMS pharmacist for longer so that they can train the returning pharmacist and provide extra support.

10.2 Antimicrobial stewardship activities

AMS Activities	Description	Issues
Comittee	Quarterly meetings, report to IPCC	April cancelled due to COVID -19
AMS Rounds	ICU, NICU, Haematology/oncology, *C.difficile*, rotating general ward. Trial AMS pharmacist to daily MAU board round. Limited capacity to continue with staff gaps over next 6 months.	NHS Benchmarking Nov19–RUH below national average AMS ward rounds/100 beds. Physical rounds interuppted by COVID -19.
C. difficile	Weekly rounds, contribution to RCA's, data on potential causitive antibiotic trends, primary care feedback of non guideline use of antibiotics.	
CQUIN/ MOP/Standard contract	19/20 UTI >65/colorectal Q4 abandoned. 20/21 CAP/UTI global - on hold until review in July. Antifungal stewardship – Q1/Q3 only achieved. Consumption target – await national admissions data.	No capacity for Anti Fungal Stewardship team with current staffing to meet Q2/4 targets.
Regional	Peer review of AMS pharmacy service by Salisbury completed. Currently recruiting to Regional AMS Lead – to engage with new post and STP/ICS leads. Regional AMS capacity benchmarking completed.	
Training	Level 1 - mandatory all pt facing staff. Level 2 update ongoing. Regular clinical pharmacists training, IPC nurse study day (ARK)	Issues with ESR incorporating ARK training package. Panel meeting cancelled twice.
Audit	Trustwide compliance audit. Vancomycin/gentamicin therapeutic levels/avoiding toxicity. ED antimicrobial use – guideline compliance. Clarithromycin guideline compliance. Penicillin allergy documentation on admission. Carbapenem review – 2 x per week.	
Guidelines	Updates: Adult Empirical Treatment, Surgical Prophylaxis, Paediatric Empirical Treatment, Fungal Infection – critical care and haemotology/oncology, Gentamicine/Vancomycin/Teicoplanin prescribing and monitoring, CAP guidance, Skin and Soft Tissue infections. Rapid dissemination COVID guidance via microguide. Sepsis care plan on ePMA.	Microguide cost increasing 10 fold Sep 2020. Review of continued use Vs Survive on Call – locally developed app.
Safety	Gentamicin/Vancomycin prescribing process update. Review of OPAT prescribing processes – ongoing. Exploration Penicillin delabelling project- liaise with Bristol/Regional AMS group – ongoing.	
Covid 19 response	Feedback to NICE rapid reviews for CAP treatment. Trials intranet info/drug procurement. PCT testing intro/audit. For inclusion in NIHR rapid research on use in COVID 19.	

Comms	World Antibiotic Awareness Week Nov 2019, Antimicrobial Stewardship Newsletter May 2019	
NHSI review July 2019	AMS resources to be ring fenced. AMR group/ ARK delivering improvements, advised prepare a business case to continue work long term – **to present strategy for AMS to CGC, date TBC** Overarching infection control /AMS strategy development and supporting improvement plan to focus on top risks for clear and firm frame for delivery.	CGC slot postponed March, cancelled May.

10.3 Antimicrobial CQUIN Performance 2019/20

Colorectal surgical prophylaxis

	Q1	Q2	Q3	Q4
Percentage of antibiotic prophylaxis prescriptions achieving CQUIN compliance	**80.0%**	**81.5%**	**81.0%**	**N/A**
Compliance is defined as single dose or appropriate further dose AND guideline compliant (YY) **Target = 90%**				

UTI inappropriate diagnosis and treatment >65 years

	Q1	Q2	Q3	Q4
Percentage of lower UTI prescriptions achieving CQUIN compliance	**55%**	**71%**	**81%**	**N/A**
Compliance is defined as diagnosis AND management of lower UTI compliant with guidelines **Target = 60% - 90%**				

CQUIN 2020/21 has been postponed until April 2021. AMR

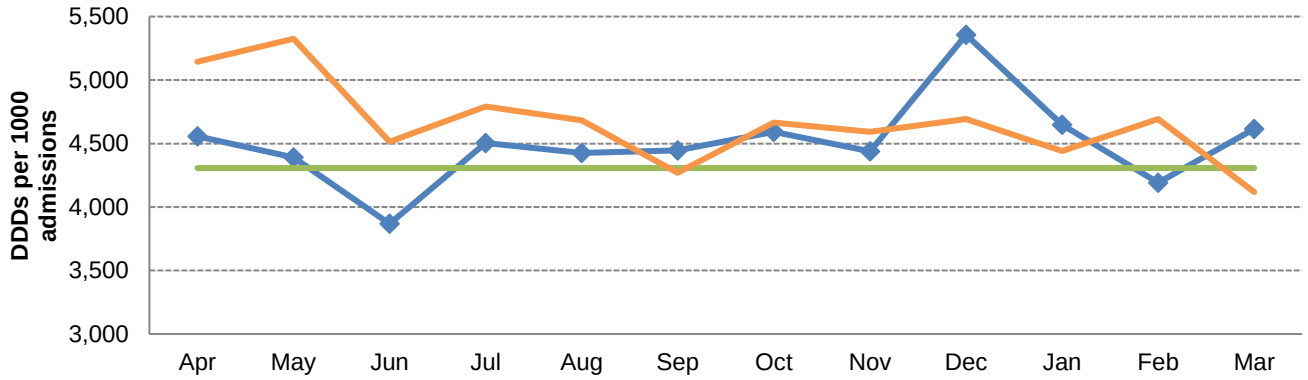
CQUINS will focus on Community Acquired pneumonia (CAP) and urinary tract infection (UTI) across all patient groups.

Actions

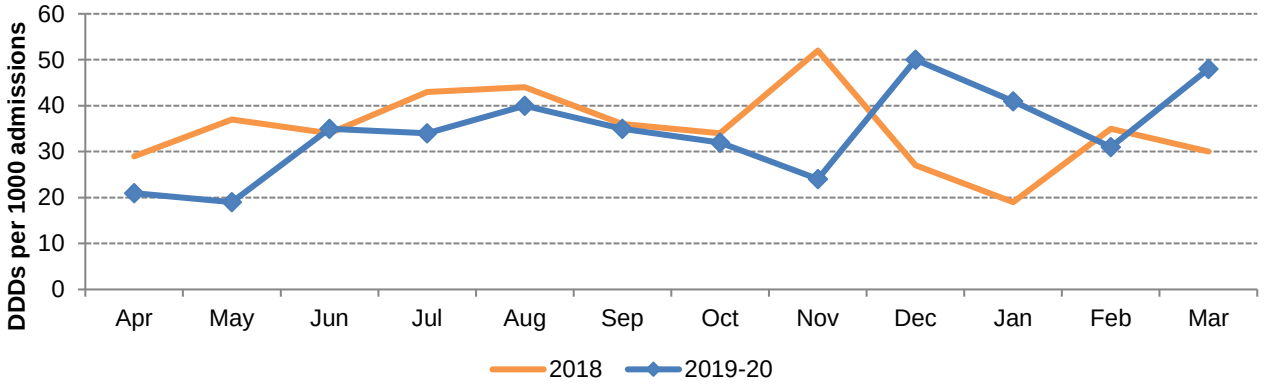
CAP – current daily review of co-amoxiclav prescribing in response to increased volume of use (and C.difficile numbers). Audit from microbiology and AMS pharmacist on clarithromycin prescribing has also highlighted inappropriate prescriptions and gaps in CAP treatment pathway regarding urinary legionella testing and response to results. Group to meet including microbiology and respiratory and acute medical physicians to improve practice. Reviewing option to create a care plan for CAP management within millennium to incorporate diagnostic pathway and treatment meeting goals of UK 5 year AMR action plan. If successful a similar approach could be taken to UTI management.

Antimicrobial Consumption

(a)Total Consumption
Provisional figures – reduction on 2018 but 1% target not met. Await final admission figures (9 month delay 2018/19).



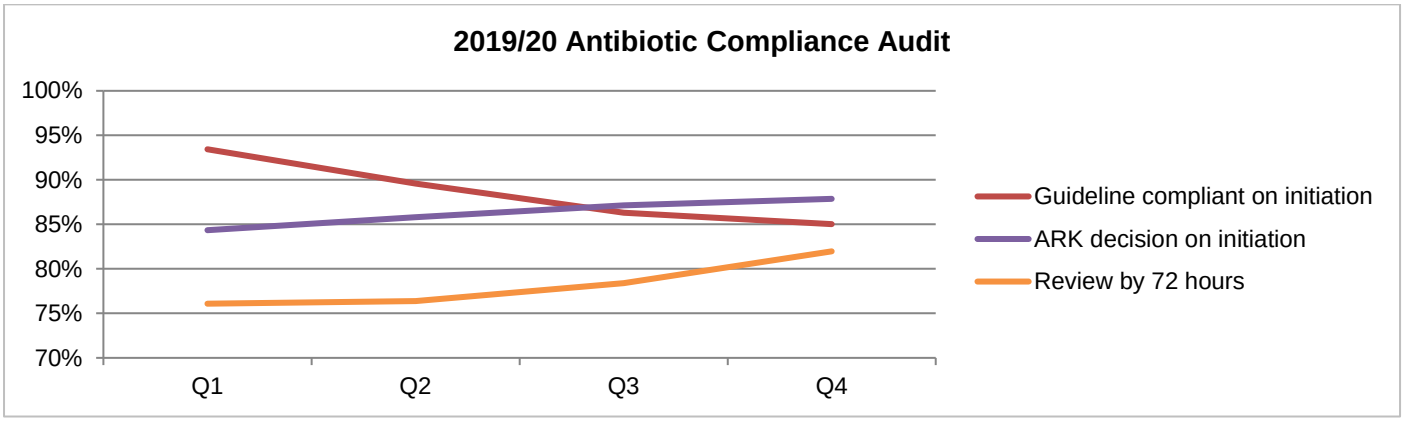
(b)Carbapenem consumption
Await confirmed admission figures for final consumption. Mirrors previous year and usage remains low compared to regional/national figures.

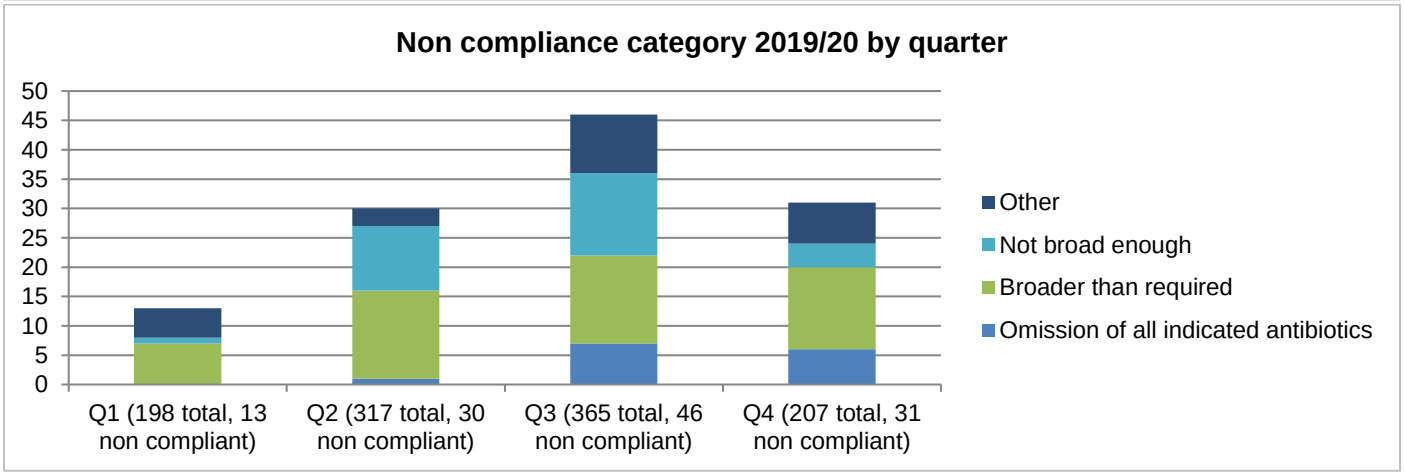


Action
Aim to have ARK mandatory training live prior to new cohort of doctors joining in Summer 2020 to encourage improved compliance with antimicrobial prescribing guidance, early review of antimicrobial therapy and appropriate early intravenous to oral switch. Antimicrobial pharmcist to provide data on performance of specilities to clinical pharmacists for feedback and discussion at clinical governance groups 3 monthly.
Plan for audit to take place in conjunction with Bath University in Autumn 2020, if all permissions in place, comparing diagnostic criteria and course lengths in common infections such as CAP, HAP, IECOPD and pyelonephritis with NICE guidance to prioritise areas for potential intervention to safely decrease antimicrobial consumption in common infections.

Training Compliance
Level 1 = 78%, Level 2 = 70%. Lowest compliance amongst Bank staff.

Guideline Compliance Audit
Audit of 1086 infections treated with antibiotics over 12 months.





Antimicrobial Stewardship at the RUH is important to improve antibiotic prescribing, protect individual patients and the local population from unintended harm from antibiotic overuse including HCAI's, and contribute to slowing antibiotic resistance.
We are committed to following the principles outlined in the DoH guidance "Antimicrobial Stewardship: Start Smart then Focus" and follow the guidance and processes set out in NICE NG15 and the Public Health England 5 and 20 year action plans on AMR
https://www.gov.uk/government/collections/antimicrobial-resistance-amr-information-and-resources#strategic-publications

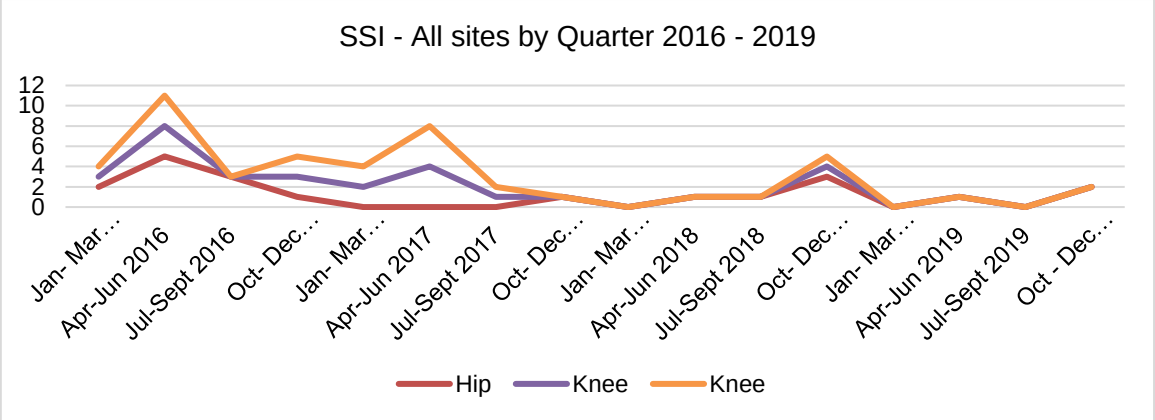
11 Surgical Site Infection Surveillance

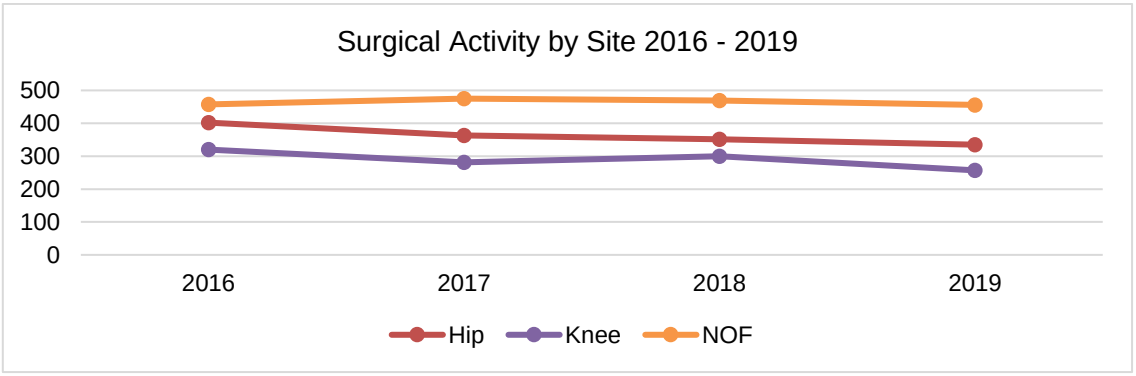
The Trust takes part in the mandatory surveillance of surgical site infections which involves the reporting of infections post-operatively in patients undergoing certain types of Orthopaedic surgery. This includes surveillance of patients prior to and post discharge and also patients who are readmitted with post-operative infections. If the infection has occurred within 30 days of the surgery, or in the case of implant surgery within one year, the incident will be reported as a surgical site infection.

The surveillance nurses are employed by the Surgical Division, and during 2019 they reported on surgical site infections in patients who had undergone hip replacement (THR), knee replacement (TKR) and repair of a fracture to the hip.

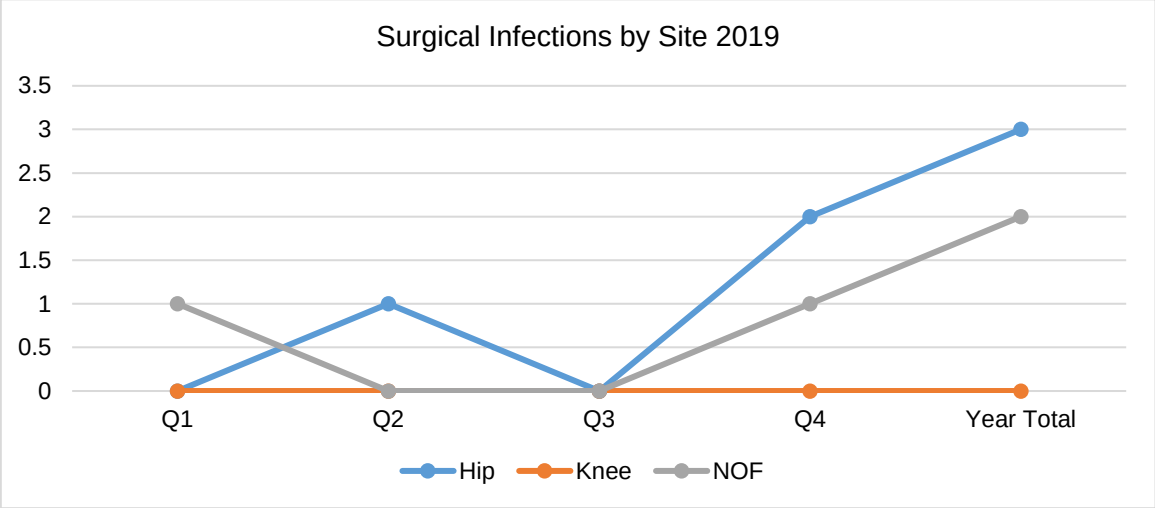
The surveillance nurses have also collected and reported data for the 12-month period on certain types of Breast surgery however this is not mandatory.

Significant work was undertaken in the previous reporting period that focused on a number of areas such as high level theatre cleaning, Infection SBAR investigations and review by Consultant Surgeon and reporting into Infection Prevention and Control Committee. Bi-monthly Surgical Site Infection Surveillance Working Group continues to meet to monitor and support the recommendations in the previous reporting period.





12 infections were reported in the 4 quarter period. 7 (58%) of the infections were patient reported and are not reportable to the PHE. Patient reported infections accounted for 68% of non-reportable surveillance in the previous reporting period. This is a reduction but remains an area of focus for the service. RUH surveillance for THR, fractured neck of femur and TKR account for 0.3%, 0.1% and 2.3% respectively. National averages indicate 0.3%, 0.1% and 0.6% across the same sites which would indicate the RUH to be an outlier for patient reported infections on TKR surgery.



12 COVID-19

12.1 SARS CoV-2

In December 2019 a cluster of cases of pneumonia of an unknown source in China were reported to the World Health Organization. In January 2020 it was identified that a novel coronavirus, SARS CoV-2, had been identified as the cause of the outbreak. The disease associated with the virus is known as COVID-19. The virus has since circulated worldwide and the World Health Organization declared a global pandemic on 11 March 2020.

The first suspected case of COVID-19 was screened at the Trust on 23 January 2020. This was followed by a number of patients who had travelled from affected regions and were also screened at the Trust. The Infection Prevention and Control Team led the screening programme, taking referrals from Public Health England and NHS 111 until mid-March 2020 when the volume of referrals increased significantly. Screening of patients was taken over by the Emergency Department and admitting wards. The first case to be confirmed at RUH was on 11 March 2020.

The pandemic has been challenging for all health and social care providers however staff at the Trust have worked collaboratively to ensure that patient safety is maintained and to protect health care workers from acquiring the infection.

Cohorting of suspected and confirmed cases commenced in March. All patients with suspected infection were either isolated or admitted to a cohort area, where beds were at least 2 metres apart. If a positive result was reported the patients were transferred to one of the confirmed cohort wards. Patients with COVID-19 requiring Intensive Care support were nursed in the Day Surgery Theatres that were staffed by ICU staff and reservists from other areas within the Trust.

The Infection Prevention and Control Team have been heavily involved with the planning aspects of patient placement and with advice on personal protective equipment. The team advised on a local policy that has been agreed for staff to cease wearing their uniforms to and from work and they arranged for hand dispensers to be installed in all public areas around the Trust. The team also led on fit testing for FFP3 masks until this was taken on by a dedicated team of fit testers.

A number of Estates works have also been required to ensure that patients with suspected or confirmed COVID-19 can be physically separated from patients who do not have the infection, for example doors have been fitted on bays throughout the Trust. The Infection Prevention and Control Team have worked closely with Estates and Facilities to advise on the infection prevention and control aspects related to these works.

A major part of the Infection Prevention and Control Team's role has been to review the guidance that has been published and updated by Public Health England and other national bodies. The guidance has been adapted into local policies and standard operating procedures. Any changes in guidance are communicated through the Trust Silver and Gold meetings and by the Communications Team in daily staff briefings.

On 31 March 2020 there had been a total of 88 confirmed COVID-19 cases and 13 deaths from the disease reported by the Trust.

13 Level 2 Infection Prevention and Control Training

Level 2 infection prevention and control training is mandatory for all patient-facing staff. Until December 2019 staff had a choice of how they received this training; either face to face training delivered by the IPCT or by e-learning. The Strategic Learning Committee took the decision to stop the classroom based sessions in December 2020. There were a number of staff who approached the IPCT requesting for face to face sessions as they had difficulty with accessing e-learning so the team reinstated some sessions however as these were poorly attended they have since ceased.

The Trust has a target of 90% compliance with Level 2 infection prevention and control training; in April 2020 the overall compliance was 86.3% however two divisions had achieved the 90% target. This is a decrease in training compliance in comparison with last year when 89.9% had been achieved at year end.

Division	Training compliance
Bank	67%
Corporate	88%
Estates and Facilities	86.9%
Medicine	90.4%
Non-Paid and Recharge	57.1%
Research and Development	97.4%
Surgery	89.9%
Women and Children's	89%
Trust	**86.3%**

14 Appendices

14.1 Infection Prevention and Control Team (IPCT) Structure and Arrangements

14.1.1 The Infection Prevention and Control Arrangements

The Chief Executive holds the ultimate responsibility for all aspects of infection prevention and control within the Trust.

The Director of Nursing and Midwifery is the designated executive lead; Director of Infection Prevention and Control (DIPC). She reports directly to the Chief Executive and the Board and she is the chair of the Infection Prevention and Control Committee (IPCC). The Director of Nursing and Midwifery is the Senior Infection Prevention and Control Nurse's line manager.

The Infection Control Doctor (ICD) is a consultant microbiologist who provides expert microbiological advice and supports the DIPC. The ICD is the deputy chair of the IPCC.

The Senior Infection Prevention and Control Nurse is responsible for the operational management of the Infection Prevention and Control Team (IPCT) and for ensuring that the Infection Prevention and Control Strategy is embedded.

The Infection Prevention and Control Nurses (IPCNs) provide expert clinical advice and support to Trust staff in the delivery of the Strategy. The team covers all sites within the Trust including the community birthing centres.

The team also provided cover via service level agreements for Avon and Wiltshire Mental Health Partnership NHS Trust (AWP) and the Independent Health Group.

14.1.2 The Infection Prevention and Control Team

The team is made up of the following staff:

- 1 WTE Senior Infection Prevention and Control Nurse Band 8a
- 1 WTE Infection Prevention and Control Nurse Band 7
- 2.5 WTE Infection Prevention and Control Nurses Band 6
- 0.8 WTE Surveillance and Administration Assistant Band 3

One of the full time band 6 posts was vacant for six months and was recruited to in November 2019. The Surveillance and Administration Assistant post was also vacant for two months. The post has been recruited to.

The Infection Control Doctor role is shared by two consultant microbiologists. From November 2019 the Lead Infection Control Doctor was on maternity leave therefore the Deputy Infection Control Doctor has covered this post with support from one of the other microbiologists.

14.1.3 Infection Prevention and Control Committee governance and reporting structure

14.2 MRSA bloodstream infections

Case 1 was a patient who was homeless and an intravenous drug user. The patient was non-compliant with treatment and despite extensive investigation no clear source was identified for the infection.

Case 2 was a patient who was also an intravenous drug user and was admitted with an infected groin injection site.

In both cases it was established that infection was unavoidable and the patients were eventually discharged when medically fit.

Four of the community onset cases were also intravenous drug users. Samples from all of these patients, including those with hospital onset of infection, were typed and it was identified that they match the strain of MRSA that has been isolated in the intravenous drug user population within the Bristol area where clusters of MRSA infections have been found. As a result all patients with a history of intravenous drug use are now screened for MRSA on admission and decolonisation commenced to prevent potential contamination of wounds.

14.2.1 MRSA bloodstream infection regional benchmarking

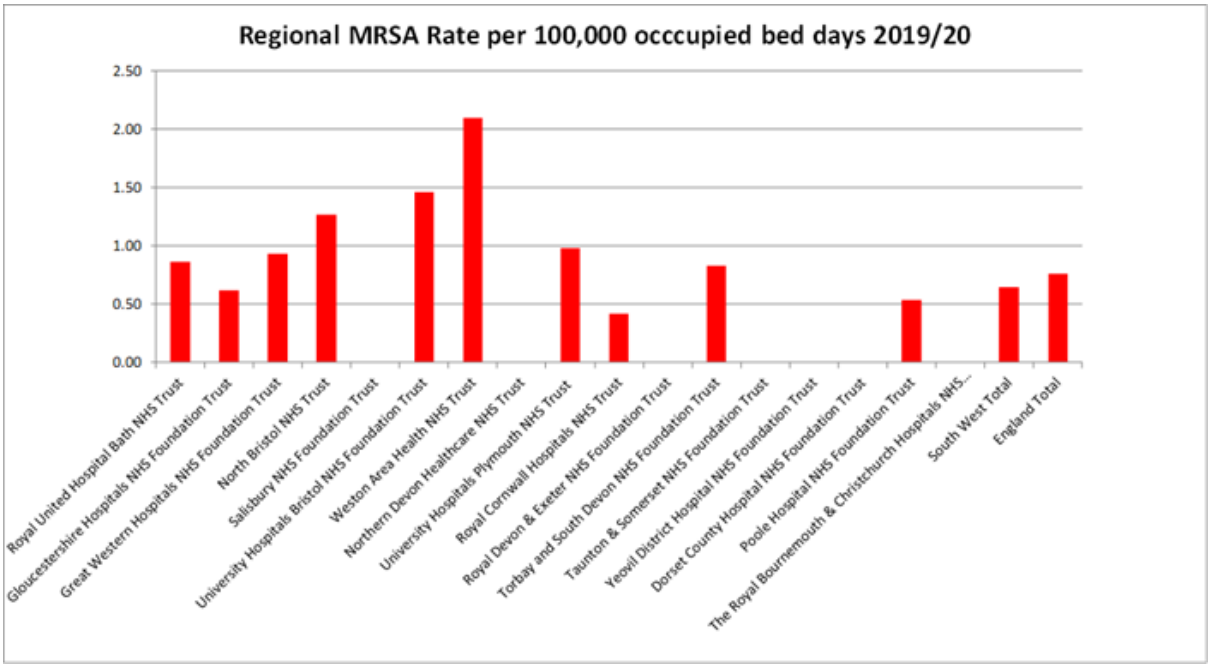


Figure 14.2: Regional MRSA rates 2019/20

The Trust has the sixth highest rate of MRSA bloodstream infection within the region and the rate is currently higher than the national average. The improvement work that is being taken forward to reduce MSSA infection should also reduce MRSA acquisition. This work along with improved targeted MRSA screening compliance will be monitored closely and performance will be reported through the existing Infection Prevention and Control governance structures.

14.3 MSSA bloodstream infections

Line associated infections accounted for more than half of the hospital onset MSSA bloodstream infections. These infections are avoidable however despite interventions that were introduced in 2019 we have only seen a small reduction in these cases.

MSSA blood stream infections were identified as our greatest challenge during the infection prevention and control summits last year. Improvement work was commenced, led by the senior sisters and matrons, and this has helped to focus teams on making small sustainable changes to reduce the risk of infection. These changes include:

- Revision of the peripheral venous cannula care record
- Switching to sterile gauze for dressings when removing lines
- A review of where cannula insertion equipment is kept
- Increasing compliance with aseptic non-touch technique training
- A review of dressings used to secure lines

Improvement strategies and successes have been shared between ward teams. Some teams have also used this as a focus on their Improving Together programme.

We will continue the work that has commenced throughout 2020/21 and we have planned to introduce more improvement strategies in the coming months.

14.3.1 MSSA bloodstream infection regional benchmarking

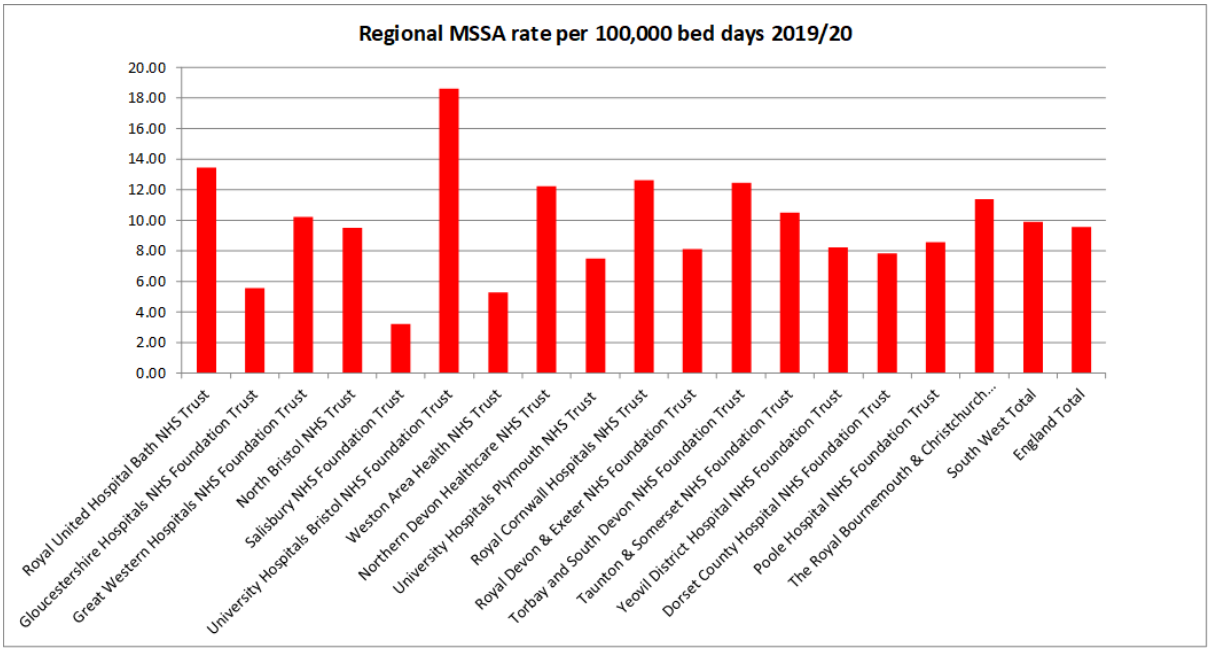


Figure 14.31: Regional MSSA rates 2019/20

The Trust remains an outlier for MSSA bloodstream infections. At the end of 2019/20 the Trust had the second highest rates within the region and remains a national outlier.

14.4 Gram negative bloodstream infections

In April 2017 the Secretary of State for Health launched an ambition to reduce Gram-negative bloodstream infections by 50% by 2021. Infection caused by these organisms has increased nationally; despite the decrease in other infections such as MRSA, *E coli, Klebsiella* spp. *and Pseudomonas aeruginosa* account for 72% of all Gram-negative bloodstream infections therefore these organisms have been identified as the key focus for reduction.

For the first two years from April 2017 a target was introduced to reduce cases of healthcare *associated E coli* bloodstream infection by 10% annually. Approximately 75% of these infections occur before admission to hospital therefore a whole health economy approach has been utilised. The target is not Trust specific and is shared with the Clinical Commissioning Groups who are rewarded with a Quality Premium for improvements in the quality of services.

14.4.*1 Escherichia coli (E coli)* bloodstream infections

The mandatory surveillance *of E coli* bloodstream infections commenced on 1 June 2011. From 2011-2017 these infections were split into community apportioned (blood cultures taken within 72 hours of admission) and trust apportioned (blood cultures taken 72 hours or more after admission).

From July 2017 the definition changed to hospital onset and community onset cases. All hospital onset cases are defined as those where the positive blood culture is taken 2 or more days after admission and are recorded as healthcare associated.

Community onset cases are where the blood culture has been taken either in the community or within the first 2 days of admission to hospital. Community onset cases are further broken down into healthcare associated and non-healthcare associated infections. Community onset healthcare

associated infections are defined as those where the patient has either been in the reporting hospital in the preceding 28 days. Non-healthcare associated infections are where the patient has not been in the reporting trust in the preceding 28 days.

PHE surveillance includes positive blood cultures taken at GP practices or community hospitals in the Trust figure as the IPCT reports these on the PHE Healthcare Associated Infections Data Capture System on behalf of primary care and provider organisations. There were 2 cases reported for Virgin Care and 1 case for Wiltshire Health and Care. With these cases deducted from the overall total there were 341 *E coli* bloodstream infections reported by the Trust.

	Hospital onset healthcare associated	Community onset healthcare associated	Community onset non-healthcare associated
Apr 2019	8	3	19
May 2019	5	3	16
Jun 2019	4	5	19
Jul 2019	6	5	23
Aug 2019	5	7	31
Sept 2019	4	2	23
Oct 2019	4	1	20
Nov 2019	4	0	21
Dec 2019	6	2	22
Jan 2020	3	4	20
Feb 2020	1	7	10
Mar 2020	3	2	23
TOTAL	**53***	**41**	**247**

*There were 53 hospital onset cases reported in 2019/20.

Figure 14.4.1.1: E coli bloodstream infections 2019/20

All patients who have a confirmed *E coli* bloodstream infection, including community onset cases, are reviewed by the microbiologists or infection prevention and control nurses who identify the most likely source of infection based on their review of the patient and their underlying pathologies. The source or cause of infection and any risk factors are reported to PHE via the HCAI data capture system.

The most common cause *of E coli* bloodstream infection was lower urinary tract infection in non-catheterised patients, which accounted for 81 (24%) cases.

The second most common source of infection was hepatobiliary which accounted for 59 (17%) cases. Hepatobiliary infections are most likely to be associated with a patient's lifestyle or with underlying cancers.

There were 37 cases (16%) where the source of infection was unknown and 24 (7%) cases where there was no clear underlying focus of infection when assessed.

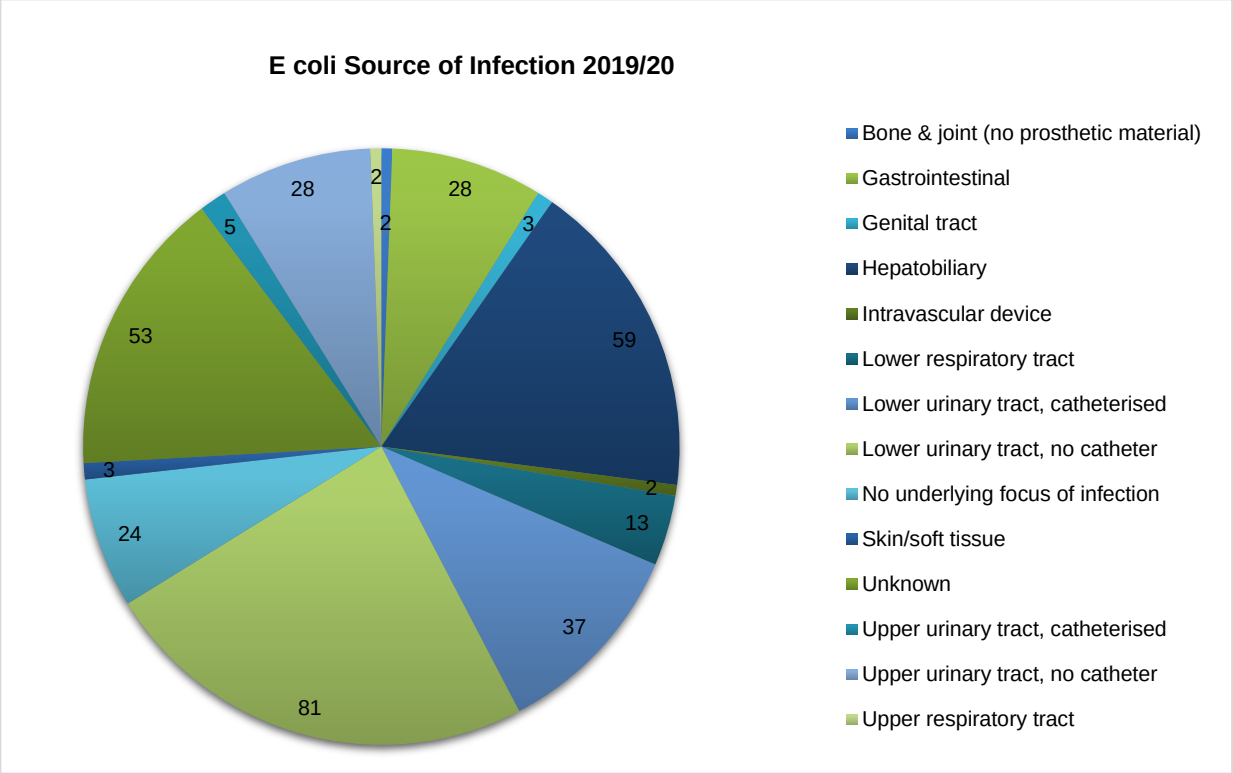


Figure 14.4.1.2: Sources of E coli bloodstream infections 2019/20

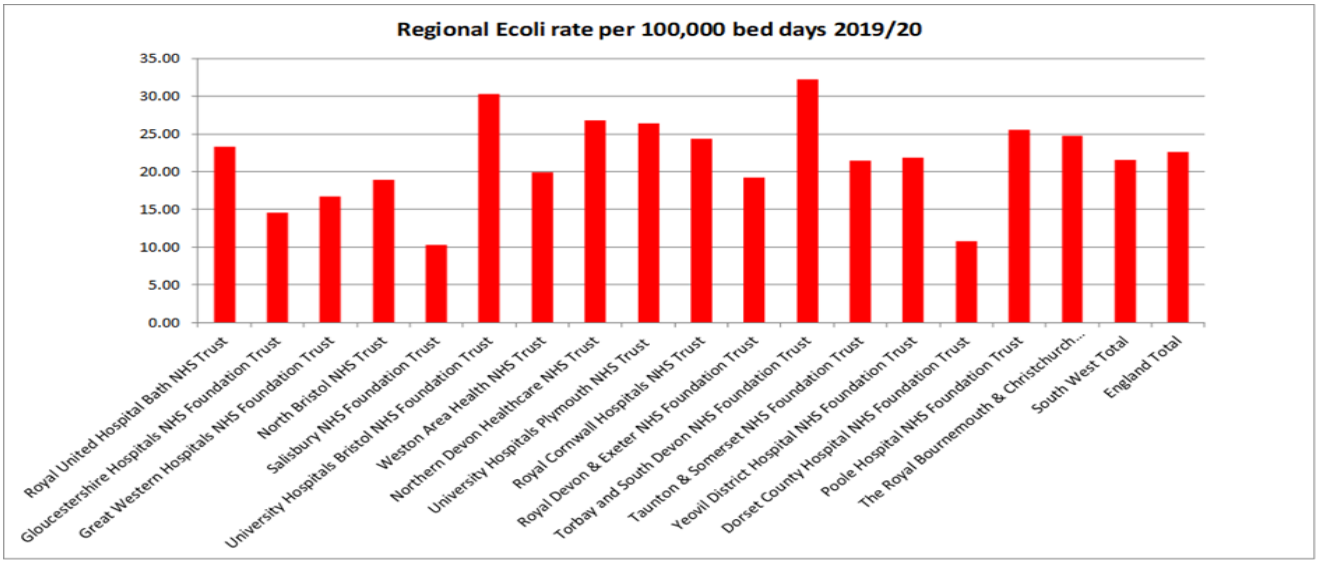


Figure 14.4.1.3: South West regional E coli rates per 100,000 bed days 2019/20

The Trust rates for *E coli* blood stream infections are slightly higher than the regional and national averages: the average rate foe England is 22.6 per 100,000 bed days whereas the RUH rate is 23.7.

14.4.*2 Klebsiella* spp. bloodstream infections

Klebsiella are Gram-negative bacteria that are found in the environment and also in the human intestinal tract. They commonly cause healthcare associated infections and are the second most frequently identified source of Gram-negative bloodstream infection after *E coli*.

The Trust has reported all *Klebsiella spp*. bloodstream infections to Public Health England via the data capture system during 2019/20. They are also reported as hospital onset healthcare associated, community onset healthcare associated and community onset non-healthcare associated cases.

Klebsiella pneumoniae was the most prevalent species isolated during 2019/20, making up 80% of cases reported.

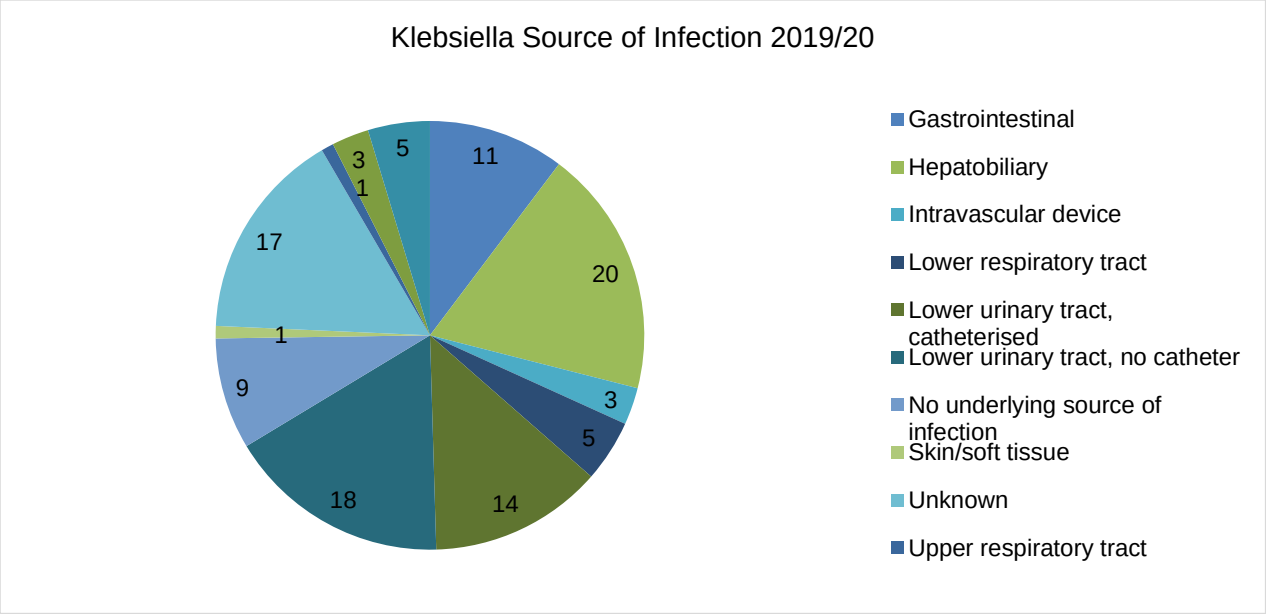


Figure 14.4.2: Source of Klebsiella spp. bloodstream infections 2019/20

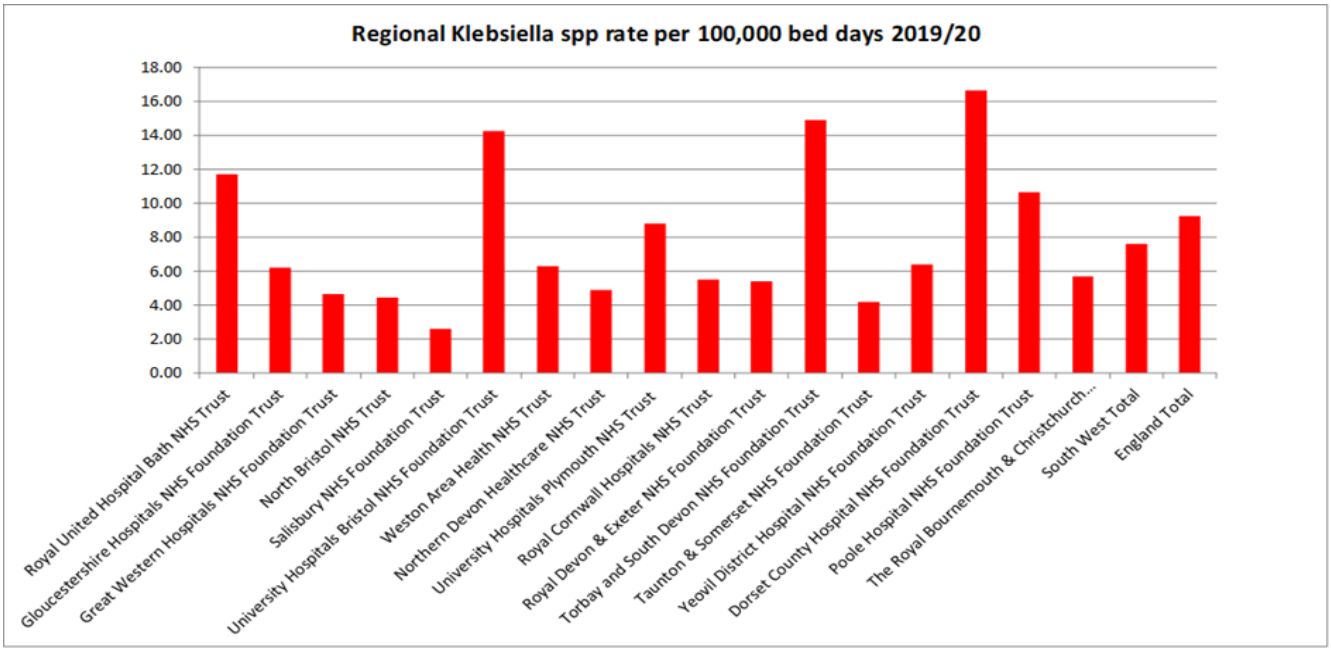


Figure 14.4.3: South West regional Klebsiella spp. bloodstream infections rates per 100,000 bed days 2019/20

The Trust rates for *Klebsiella spp.* bloodstream infections are higher than both the regional and national averages. The average rate for hospital onset cases in England is 9.2 per 100,000 bed days, the rate for the Trust is 11.9.

14.4.3 *Pseudomonas aeruginosa* bloodstream infections

Pseudomonas aeruginosa are Gram-negative bacteria found in soil and water. It is an opportunistic pathogen which can cause a wide range of infections, particularly in patients who are immunocompromised. The organism is known to cause infections by contaminating invasive devices such as urinary catheters.

The Trust has reported *all Pseudomonas aeruginosa* bloodstream infections to Public Health England via the data capture system during 2019/20.

The same process is used as with the other Gram-negative bloodstream infections; each case is reviewed by a microbiologist and the most likely source and risk factors are identified.

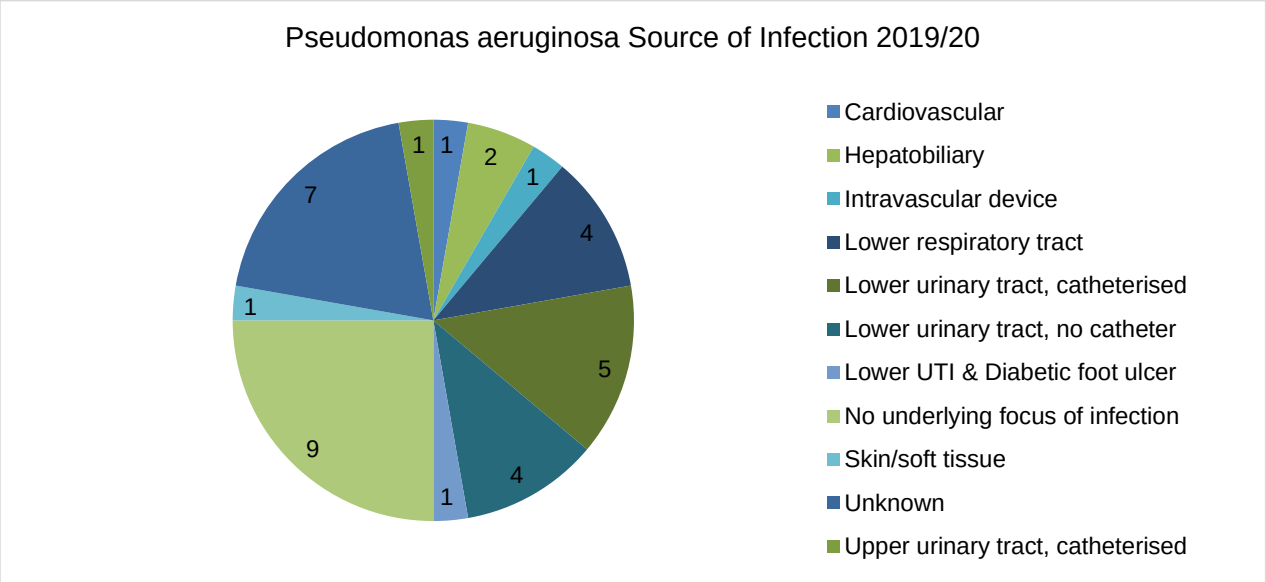


Figure 14.4.3: Source of Pseudomonas aeruginosa bloodstream infections 2019/20

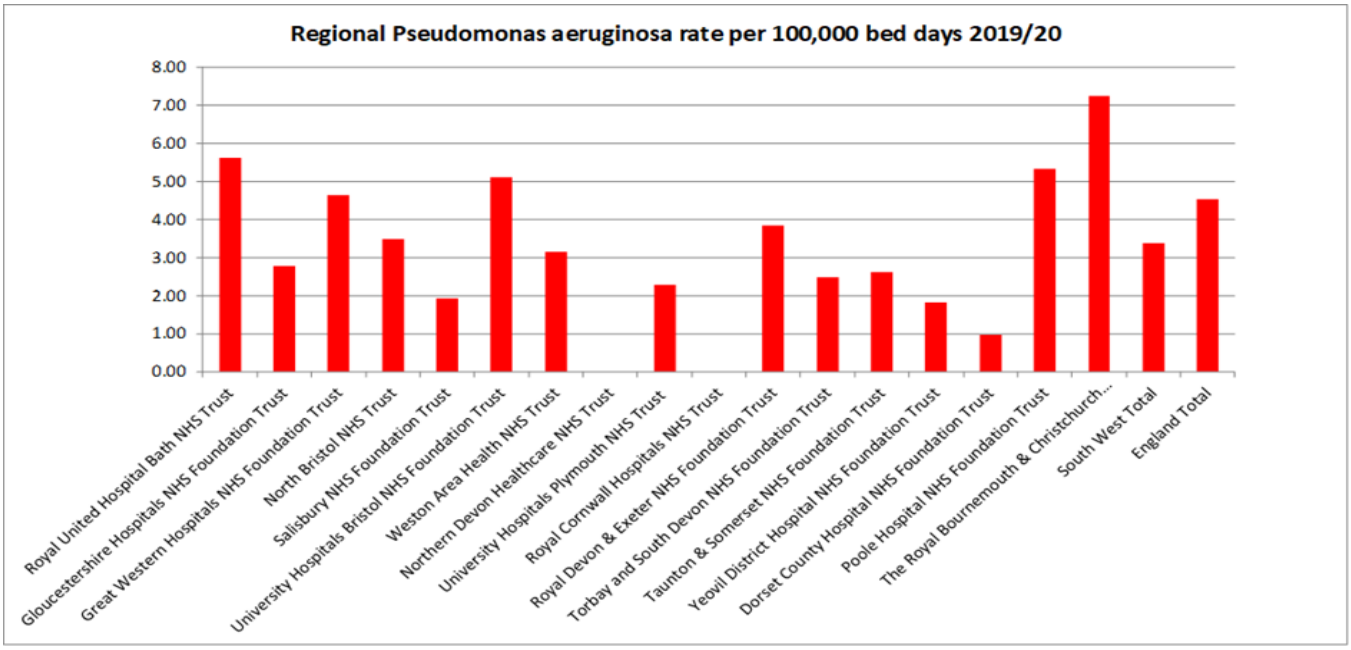


Figure 14.4.4:South West regional Pseudomonas aeruginosa bloodstream infection rates per 100,000 bed days 2019/20

The Trust rates for *Pseudomonas aeruginosa* bloodstream infections are higher than both the regional and national averages. The average rate for hospital onset cases in England is 4.4 per 100,000 bed days, the rate for the Trust is 5.3.

14.5 Clostridium difficile infections

The reporting of the number of cases of Clostridium difficile (CDI) infections is mandatory for all NHS Trusts. All cases over 2 years of age must be reported.

There are changes to the reporting algorithm that have been implemented from April 2019. All trusts will have both hospital onset and community onset healthcare associated cases as part of the Clostridium difficile objective. The timescale for diagnosis of infection has also been reduced; from April 2019 all samples taken two or more days after admission will be trust attributed. At the end of March 2020 the hospital onset CDI rate for the Trust was 10.5 per 100,000 bed days in comparison with the national average of 15.4 per 100,000 bed days.

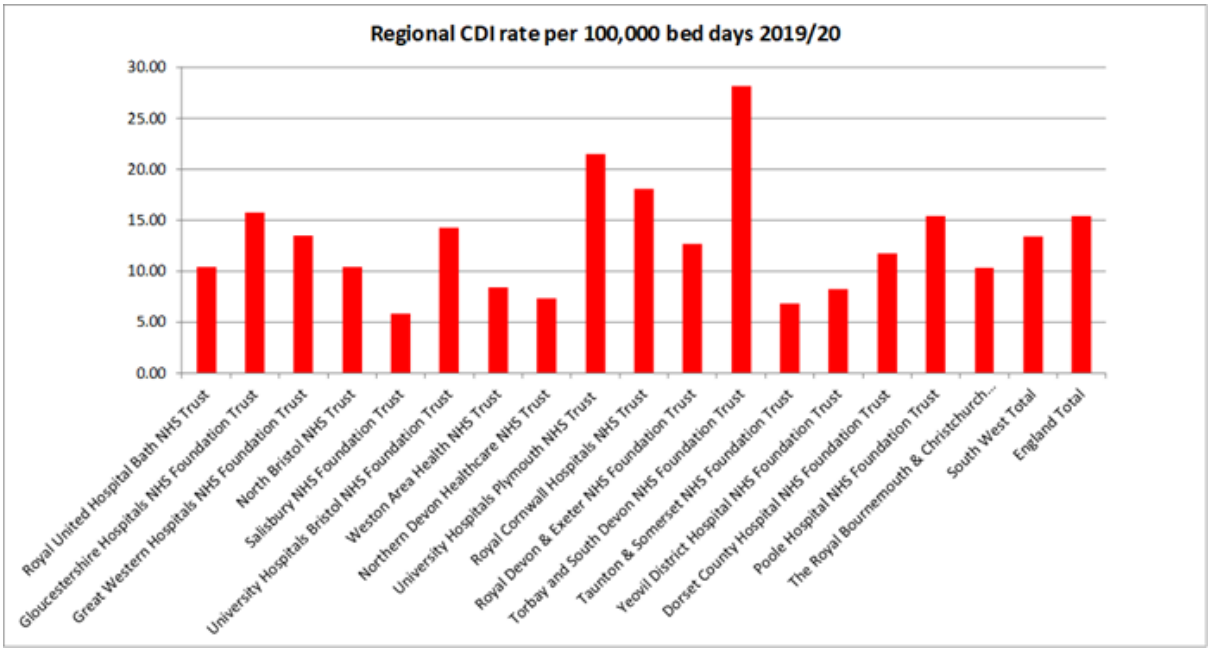


Figure 14.5: Regional Clostridium difficile infection rates 2019/20

14.6 Norovirus

Norovirus is a frequent cause of outbreaks in hospitals. Approximately 3000 people are admitted to hospitals in England with norovirus each year and this infection spreads very quickly placing a huge burden on health care services.

In order to reduce the spread of norovirus prompt isolation of infected patients is essential. 8.7% of the Trust bed base is single side rooms with en-suite toilet facilities in comparison with 20.7% which is the average in trusts in England. The lack of appropriate side rooms has an impact on how outbreaks are managed and this risk is on the Trust risk register. If patients are not isolated the virus, which is very infectious, can spread to neighbouring patients. The most effective way of managing an outbreak is to isolate the area where symptoms have occurred and prevent other patients from being admitted until symptoms have ceased. Staff working in the area must adhere to high standards of hand hygiene and use of personal protective equipment. The isolated area

can be a bay or a whole ward depending on the layout of the area and the number of patients involved.

Month	Area affected	Bed days lost
April 2019	MAU Area C	4
	Haygarth Bay 3	9
May 2019	Parry Bay 1	1
	ASU A&B Bays	2
	Waterhouse	6
June 2019	Respiratory	75
July 2019	Midford Bay 3	2
	Parry Bay 3	8
September 2019	Waterhouse Bay 3	2
November 2019	Parry	16
	William Budd Bays 1&2, followed by whole ward	15
	Haygarth Bay 1	1
	Pulteney Bay 4	1
	Pulteney Bay 2	4
	Haygarth Bay 3, followed by whole ward	28
	William Budd Bay 2	0
December 2019	Combe Bay 1	1
	Medical Short Stay female Bay	6
	Robin Smith Bay 5	0
	Midford Bay 4	2
	ACE Area C	2
	Forrester Brown	0
	Parry Bays 1&3	5
	Waterhouse Bay 2, followed by whole ward	8
	Haygarth Bay 2	2
	Combe	22
January 2020	Forrester Brown Bay 2	3
	Waterhouse Bays 1&2	10
	Combe Bay 3	0
	Pulteney Bay 3	3
	William Budd Bay 3	2
	Waterhouse Bay 1	0
	Robin Smith Bay 3	1
February 2020	Haygarth Bay 3	0
	ACE Areas A&B	6
	Midford	17
	Parry Bay 2	2
	Parry Bay 3	2
March 2020	Midford Bay 1	5
Total number of bed days lost during 2019/20		**273**

Figure 14.6: Closures due to norovirus outbreaks

It is not possible to provide any comparative data with other local trusts as the voluntary reporting of outbreaks to PHE is not undertaken by all neighbouring trusts.

14.7 Influenza

Patients with possible influenza must be isolated immediately however when bed capacity is high there can be delays in isolating patients and this leads to closure of bays until all patient contacts can be isolated. If all patient contacts cannot be isolated the bay will remain closed until all patients have exceeded the incubation period without developing symptoms. When bays are closed the infection prevention and control team review the patients at least once a day to monitor for signs of infection. When the bay is ready to reopen a deep clean is carried out before any other patients are admitted.

Table below shows the areas that were closed during 2019/20 and the number of bed days that were lost in each area.

The use of Parry Ward as a flu cohort ward has assisted with isolation of patients and reduced the number of potential bay closures that may have resulted if patients were not either isolated or transferred to Parry.

Month	Area affected	Bed days lost
April 2019	ACE Area C	8
	ASU C Bay	0
	Cheselden Bays 1&2	8
	Robin Smith Bay 6	2
	Cardiac Bay 3	7
	Respiratory	22
	Parry Bay 4	5
	Cardiac Bay 5	3
	Midford Bay 4	8
May 2019	Haygarth Bay 1	3
July 2019	Parry Bay 2	5
September 2019	Respiratory Bays 1&3	1
December 2019	Cardiac Bay 5	1
	Waterhouse Bay 2	4
	William Budd Bay 1	2
	Combe Bay 2	2
	Midford Bay 3	1
	MAU Areas A&C	2
	MTU	2
	William Budd Bay 2	4
	Pulteney Bay 4	2
	Waterhouse Bay 3	2
	Cheselden Bay 2	4
	ASU A Bay	5
	Respiratory Bays 1&3	8
	Parry Bay 1	8
	Haygarth Bays 1&2	9
	Haygarth Bay 3	1
	Haygarth Bay 4	3
	Respiratory Bay 2	9
January 2020	Parry Bay 4	0
	Pulteney Bay 4	5
	Pulteney Bay 3	5
	Cardiac Bay 1	2

Month	Area affected	Bed days lost
	Cardiac Bay 2	2
	Cardiac Bay 1	4
February 2020	Haygarth Bay 1	0
	ASU A Bay	13
	ASU B Bay	10
Total number of bed days lost during 2019/20		**182**

Figure 14.7: Ward/bay closures due to confirmed Influenza A 2019-20

14.8 Serious Incidents

There were two serious infection prevention and control incidents reported during 2019/20.

The first incident was an outbreak of norovirus on Respiratory Ward in June 2019. The ward was closed for 11 days and there were 14 confirmed cases. The outbreak led to the loss of 75 bed days. On investigation it was identified that the index case was a patient who had been having diarrhoea and vomiting at home prior to admission. This information was not communicated to the staff on Respiratory and the patient was not isolated until norovirus had been detected. Incomplete compliance with PPE use was also noted. On completion of the investigation the findings were reported to the Operational Governance Committee and an action plan put in place. All actions have since been completed.

The second incident was a patient who developed a healthcare associated MSSA bloodstream infection on Acute Stroke Unit and died three days after this was diagnosed. The probable source of the infection was an infected peripheral venous cannula site. MSSA was given as the joint cause of death along with pneumonia on the patient's death certificate. The incident was investigated and it was identified that the number and complexity of cannulations were indicated as contributory factors. Actions were identified and these included competency training for staff who insert peripheral venous cannula and documentation checks. The incident was reported at the Infection Prevention and Control Committee meeting and the senior sister shared the learning from the incident. All actions have been completed.

14.9 Cleaning

Work has been on-going throughout the year to ensure the Trust meets the standards laid out in the National Specifications of Cleanliness in the NHS (2007). Overall audit score for each risk level increased over the year:

Risk Level	April 2019	March 2020
Very High Risk – 98%	96%	97.79%
High Risk – 95%	87.99%	95.25%
Significant Risk – 85%	89.15%	93.30%

The improvement in cleaning has been achieved through the introduction of microfibre cloths, a new staff allocation and annual leave process, and improved supervision. The auditing system has also to fully meet the requirements of the National Specifications.

The annual Patient Led Assessment of the Care Environment (PLACE) was completed in November 2019 using a revised question set. Healthwatch and Trust volunteers took part, together with IPC, Facilities and Estates staff and an external validator. Results for Cleaning (99.69%) and Condition, Appearance and Maintenance (96.34%) are either above or at the national average score. Further work is required to improve Privacy and Dignity, Dementia and Disability elements of the assessment.

Royal United Hospitals Bath
NHS Foundation Trust

Report to:	**Public Board of Directors**	**Agenda item:**	**13.2**
Date of Meeting:	**29 July 2020**		

Title of Report:	**Infection Prevention and Control Board Assurance Framework**
Status:	**For approval**
Board Sponsor:	**Lisa Cheek, Director of Nursing and Midwifery/Director of Infection Prevention and Control**
Author:	**Yvonne Pritchard, Senior Infection Prevention and Control Nurse**
Appendices	**Appendix 1: IPC Board Assurance Framework** **Appendix 2: IPC Board Assurance Framework Action plan**

1. Executive Summary of the Report

NHS England have developed the Board Assurance Framework for providers to assess themselves against the Public Health England and other COVID-19 related guidance. The framework is intended to demonstrate that the Trust is compliant with the relevant COVID-19 guidance and also that other regulatory activities have continued, for example mandatory surveillance of healthcare associated infections.

The framework is structured around the 10 criteria of the Health and Social Care Act 2008: code of practice on the prevention and control of infections and related guidance, also known as the Hygiene Code.

The Trust Board Assurance Framework provides evidence to support the key lines of enquiry. Where gaps in assurance have been identified an action plan will be created to address this and mitigating actions will be implemented.

1.1 Table summarising the results

Key lines of enquiry	Rating (RAG)	Summary of gaps identified
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	Yellow	Separate risk logs: proposal to record overarching COVID-19 risks on Datix.
2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections	Amber	Insufficient cleaning staff to cover twice daily cleaning. Shortage of chlorine releasing chemical for environmental

		decontamination. Cleaning department are unable to provide immediate response to clean areas where PPE has been removed. There is no audit in place for the cleaning of electrical equipment. Equipment cleanliness audit scores are below 100%.
3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance	Amber	The systems and professionals in place to deliver the objectives of Antimicrobial Stewardship is challenged in its current format by staff shortage. There is an A3 review currently taking place to see how a more sustainable system can be supported. The work has been continuing at a reduced offering but focused on highest risk areas. Reduced ARK activity due to COVID-19.
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	Yellow	Recording of infection status on the discharge summary
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	Green	
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	Yellow	Staff not reporting their symptoms through the appropriate channels.
7. Provide or secure adequate isolation facilities	Green	

8. Secure adequate access to laboratory support as appropriate	Green	
9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections	Green	
10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection	Yellow	Cleaning staff are not segregated to work on designated areas consistently. Risk assessments outstanding for at risk staff groups.

Green	Evidence available at the time of assessment shows the line of enquiry is met
Yellow	Evidence available at the time of assessment shows that the line of enquiry is mostly met. Impact on people who use services or staff is low. Action required is minimal
Amber	Evidence available at the time of assessment shows that the line of enquiry is mostly met. Impact on people who use services or staff is medium. Action required is moderate
Red	Evidence available at the time shows that the line of enquiry is not being met. Impact on people who use services or staff is high/significant. Immediate action is required

The key lines of enquiry that score yellow are where there are minor gaps in assurance and actions are underway to address these. The elements that score amber or red have action plans in place which will be monitored by the Strategic Infection Prevention and Control Committee.

The main gaps in assurance for key line of enquiry 2 relate to staffing within the Cleaning Department. Agency staff have been recruited to fill these gaps in the short term. Equipment cleanliness is being addressed by increasing the frequency of cleaning and following up with weekly audits by the matrons.

The gaps in assurance for key line of enquiry 3 have been affected by staff shortages. There is an A3 review currently taking place to see how a more sustainable system can be supported. The work has been continuing at a reduced offering but focused on highest risk areas. Reduced ARK activity due to COVID-19.

2.	**Recommendations (Note, Approve, Discuss)**
For approval	

3.	Legal / Regulatory Implications
Health and Safety at Work Act 1974. The Health and Social Care Act 2008: code of practice on the prevention and control of infections and related guidance.	

4.	Risk (Threats or opportunities, link to a risk on the Risk Register, Board Assurance Framework etc)
180 Lack of isolation facilities Risk registers for Bronze sub-groups, Silver and Gold.	

5.	Resources Implications (Financial / staffing)
Increased staffing required for maintaining twice daily cleaning of the clinical environment.	

6.	Equality and Diversity
None identified	

7.	References to previous reports
None.	

8.	Freedom of Information
Private: the Board Assurance Framework is for internal use at present	

Publications approval reference: 001559

Infection prevention and control board assurance framework

Royal United Hospitals Trust NHS Foundation Trust 5 June 2020, Version 1.2

Foreword

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

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

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

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

Ruth May
Chief Nursing Officer for England

1. Introduction

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

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

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

2. Legislative framework

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

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

Robust risk assessment processes are central to protecting the health, safety and welfare of patients, service users and staff under both pieces of legislation. Where it is not possible to eliminate risk, organisations must assess and mitigate risk and provide safe systems of work. In the context of COVID-19, there is an inherent level of risk for NHS staff who are treating

and caring for patients and service users and for the patients and service users themselves in a healthcare setting. All organisations must therefore ensure that risks are identified, managed and mitigated effectively.

Infection Prevention and Control board assurance framework

1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users				
Key lines of enquiry	**Evidence**	**Supporting evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure:				
• infection risk is assessed at the front door and this is documented in patient notes	All ED attendances have a COVID 19 proforma completed. This includes a check for whether patients have COVID 19 symptoms and it forms part of their scanned patient record from ED. Within Maternity all services pathways and action cards have been created for all admissions. All women needing to attend are symptom screened over the phone prior to attending. Pathways and action cards developed for Paediatric, childrens therapies, Neonatal unit and sexual health.	 ED Covid Screen V4.docx  Patient attends as 111 walk in.docx  Patient attends via ambulance.docx  Maternity Services.zip	Nil	N/A

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**	**Supporting evidence**	**Gaps in Assurance**	**Mitigating Actions**
	All patient pathways were reviewed and approved through the Clinical Pathways COVID_19 Group Direct admit patients with non COVID symptoms follow routine pathways as agreed through clinical pathways. COVID 19 suspected group attend ED / RAU flow pathway dependant on acuity. Patients infection risk is also assessed and documented on aramis upon non elective arrival.	 W&C Action Cards.zip  Sexual Health Pathways COVID-19.		
• patients with possible or confirmed COVID-19 are not moved unless this is essential to their care or reduces the risk of transmission	Patients that are possible or confirmed COVID-19 are placed in a dedicated side room on a dedicated ward or cohort. Paediatric; highly suspicious patients are admitted via a different entrance as shown on pathway. Urgent clinical transfers are only authorised by Consultants. COVID-19 patients are identified on the electronic site board and patient placement is reviewed 3 times a day.		Nil	Any unauthorised transfers are escalated and investigated via the Trust Datix system and learning shared.

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**	**Supporting evidence**	**Gaps in Assurance**	**Mitigating Actions**
• compliance with the national guidance around discharge or transfer of COVID-19 positive patients	The whole system has changed to a discharge to assess model in line with national guidance. All hospital discharges are Health funded as instructed. All social care assessments are now not completed in the acute trusts. Only exception is when mental capacity is involved and again this is as per national guidance. Discharge and isolation stepdown guidance for patients with COVID-19 in place.	 Discharge Pathways - Weekly_38_312219		Exceptions are reported daily at Silver Command.
• patients and staff are protected with PPE, as per the PHE national guidance	PPE supplied to all clinical departments. Guidance on use of PPE available on the Trust intranet including posters for departments, videos and simple 'how to' guides. Weekly virtual meeting with ward managers / Heads of Department to discuss any changes to guidance and address any concerns. Fit testing records held centrally. PPE champions established to support staff. Matrons working	RUH PPE Guide:  20200611_WearingPPE_FAQ_FINAL v6 7 J Daily PPE Stock report to Silver/Gold:  20200703 PPE Daily Stock Take v.4.xlsx PPE Group risk register:	Nil	N/A

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**	**Supporting evidence**	**Gaps in Assurance**	**Mitigating Actions**
	hours extended to support PPE compliance. Patients and staff issued with a surgical mask on arrival to the hospital with manned stations at entrances to the hospital. Daily PPE huddle in place to ensure a timely response to any issues. PPE stock levels monitored through the ICC and reported to Gold. Robust procurement model within the Trust supports having the right PPE available at the right time and in the right place. .	PPE - Risks & Action Log 11.06.20 .xlsx		
• national IPC guidance is regularly checked for updates and any changes are effectively communicated	PHE guidance is checked daily by the IPC Team and any updates communicated to Silver and Gold. All guidance is reviewed through Resilience inbox and disseminated through the Incident Coordination Centre (ICC). IPC reference group	2 examples of Daily Briefings: 20200612_StaffBrief face coverings.pdf	Nil	N/A

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**	**Supporting evidence**	**Gaps in Assurance**	**Mitigating Actions**
to staff in a timely way	meets weekly to ensure Trust compliance.	Information for all staff - PPE informatior IPC Reference Group Charter ICC Manager SOP: ICC Manager SOP v11.doc		
• changes to guidance are brought to the attention of boards and any risks and mitigating actions are highlighted	Any changes are brought to the attention of Gold and risks are highlighted. This is recorded in the Gold meeting actions.	Gold Meeting notes	Nil	N/A
• risks are reflected in risk registers and the Board	Risks are recorded at Bronze, Silver and Gold levels. Recorded on the appropriate risk registers.	COVID-19 Risk Dashboard	Separate risk log that is not currently on Datix	To add overarching risks on the Risk Register

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**	**Supporting evidence**	**Gaps in Assurance**	**Mitigating Actions**
Assurance Framework where appropriate		Board of Directors Minutes Board Assurance Framework		
• robust IPC risk assessment processes and practices are in place for non COVID-19 infections and pathogens	IPC risk assessments have remained in place throughout the Pandemic. Mandatory surveillance has continued and all relevant infections are reported through the PHE data capture system. Root cause analysis investigation is carried out for hospital onset infections. These are held by the IPC Team. Bi weekly senior sisters meetings chaired by a medical matron in place monitoring all non covid HCAI, and reviewing action plans and ensuring Trust wide processes in place. Weekly HCAI report widely circulated showing infection rate, and audit results. Operational IPC group in place reporting into the strategic IPC committee.	IPC policies For example: *Clostridium difficile*  Yellow_617_Clostridium_Difficile_policy (1).pdf MRSA  Yellow_612 (1).pdf Influenza  Yellow_623_Control_and_treatment_of_Influenza_A.pdf Isolation  Yellow_627.pdf Meningitis  Yellow_616_Meningitis_Policy (1).pdf	Nil	N/A

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**	**Supporting evidence**	**Gaps in Assurance**	**Mitigating Actions**
		Hand decontamination Yellow_613.pdf Standard IPC precautions Yellow_622_Universal_Standard_Infection_Control_Policy.pdf		

Summary of performance for the Key lines of enquiry (rating based on the self-assessment and supporting evidence available)	**Rating (RAGB)**	**Rationale for rating**
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	Yellow	Key requirements are mostly met with minimal action required. COVID-19 risks are currently recorded on a separate risk log to the Trust Risk Register. It is proposed to record overarching COVID-19 risks on Datix.

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**	**Supporting evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure:				
• designated teams with appropriate training are assigned to care for and treat patients in COVID-19 isolation or cohort areas	IPC training records on ESR. Regular updates are included in Trust wide staff communications Support for appropriate PPE use includes: • Extended matron hours to support PPE in and out of hours • 51 PPE Champions identified to date and going through induction training to support their own teams using PPE well • Videos, how to guides and full PPE guide available on intranet, and promoted to staff through daily video briefings and daily all	IPC training records on ESR.	There are not fully designated teams (although national guidance states where possible).	Designated teams for high risk areas (e.g. Critical Care, Oncology, Enhanced Respiratory Care)

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**	**Supporting evidence**	**Gaps in Assurance**	**Mitigating Actions**
	staff briefing, workplace and intranet. • Donning and doffing training in key areas, delivered by IPC team, Resus team and PPE Champions in some areas • Donning/doffing buddies approach in ICU and Theatres.			
• designated cleaning teams with appropriate training in required techniques and use of PPE, are assigned to COVID-19 isolation or cohort areas.	All wards have dedicated cleaners. COVID-19 isolation and cohort areas are particularly monitored to ensure the designated cleaners are not moved to other wards. Deputy Head of Hotel Services sits on the PPE group to oversee PPE support/guidance/provision for the cleaning teams. Specific FAQs for cleaning teams covered in the PPE guide, and training given to	PPE training records PPE guidance Cleaning Allocation Sheet  Cleaning Allocation Sheet template (1).xl	Bank staff used to cover annual leave and sickness	On COVID-19 areas the same staff are used for duration of the absence

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**	**Supporting evidence**	**Gaps in Assurance**	**Mitigating Actions**
	cleaning teams on appropriate use of PPE.			
• decontamination and terminal decontamination of isolation rooms or cohort areas is carried out in line with PHE and other national guidance	Special Clean SOP matches the PHE guidance for environmental decontamination.	COVID-19 Flowchart SOP Covid19 Flow Chart Cleaning SOPFinal ;	Nil	N/A
• 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	Frequency of cleaning increased where possible within existing staffing resource. A new infection prevention and control assurance checklist has been developed. Matrons auditing this monthly in their clinical areas which includes a section on cleaning. A spreadsheet for the twice daily cleans required for non clinical equipment is in place and also audited by the matrons.	Infection prevention and control assurance checklist Infection Prevention and Con Domestic Services Workplan Proposed Agency Rota.xlsx Domestic Services work plan second cl	Existing staffing resource does not allow for twice daily cleaning in wards	60 WTE additional cleaners being recruited to complete a second clean on frequently touched surfaces. Expected to start late June.

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**	**Supporting evidence**	**Gaps in Assurance**	**Mitigating Actions**
• attention to the cleaning of toilets/bathrooms, as COVID-19 has frequently been found to contaminate surfaces in these areas	Ward based patient toilets cleaned at least twice a day. Public toilets cleaned six times a day		Nil	N/A
• cleaning is carried out with a neutral detergent, a chlorine based disinfectant, in the form of a solution at a minimum strength of 1,000ppm available chlorine, as per national guidance. If an alternative disinfectant is used, the local infection prevention and control team (IPCT) should be consulted on this to ensure that this is	Cleaning is carried out using a chlorine containing tablet with detergent at strength of 1000ppm. Where appropriate for surface decontamination IPC have advised disinfectant Clinell wipes with known activity against Coronavirus.		Possible limited global supply of chlorine containing tablets	Mutual aid system in place

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**	**Supporting evidence**	**Gaps in Assurance**	**Mitigating Actions**
effective against enveloped viruses				
• manufacturers' guidance and recommended product 'contact time' must be followed for all cleaning/disinfectant solutions/products as per national guidance	No contact times recommended for product for COVID-19 Manufacturer guidance is followed for contact times – e.g. Clinell wipes 60 seconds, SoChlor The Sochlor (GV Health) at 1000ppm 'ensures activation of COVID-19 in a few minutes'. It conforms to EN14476 virucidal activity. Clinell Universal wipes (Gama Healthcare) are proven against coronaviruses in a 60 second contact time and have been tested against EN14476.	PPE guidance re Clinell wipes:  2020409_StaffBrief decontam guidance.p SoChlor	Nil	N/A

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**	**Supporting evidence**	**Gaps in Assurance**	**Mitigating Actions**
• 'frequently touched' surfaces, e.g. door/toilet handles, patient call bells, over-bed tables and bed rails, should be decontaminated at least twice daily and when known to be contaminated with secretions, excretions or body fluids	Where time allows, frequently touched surfaces are cleaned several times a day. Support from volunteers to help achieve this	Proposed Agency Rota.xlsx Domestic Services work plan second cl	Insufficient resource to ensure all frequently touched surfaces are cleaned at least twice daily	60 WTE additional cleaners being recruited to complete a second clean on frequently touched surfaces. Expected to start late June.
• Electronic equipment, e.g. mobile phones, desk phones, tablets, desktops and keyboards should be cleaned at least twice daily	The nursing cleaning schedule has been updated to meet the new requirements of a twice daily clean. This new schedule was cascaded to all clinical areas through the matrons.	Cleaning Spreadsheet - UPDA	Records held locally and no audit in place.	Assessment monthly as part of the matron's assurance audit. Plans being developed to have a weekly check and sign off by the matrons.
• Rooms/areas where PPE is removed must be decontaminated,	Room/areas where PPE is removed are cleaned once or twice a day in line with daily cleaning schedule		Cleaning is not able to be timed to coincide with periods immediately after PPE removal.	Robust cleaning schedules and monitoring of these are in place.

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**	**Supporting evidence**	**Gaps in Assurance**	**Mitigating Actions**
timed to coincide with periods immediately after PPE removal by groups of staff (at least twice daily)				
• linen from possible and confirmed COVID-19 patients is managed in line with PHE and other national guidance and the appropriate precautions are taken	SOP for disposal of linen is in line with PHE guidelines, including using alginate bag and double bagging, and labelling outer bag.	Covid19 Soilen Linen SOP 2020-04-(	Nil	N/A
• single use items are used where possible and according to Single Use Policy	The Trust has a decontamination policy which sets out requirements for use of single use items	Decontamination Policy: Decontamination Policy.pdf	Nil	N/A
• reusable equipment is appropriately decontaminated in line with local and PHE and other national policy	The Trust has a decontamination policy which includes requirements for reusable equipment Audits of equipment cleanliness are carried out	Decontamination Policy: Decontamination Policy.pdf	Not all areas are scoring 100% for the audits	Results are disseminated weekly to the matrons for immediate action and also reviewed at the Infection Prevention

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**	**Supporting evidence**	**Gaps in Assurance**	**Mitigating Actions**
	by the IPC Team and results reported to Senior Sisters/Matrons. Where reusable PPE is supplied (safety glasses, some respirators, washable gowns), a clearly documented decontamination process is in place and shared with the staff involved.	Audit of equipment cleanliness RUH reusable respirator decontamination SOP: JSP Force 10 Decontamination Inst Flow chart for use of reusable respirator: FFP3 flow chart v07.xlsx		and Control Operational Group
• Review and ensure good ventilation in admission and waiting areas to minimize opportunistic airborne transmission	All admission and waiting areas reviewed to ensure they have natural ventilation, or functioning mechanical ventilation. Waiting areas reviewed as per social distancing guidelines to reduce density of people, and	Schedule of AGP safe areas held on intranet.	Nil	N/A

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**	**Supporting evidence**	**Gaps in Assurance**	**Mitigating Actions**
	therefore reduce likelihood of bio-burden. Specific departments carrying out AGP's have been assessed to ensure air changes above recommended and adjustments made where appropriate.			

Summary of performance for the Key lines of enquiry (rating based on the self-assessment and supporting evidence available)	**Rating (RAGB)**	**Rationale for rating**
Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections	Amber	Key requirements are mostly met with moderate action required. The following gaps are identified: • Insufficient cleaning staff to cover twice daily cleaning • Shortage of chlorine releasing chemical for environmental decontamination • Cleaning department are unable to provide immediate response to clean areas where PPE has been removed • There is no audit in place for the cleaning of electrical equipment • Equipment cleanliness audit scores are below 100%

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**	**Supporting evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and process are in place to ensure:				
• arrangements around antimicrobial stewardship are maintained	Clinical advice on appropriate use of antimicrobials is available 24/7 from the consultant microbiology team who also provide daily virtual ICU ward rounds. 2x weekly meropenem reviews Guidelines are in place for appropriate prescribing of antibiotics. COVID section added to antibiotic prescribing app 'Microguide'. Paediatric RUH guidelines reviewed and added. Review of CAP and skin and soft tissue guidelines. Specific COVID additions on antifungal use on ITU; antibiotic prescribing based on the introduction of Procalcitonin to enhance AMS. PCT audit in progress to ensure	Antibiotic prescribing guidelines available on microguide: https://viewer.microguide.global/guide/1000000168 Trust clinical guideline written by biochemistry and includes limitations to its use and how to interpret: https://viewer.microguide.global/guide/1000000168#content,ba251	AMS work is re-prioritised currently due to maternity leave in the team.COVID has also reduced ability to attend MDT, AMS ward rounds and C.Diff ward rounds. Reduction in teaching and e-learning. Antibiotic guidelines are in place but regular review is reduced from July onwards due to microbiology staff shortages (AMS lead is now on maternity leave)	Locum cover is sought. Business case for further consultant microbiologist is pending. Prioritisation of work ongoing and if locums are found AMS activity will increase. Locum cover is sought. Business case for further consultant microbiologist is pending.

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**	**Supporting evidence**	**Gaps in Assurance**	**Mitigating Actions**
	appropriate use of diagnostic test in appropriate patients.	bd1-a07b-46b8-96ab-0def778b144d Respiratory COVID pathway: https://www.ruh.nhs.uk/covid19/documents/respiratory_guidance/COVID-19_Clinical_Assessment_Flowchart.pdf?t=54924.63		
	Increased remote live auditing of prescribing practice via ePMA AMS team continue to support AMS CQUINs – CAP/UTI. (Baseline continuing despite CQUIN on hold until April 2021 Ward pharmacist review antimicrobial prescribing on daily ward cover - referral to Microbiology consultant if deviations from Trust antibiotic guidelines occur.	Audit re appropriateness of clarithromycin and co-amoxiclav prescribing and ensure flagged to clinicians for immediate review. Guideline compliance audits	AFS CQUIN has not been supported due to staff shortages. AMS pharmacist capacity reduced.	Work in progress to develop further antimicrobial pharmacist support. Discussion with Pharmacist and Pathology Directors ongoing

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**	**Supporting evidence**	**Gaps in Assurance**	**Mitigating Actions**
	Review datix incidents for gentamicin and vancomycin and audit guideline compliance for prescribing and monitoring. Level 1 and 2 AMS mandatory training for relevant staff groups	Audit results – fed back to pharmacy / acute medicine teams. Re audit autumn 2020. Compliance with training via education STAR records		
• mandatory reporting requirements are adhered to and boards continue to maintain oversight	PHE Healthcare Associated Infection DSC Mandatory Surveillance ongoing. All AMR local indicators (PHE Fingertips) Laboratory reporting of infections to PHE has continued. 3 monthly audit of antibiotic consumption and prescribing data (guideline compliance, 72 hour review, ARK compliance and use of WHO AWARE antibiotics) by AMS team fed-back to IPCC, Quality		Quarterly Trust AMS & Medical director meetings to review progress usually occur (NHSi requirement); April meetings were cancelled due to COVID. Trust meeting booked for 13th July ARK activity difficult to sustain under current model of delivery.	To ensure future AMS meetings are re-scheduled. Discussion with microbiology consultants and pathology director occurred 22/6/20 – agreed Consultants would support these meetings. A3 on antimicrobial stewardship and ARK is in development to review current model of delivery and options for making more sustainable (eg skill mix and professional representation/balance

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**	**Supporting evidence**	**Gaps in Assurance**	**Mitigating Actions**
	Board and Clinical governance committee.			in the team.) To be presented to CGC (postponed due to COVID- rescheduled)

Summary of performance for the Key lines of enquiry (rating based on the self-assessment and supporting evidence available)	**Rating (RAGB)**	**Rationale for rating**
Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance	Amber	Key requirements are mostly being met. Action required is moderate. The systems and professionals in place to deliver the objectives of Antimicrobial Stewardship is challenged in its current format by staff shortage. There is an A3 review currently taking place to see how a more sustainable system can be supported. The work has been continuing at a reduced offering but focused on highest risk areas. Reduced ARK activity due to COVID-19.

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**	**Supporting evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure:				
• implementation of national guidance on visiting patients in a care setting	Trust wide visiting guidance is in place and is reviewed regularly.	See bullet point 3 below	Nil	N/A
• 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 in place on isolation rooms. Restricted access is in place for high risk areas		There is no standard signage in place defining cohort areas.	The IPC Team will develop standard signage for cohort areas which will be used in the eventuality of a second peak.
• information and guidance on COVID-19 is available on all Trust websites with easy read versions	Information for patients and the public is available and regularly updated on the Trust website. This includes guidance around any restrictions on visiting and guidance on what to expect such as protecting yourself and others.	 Information leaflet for visitors 17th June  Guidance for staff around Visiting updat  End of life visiting on Intensive Care during	Easy read versions of Trust COVID-19 patient information is not available.	Easy read versions of PHE guidance are available on the gov.uk website and these can be printed for patients.

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**	**Supporting evidence**	**Gaps in Assurance**	**Mitigating Actions**
	We have guidance for staff around visiting which has been updated regularly in line with national guidance for both general visiting and for visiting loved ones with COVID whether on an acute general ward or in the Intensive Care Unit. We also have information leaflets for the public around end of life visiting, general visiting and we are in the process of drafting guidance for visiting arrangements for individual wards as each are geographically different in terms of layout and size therefore to meet social distancing guidelines the ability to support visiting is different in each ward area. The staff intranet also features an extensive COVID-19 resource	 Information for visitors to Mary Ward  End of Life info leaflet updated 21st /		

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**	**Supporting evidence**	**Gaps in Assurance**	**Mitigating Actions**
	section, key message area and our communication brief for staff including our film provides useful updates on a daily basis.			
• 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 recorded on Patient Flow for internal transfers. SBAR in place for internal transfers which includes an infection status.	 COVID19 Discharge Form FINAL (1) (1).dc  138843 RUB 1WRU406 Patient W	Recording of infection status on the discharge summary form.	The discharge referral form includes the COVID-19 status at the point of referral

Summary of performance for the Key lines of enquiry (rating based on the self-assessment and supporting evidence available)	**Rating (RAGB)**	**Rationale for rating**
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	Yellow	Key requirements are mostly met with minimal action required. Infection status is not routinely recorded on the discharge summary.

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**	**Supporting evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure:				
• front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed COVID-19 symptoms to minimise the risk of cross-infection	ED operates red and green clinical spaces in all areas of the emergency department. Placement of these patients is based on a written triage assessment. Paediatrics has specific area for Red and Green patients. Maternity utilise appropriate bays and side rooms. Direct admit Surgery triage in Surgical Assessment Unit and place in appropriate side rooms and allocated bays. Medical direct Admits are triaged. Possible and confirmed patients are isolated or segregated in the socially distanced bays.		Nil	N/A

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**	**Supporting evidence**	**Gaps in Assurance**	**Mitigating Actions**
• mask usage is emphasized for suspected individuals	Masks are in use for these patients.	RUH PPE Guide:  20200611_WearingPPE_FAQ_FINAL v6 7 Ju FAQs / Staff Brief	PPE guidance to be updated	
• ideally segregation should be with separate spaces, but there is potential to use screens, e.g. to protect reception staff	Assessment of inpatient areas complete, and outpatient and reception areas undertaken. Gaps in compliant social distancing practice identified and mitigating actions have been put in place.	Examples of actions implemented: • Segregation of waiting areas • Installation of screens on receptions • Beds separated, curtain tracks adjusted to accommodate.	None. Each area that require segregation to operate safely have screens. As more services are reinstated any future requirements will be highlighted to the Phase II working groups.	N/A
• for patients with new onset symptoms it is important to achieve isolation and instigation of contact tracing as soon as possible	Patients are cared for in socially distanced bed space. Patients are swabbed following new onset of symptoms and isolated. Senior nurse on the ward identifies ward based		There could be delays in isolating patients due to limited availability of side rooms	Patients requiring isolation are highlighted by the site team and escalated to Silver Command

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**	**Supporting evidence**	**Gaps in Assurance**	**Mitigating Actions**
	contacts in-line with government guidance.			
• patients with suspected COVID-19 are tested promptly	Clinicians are following the PHE guidance (Investigation and initial clinical management of hospital cases) for testing. Guidance on swabbing procedures has been developed	COVID Assessment Flow chart Intranet Section – Laboratory specimens on patients with suspected COVID.	Nil	N/A
• patients that test negative but display or go on to develop symptoms of COVID-19 are segregated and promptly re-tested	Patients are swabbed following new onset of symptoms and isolated.		Nil	N/A
• patients that attend for routine appointments who display symptoms of COVID-19 are managed appropriately	Virtual appointments are predominantly undertaken with face to face appointments only carried out where clinically necessary. If patients need to attend their appointment letter requests that they do not do so if symptomatic. Patients are also asked if they have symptoms	Outpatient_guidance_FINAL.pdf	Nil	N/A

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**	**Supporting evidence**	**Gaps in Assurance**	**Mitigating Actions**
	when they attend and are not seen if symptomatic.			

Summary of performance for the Key lines of enquiry (rating based on the self-assessment and supporting evidence available)	**Rating (RAGB)**	**Rationale for rating**
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	Green	Key requirements are met.

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**	**Supporting evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure:				
• all staff (clinical and non- clinical) have appropriate training, in line with latest PHE and other guidance, to ensure their personal safety and working environment is safe	Local training records all departments. Daily Trust wide communications to alert staff to updated guidance. Risk assessments by line managers for at-risk staff.	Fit testing records (respirators) Example of All Staff comms updating staff on fit testing for a new model of respirator  2020429_StaffBrief fit testing on new mo	Nil	N/A
• 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	Training provided by IPC team and Resus team for staff using PPE. RUH PPE Guide and supporting posters, videos and leaflets in place to support face to face / virtual training. PPE Guardians providing local training and	Example of all staff comms promoting the Trusts skin care guide to support staff wearing PPE safely:  2020423_StaffBrief skin protection.pdf PHE AGP donning guide:	Nil	N/A

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**	**Supporting evidence**	**Gaps in Assurance**	**Mitigating Actions**
	undertaking regular audits/observations of compliance.	 PHE_COVID-19_Don ning_gown_version.pc		
• a record of staff training is maintained	PPE fit testing and PPE Champion training records held centrally. Local records held of PPE donning/doffing training sessions.	Staff training records	Nil	N/A
• appropriate arrangements are in place that any reuse of PPE in line with the CAS alert is properly monitored and managed	PPE stock stored centrally and delivered to areas as required. Daily updates of PPE stock levels are reported. A risk assessment was completed by the PPE sub-group against the 17 April CAS alert (available in the next column) and presented to Gold. Where reusable PPE was used (safety glasses, washable long sleeve gowns and resuable respirators) arrangements were in place to ensure appropriate	Assessment against 17.04.20 CAS alert:  Risk assessment and reccommendations - F RUH reusable respirator decontamination SOP:  JSP Force 10 Decontamination Inst Link to RUH PPE guide (including guidance on	Nil	Mutual aid is requested if PPE cannot be acquired through the Supply Chain. Reusable FFP3 masks are available for staff who have failed fit testing on single use masks.

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**	**Supporting evidence**	**Gaps in Assurance**	**Mitigating Actions**
	decontamination, use and monitoring of the line of PPE, including: ▪ Washable long sleeve gowns were rolled out to ED, DICU, ICU and Theatres only to ensure that correct processes were followed ▪ Reusable respirators are only used in areas which are able to implement the Trust's decontamination SOP ▪ Cleaning guidance for reusable safety glasses in the Trust's PPE Guide, promoted via AllStaff comms and supplied to individual departments at the same time that the glasses were distributed. Alerts re the quality/efficacy of NHS Supply Chain products	decontaminating reusable safety glasses) RUH PPE Guide (including guidance on safely decontaminating reusable safety glasses):  20200611_WearingPPE_FAQ_FINAL v6 7 Ju		

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**	**Supporting evidence**	**Gaps in Assurance**	**Mitigating Actions**
	are received by the ICC (through the Resilience inbox)			
• any incidents relating to the re-use of PPE are monitored and appropriate action taken	Incidents reported via Datix and investigated. Actions recorded by investigators. Matrons and PPE champions supporting monitoring and taking actions as required. Category on datix introduced for PPE. A member of the Trust's Health and safety team sits on the PPE sub group so any Datix incidents can be bought to the attention of the group.		Nil	N/A
• adherence to PHE national guidance on the use of PPE is regularly audited	PPE usage is reviewed (2x weekly) Using a PPE checklist – this is carried out by Team Leaders / Department managers who may delegate this role to PPE champions. Data from audit is held locally.	Using a PPE checklist – this is carried out by Team Leaders / Department managers who may delegate this role to PPE champions.	Nil	N/A

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**	**Supporting evidence**	**Gaps in Assurance**	**Mitigating Actions**
		Data from audit is held locally.		
• staff regularly undertake hand hygiene and observe standard infection control precautions	Monthly hand hygiene audits. PPE champions /IPC Team observing SIPCs as part of their daily ward/department visits. Poor compliance is escalated to the Senior Sister and Matron.	 Infection Prevention and Con	Nil	N/A
• hand dryers in toilets are associated with greater risk of droplet spread than paper towels. Hands should be dried with soft, absorbent, disposable paper towels from a dispenser which is located close to the sink but beyond the risk of splash contamination as per national guidance	Matrons have confirmed that there are no hand driers in clinical environments.		Nil	N/A
• guidance on hand hygiene, including drying, should be	Posters providing guidance on hand hygiene		Nil	N/A

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**	**Supporting evidence**	**Gaps in Assurance**	**Mitigating Actions**
clearly displayed in all public areas as well as staff areas	and drying of hands are in all staff and public areas.			
• staff understand the requirements for uniform laundering where this is not provided for on site	Covered by the Trust PPE guide, and promoted through the All Staff briefing. This is also included inIPC level 2 mandatory training. Additional changing facilities were provided during the first phase Covid response to support adherence with the Uniform Policy. All staff are asked to wear civilian clothes to work. Designated areas available for changing and showering. At the end of each shift uniforms are put into a designated bag and advise given as per washing instructions.	RUH PPE Guide:  20200611_WearingPPE_FAQ_FINAL v6 7 Ju All staff briefing including guidance on uniform wearing and additional changing facilities:  2020428_StaffBrief including Uniforms.pd	Nil	N/A

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**	**Supporting evidence**	**Gaps in Assurance**	**Mitigating Actions**
• all staff understand the symptoms of COVID-19 and take appropriate action in line with PHE and other national guidance if they or a member of their household display any of the symptoms.	Dedicated absence line for staff to report absence, managed by ICC and staffing command. ICC Staffing Command advise staff on actions to take. Advice is documented. Screening available to staff and household members via Occupational Health. Daily staff brief used to inform and remind staff of the importance of reporting absence early. In addition there is a quick link on the clinical intranet home page to the absence reporting flow chart. ,	 Absence_reporting_flowchart.pdf  ICC_guidance_for_staff.pdf  2020_03_18_Staff_Brief.pdf  2020_04_03_Staff_Brief.pdf	Some staff do not report their symptoms in line with Trust/PHE guidance.	Further communications to be circulated reminding staff of their responsibility to report symptoms.

Summary of performance for the Key lines of enquiry (rating based on the self-assessment and supporting evidence available)	**Rating (RAGB)**	**Rationale for rating**
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	Yellow	Key requirements are mostly met with minimal action required. Staff are not always reporting their symptoms through the appropriate channels.

7. Provide or secure adequate isolation facilities				
Key lines of enquiry	**Evidence**	**Supporting evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure:				
• patients with suspected or confirmed COVID-19 are isolated in appropriate facilities or designated areas where appropriate	Use of appropriate wards and clinical pathways which are regularly reviewed allowing bed base to be reactive to COVID numbers. Currently (19/6/20) Helena ward is dedicated for COVID patients utilising side rooms. Criteria in place to increase capacity if required.	 Helena Covid Ward SOP V3.docx	Nil	Patients isolated where possible. If unable to isolate, patients are cohorted and all beds are more than 2 metres apart to ensure that social distancing is maintained. Patients use designated 'bay' toilets to reduce cross-contamination**.**
• 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	Doors have been installed on all bays. Designated 'bay' toilets used. Social distancing measures have been put in place and beds have been removed to support this (currently 107 beds). Estates works have been carried out where required: improved ventilation, bed curtain track changes to ensure social distancing etc.,		There is no standard signage on cohort areas regarding risk on entry.	IPC Team will develop signage for cohort areas.

7. Provide or secure adequate isolation facilities				
Key lines of enquiry	**Evidence**	**Supporting evidence**	**Gaps in Assurance**	**Mitigating Actions**
• patients with resistant/alert organisms are managed according to local IPC guidance, including ensuring appropriate patient placement	IPC Team continue to follow up patients with resistant/alert organisms and advise on IPC precautions and isolation according to pre-established policies. Multidrug resistant organisms are flagged to clinical teams, patient contact tracing conducted as needed, environmental decontamination undertaken and there is ongoing surveillance for any linked cases.	Antibiotic Resistant Organisms Policy  Yellow_630.pdf	Nil	N/A

Summary of performance for the Key lines of enquiry (rating based on the self-assessment and supporting evidence available)	**Rating (RAGB)**	**Rationale for rating**
Provide or secure adequate isolation facilities	Green	Key requirements are met.

8. Secure adequate access to laboratory support as appropriate				
Key lines of enquiry	**Evidence**	**Supporting evidence**	**Gaps in Assurance**	**Mitigating Actions**
There are systems and processes in place to ensure:				
• testing is undertaken by competent and trained individuals	Laboratory manager ensures that staff are trained to carry out testing and holds training records.	Training records Laboratory SOP for processing samples	Nil	N/A
• patient and staff COVID-19 testing is undertaken promptly and in line with PHE and other national guidance	Patient testing is undertaken promptly (see Section 5) Staff testing pathways are in place, managed by ICC and Occupational Health. Records of tests undertaken are kept.	 RUH Healthcare Worker Testing Stra  Occupational Spreadsheet.docx  COVID 7 DAY RESWAB May 2020 S  BAFSNAPSHOT.docx	Nil	N/A
• screening for other potential infections takes place	Patient risk assessments are completed on admission. Screening for other infections, e.g. MRSA, CPE,continues		Nil	N/A

8. Secure adequate access to laboratory support as appropriate				
Key lines of enquiry	**Evidence**	**Supporting evidence**	**Gaps in Assurance**	**Mitigating Actions**
	as normal. Laboratory records are available to demonstrate this.			

Summary of performance for the Key lines of enquiry (rating based on the self-assessment and supporting evidence available)	**Rating (RAGB)**	**Rationale for rating**
Secure adequate access to laboratory support as appropriate	Green	Key requirements are met.

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**	**Supporting evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure that:				
• staff are supported in adhering to all IPC policies, including those for other alert organisms	IPC training records on ESR/STAR. Local IPC Champions undertaking local training. C diff workbook compliance recorded by Senior Sisters. Training reported to IPCC Operational Group.	IPCC Op Group data summary for training	Nil	N/A
• any changes to the PHE national guidance on PPE are quickly identified and effectively communicated to staff	All changes in PPE guidance are reported to the PPE Sub-Group and included in Trust wide daily communications. The PPE Sub-Group has met daily throughout the COVID response, and has held responsibility for the Trust's PPE Guide and associated documentation. When new updates have been received, the approach taken has been: ▪ PPE Sub-Group, including IPC to review	Example All Staff briefing:  20200612_StaffBrief face coverings.pdf	Nil	N/A

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**	**Supporting evidence**	**Gaps in Assurance**	**Mitigating Actions**
	the changes and agree RUH adoption/approach ▪ Significant changes in approach agreed at Gold Comms representative on the PPE Sub-Group has then led on agreeing the most approach communication method, including updating the PPE Guide; All Staff briefing; daily Exec video; updating intranet; visits to departments by IPC/Matrons; discussion at weekly PPE briefing for Ward Managers/Heads of Department; briefing to the PPE Champions, briefing on workplace.			
• all clinical waste related to confirmed or suspected COVID-19 cases is handled, stored and managed in accordance with	SOP C0611 from NHS E/I being implemented to reduce 'over-treatment' of waste in line with HTM 0701 Waste audits completed in all areas annually with re-	C0611 COVID-19 Waste Management	Nil	N/A

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**	**Supporting evidence**	**Gaps in Assurance**	**Mitigating Actions**
current national guidance	audits for area with poor performance. Clear graphical waste type labels stuck on bin lids to aid correct segregation	02.07.2020 Haygarth Ward was 24.06.2020 Midford ward waste audit.dc Waste Bin labels RUH.pdf		
• PPE stock is appropriately stored and accessible to staff who require it	PPE stock stored centrally and delivered to areas as required. Daily updates of PPE stock levels are reported. To support management of PPE, a separate PPE Store was established, and a dedicated phone line put in place. Out of hours, a PPE sub-store is located in the centre of the building and can be accessed by any team via Security.	Map of RUH PPE store and PPE Sub-Store, from Covid intranet pages: 	Nil	Mitigation – mutual aid is requested if PPE cannot be acquired through the Supply Chain. Reusable FFP3 masks are available for staff who have failed fit testing on single use masks.

Summary of performance for the Key lines of enquiry (rating based on the self-assessment and supporting evidence available)	Rating (RAGB)	Rationale for rating
Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections	Green	Key requirements are met.

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**	**Supporting evidence**	**Gaps in Assurance**	**Mitigating Actions**
Appropriate systems and processes are in place to ensure:				
• staff in 'at-risk' groups are identified and managed appropriately including ensuring their physical and psychological wellbeing is supported	Risk assessments for BAME staff, risk assessments available for all staff that have been identified in an "at risk category" held by line managers. Central records held of all completed risk assessments, daily figures reported at Trust, division / department, speciality, ward and team level to drive an increase in completed risk assessments. Letter sent to all BAME staff sign-posting psychological well-being support. A handbook of all available support is available in both hard copy and electronically.	 FINAL Letter to BAME Staff 27.4.20 v  PRINTABLE VERSION 20200415_	Nil	Occupational Health advice being given to any staff seeking reassurance, advice and help. Redeployed staff to non-patient facing or low risk areas. Review of current health and wellbeing offering to ensure it is accessible to all staff groups.

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**	**Supporting evidence**	**Gaps in Assurance**	**Mitigating Actions**
• staff required to wear FFP reusable respirators undergo training that is compliant with PHE national guidance and a record of this training is maintained	Fit testing/training records for staff who use reusable respirators are held centrally.	RUH reusable respirator decontamination SOP:  JSP Force 10 Decontamination Inst	Nil	N/A
• consistency in staff allocation is maintained, with reductions in the movement of staff between different areas and the cross-over of care pathways between planned and elective care pathways and urgent and emergency care pathways, as per national guidance	Staff are identified and allocated to work in the individual areas to minimise movement of staff. Staff moved only between COVID cohorted wards. When areas are identified as an outbreak / cluster or a risk is identified of concern staff are not redeployed from these areas to work elsewhere in the Trust. Planned/elective care pathways have designated daily staffing to ensure no cross-over	C30 staffing model Theatres staffing model	Cleaning staff not segregated	All other transmission mitigation is 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**	**Supporting evidence**	**Gaps in Assurance**	**Mitigating Actions**
	with urgent/emergency care pathway staffing.			
• all staff adhere to national guidance on social distancing (2 metres) wherever possible, particularly if not wearing a face mask and in non-clinical areas	Trust wide message to ensure staff adhere to social distancing measures. All staff supported and empowered to challenge staff who are not adhering to social distancing measures. Signage to promote adherence across the Site.	Maximum occupancy room poster:  Keep_your_distance_room_poster.pdf Staff brief on distancing:  Staff_brief_20200703 social distancing.pdf Covid-secure risk assessment:  COVID Safe RA final.docx	Nil	N/A
• consideration is given to staggering staff breaks to limit the density of healthcare workers in specific areas.	Staff breaks are currently staggered. Staff room doors clearly indicate the maximum number of people allowed at any time. Where possible staff are		Nil	N/A

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**	**Supporting evidence**	**Gaps in Assurance**	**Mitigating Actions**
	encouraged to use alternative or outdoor spaces for their breaks.			
• staff absence and well-being are monitored and staff who are self-isolating are supported and able to access testing	All symptomatic staff who phone the ICC are referred to Occupational for testing. Household members are also tested to reduce the number of isolating staff. Testing was available 7 days a week. This was reduced to 5 days a week from 19 June. Occupational Health are able to put on additional clinics should a track and trace be instigate (this has been done on a Sunday due to timings of swabs). Staff are offered the option to attend regional testing centres if they prefer, although most chose RUH testing. Accommodation is provided free of charge for any staff requiring to self-isolate or shield their family.		Not all staff are contacting the ICC and this is logged as a risk.	Bristol Airport and home testing kits are available to all staff. Since the opening of the ICC regular communications has been sent out to all staff advising them to use the absence line for all sickness. Individual cards have been distributed to all staff giving information of when to call and the number to call to report sickness or absence and what to do when returning to work. ICC will email the individual's line manager to explain if colleague had been particularly upset/distressed on the phone alongside offer of EAP so that line managers can support staff.

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**	**Supporting evidence**	**Gaps in Assurance**	**Mitigating Actions**
• staff that test positive have adequate information and support to aid their recovery and return to work.	When results are given, further information and advice is provided about physical and mental health. At this time the staff member is also offered a welfare check from pastoral support. Essential supplies are provided by the hospital for any staff in isolation in hospital accommodation if required. Phone calls by ICC on return to work date to assess fitness to return		Nil	Welfare Checks for distressed staff are performed by the ICC, as well as a referral being sent to pastoral support. All referrals are documented on the individual forms. The ICC Also email the member of staffs line manager to explain if colleague had been particularly upset/distressed on the phone

Summary of performance for the Key lines of enquiry (rating based on the self-assessment and supporting evidence available)	**Rating (RAGB)**	**Rationale for rating**
Have a system in place to manage the occupational health needs and obligations of staff in relation to infection	Yellow	Key requirements are mostly met with minimal action required. The following gaps have been identified: • Cleaning staff are not segregated to work on designated areas consistently • Risk assessments outstanding for at risk staff groups

Infection Prevention and Control Board Assurance Framework Action Plan

KLOE Ref No	1
KLOE Statements	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.
Summary of gaps identified	Separate risk log which is currently not on Datix.

Action no	**Actions required** *(specify "None", if none required)*	**Action by date**	**Person responsible** *(Name and grade)*	**Status**	**Comments/action status** *(Provide examples of action in progress, changes in practices etc)*
1	Review of overlap and dependencies between the Phase 2 (BANU) risks, the COVID19 specific risks and the Trust corporate risks recorded on Datix	31/07/2020	Fiona Abbey, Transformation Programme Manager Rob Eliot, Quality Assurance and Clinical Audit Lead	Blue	Initial meeting held with Transformation Programme Manager, Quality Assurance and Risk Business Analyst, Quality Assurance and Clinical Audit Lead and Interim Resilience Manager. Risks on COVID-19 risk log and Datix reviewed.
2	Agree approach for recording of COVID-19 risks on the Risk Register on Datix	31/08/2020	Fiona Abbey, Transformation Programme Manager Rob Eliot, Quality Assurance and Clinical Audit Lead	Green	Following the initial meeting it has been proposed to record overarching risks on Datix which cover the main COVI9-19 and BANU workstreams. Further meeting held on 21 July. There are currently 3 major COVID-19 risks. These will be added to the risk register on Datix by August and reported to Management Board through the monthly risk register update paper.

On completion of all actions above, please provide examples / evidence of how these actions have led to improvements. Include any relevant KPIs (Process and Outcome Measures)

Do the actions taken and the evidence provided give sufficient assurance that the gaps identified for the KLOE has been addressed and can be closed down?
☐ Yes ☐ No **If No, please state why this recommendation cannot be closed down and what further actions are required to ensure the recommendations are met:**

Status	
Red	Cause for concern. No progress towards completion. Needs evidence of action being taken
Amber	Delayed, with evidence of actions to get back on track
Green	Progressing to time, evidence of progress
Blue	Action complete

KLOE Ref No	2
KLOE Statements	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.
Summary of gaps identified	• Designated cleaning teams are not consistently provided as cleaning bank staff are used to cover annual leave and sickness • Existing cleaning staff resource does not allow for twice daily cleaning in wards • Records of twice daily nurse equipment cleaning held locally and no audit in place • Less than 100% compliance with cleanliness of re-usable equipment

Action no	**Actions required** *(specify "None", if none required)*	**Action by date**	**Person responsible** *(Name and grade)*	**Status**	**Comments/action status** *(Provide examples of action in progress, changes in practices etc)*
1	Implementation of monthly audit for wards/department to audit cleanliness of non-clinical equipment	13/07/2020	Simon Andrews Deputy Head of Nursing	Green	Draft audit template taken from clinical equipment cleanliness to test in area 09/07/2020. Escalation plan in place if audit result <90%.
2	Clinical equipment cleanliness audit results reviewed weekly with Matron/Senior Sister and re-audit of areas with a less than 90% audit result weekly.	01/08/2020	Anita West, Matron Kenny Gale, Matron Di Dorrington, Matron	Green	Audit results reviewed at weekly Senior Sister infection prevention and control meeting led by Medical Matron. Escalation process in place for those areas achieving < 90%.
3	Individual ward/department action plans with weekly review for those areas less than 90%.	Ongoing	Anita West, Matron Kenny Gale, Matron Di Dorrington, Matron	Green	
4	Increase cleaning resource to allow for twice daily cleaning	31/08/2020	Philip Watson, Head of Facilities	Amber	40% of the planned 60 WTE agency staff are in place and working. Remaining agency staff awaiting recruitment clearance.
5	Create dedicated cleaning teams for COVID isolation/cohort wards to cover leave/sickness	31/07/2020	Philip Watson, Head of Facilities	Red	Over-staffing required on these wards to ensure leave/sickness cover

On completion of all actions above, please provide examples / evidence of how these actions have led to improvements. Include any relevant KPIs (Process and Outcome Measures)

Do the actions taken and the evidence provided give sufficient assurance that the gaps identified for the KLOE has been addressed and can be closed down?
☐ Yes ☐ No **If No, please state why this recommendation cannot be closed down and what further actions are required to ensure the recommendations are met:**

Status	
Red	Cause for concern. No progress towards completion. Needs evidence of action being taken
Amber	Delayed, with evidence of actions to get back on track
Green	Progressing to time, evidence of progress
Blue	Action complete

KLOE Ref No	3
KLOE Statements	Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.
Summary of gaps identified	• Capacity for microbiology Consultant input into AMS reduced is reduced from July onwards due to critical microbiology staff shortages • AFS CQUIN has not been supported due to staff shortages • AMS pharmacist capacity reduced • Quarterly TRUST AMS and medical Director meetings to review progress (cancelled) • A3 on antimicrobial stewardship and ARK not presented to CGC

Action no	**Actions required** *(specify "None", if none required)*	**Action by date**	**Person responsible** *(Name and grade)*	**Status**	**Comments/action status** *(Provide examples of action in progress, changes in practices etc)*
1	Business case for 5th Consultant pending. Locums being actively sourced	July 2020	Moya O'Doherty Clinical Director Pathology Nicky Ashton Surgical Divisional Manager	Amber	BC re-submitted 24/5/20, reviewed at TIG - awaiting feedback
2	AFS CQUIN has been postponed until April 2021	April 2021	Katia Montella	Amber	Amber because postponed until next year
3	Discussions have taken place with Pharmacy Director who is supportive of increasing hours for AMS pharmacist.	September 2020	Uzoma Ibechukwu Chief Pharmacist	Green	Pathology and Pharmacy plan to review AMS framework and draft 5 year plan (to be picked up in A3, see below)
4	AMS quarterly Trust meetings and meeting with medical director to be re-instated	July 2020	Bernie Marden, Medical Director	Amber	Trust meeting booked 13th July
5	A3 review of AMS resources and strategy to be progressed. To contact Coach House to ask for support and resources to review the trust approach to AMS. This will mirror Trust break	September 2021	Uzo Ibechukwu Chief Pharmacist Moya O'Doherty Pathology Director	Amber	An action from Dec 2019 CGC was to review AMS using A3 approach but due to Covid this never took place. This now will now be led by the Chief

Action no	Actions required *(specify "None", if none required)*	Action by date	Person responsible *(Name and grade)*	Status	Comments/action status *(Provide examples of action in progress, changes in practices etc)*
	though objective to reduce hospital acquired infections with AMS being contributory to this				Pharmacist and the Clinical Lead for Pathology plus involvement from individual specialist teams. The Head of The Coach House has agreed to support.

On completion of all actions above, please provide examples / evidence of how these actions have led to improvements. Include any relevant KPIs (Process and Outcome Measures)

Do the actions taken and the evidence provided give sufficient assurance that the gaps identified for the KLOE has been addressed and can be closed down?
☒ Yes ☐ No **If No, please state why this recommendation cannot be closed down and what further actions are required to ensure the recommendations are met:**

Status	
Red	Cause for concern. No progress towards completion. Needs evidence of action being taken
Amber	Delayed, with evidence of actions to get back on track
Green	Progressing to time, evidence of progress
Blue	Action complete

KLOE Ref No	4
KLOE Statements	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.
Summary of gaps identified	• There is no standard signage in place for defining cohort areas • Recording of infection status on discharge summaries

Action no	**Actions required** *(specify "None", if none required)*	**Action by date**	**Person responsible** *(Name and grade)*	**Status**	**Comments/action status** *(Provide examples of action in progress, changes in practices etc)*
1	Signage to be developed for the cohort areas	30/06/2020	Yvonne Pritchard, Senior Nurse, Infection Control	Blue	Completed. Signage now available.
2	Update the discharge summary template to include infection status	30/09/2020	Jessica Flower, Change Lead	Green	

On completion of all actions above, please provide examples / evidence of how these actions have led to improvements. Include any relevant KPIs (Process and Outcome Measures)

Do the actions taken and the evidence provided give sufficient assurance that the gaps identified for the KLOE has been addressed and can be closed down?

☐ Yes
☐ No

If No, please state why this recommendation cannot be closed down and what further actions are required to ensure the recommendations are met:

Status	
Red	Cause for concern. No progress towards completion. Needs evidence of action being taken
Amber	Delayed, with evidence of actions to get back on track
Green	Progressing to time, evidence of progress
Blue	Action complete

KLOE Ref No	5
KLOE Statements	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.
Summary of gaps identified	• PPE guidance to be updated

Action no	**Actions required** *(specify "None", if none required)*	**Action by date**	**Person responsible** *(Name and grade)*	**Status**	**Comments/action status** *(Provide examples of action in progress, changes in practices etc)*
1	PPE guidance to be updated to reflect changing of masks	31/07/2020	Fiona Bird, Head of Business Development	Green	

On completion of all actions above, please provide examples / evidence of how these actions have led to improvements. Include any relevant KPIs (Process and Outcome Measures)

Do the actions taken and the evidence provided give sufficient assurance that the gaps identified for the KLOE has been addressed and can be closed down?

☐ Yes
☐ No

If No, please state why this recommendation cannot be closed down and what further actions are required to ensure the recommendations are met:

Status	
Red	Cause for concern. No progress towards completion. Needs evidence of action being taken
Amber	Delayed, with evidence of actions to get back on track
Green	Progressing to time, evidence of progress
Blue	Action complete

KLOE Ref No	7
KLOE Statements	Provide or secure adequate isolation facilities.
Summary of gaps identified	• No standard signage on cohort areas

Action no	**Actions required** *(specify "None", if none required)*	**Action by date**	**Person responsible** *(Name and grade)*	**Status**	**Comments/action status** *(Provide examples of action in progress, changes in practices etc)*
1	Signage to be developed for the cohort areas	30/06/2020	Yvonne Pritchard, Senior Nurse, Infection Control	Blue	Completed. Signage now available.

On completion of all actions above, please provide examples / evidence of how these actions have led to improvements. Include any relevant KPIs (Process and Outcome Measures)

Do the actions taken and the evidence provided give sufficient assurance that the gaps identified for the KLOE has been addressed and can be closed down?

☐ Yes
☐ No

If No, please state why this recommendation cannot be closed down and what further actions are required to ensure the recommendations are met:

Status	
Red	Cause for concern. No progress towards completion. Needs evidence of action being taken
Amber	Delayed, with evidence of actions to get back on track
Green	Progressing to time, evidence of progress
Blue	Action complete

KLOE Ref No	10
KLOE Statements	Have a system in place to manage occupational health needs and obligations of staff in relation to infection
Summary of gaps identified	Percentage of BAME staff risk assessments completed below 80%

Action no	**Actions required** *(specify "None", if none required)*	**Action by date**	**Person responsible** *(Name and grade)*	**Status**	**Comments/action status** *(Provide examples of action in progress, changes in practices etc)*
1	Central collation of BAME risk assessments completed in divisions and departments	23/07/2020	Victoria Downing-Burn, Deputy Director for People	Green	Compliance figures to be submitted to NHSE/I by 23.7.20. Daily updates are available.
2	Line managers to be made aware of outstanding risk assessments	Daily	Andrew Howse, Senior Workforce Analyst	Green	Names of those without RAs circulated daily to Divisional Leads for cascading to Ward/Department Manager
3	Establish the total number of BAME staff available for risk assessment (excluding those who are absent)	01/06/2020	Andrew Howse, Senior Workforce Analyst	Blue	
4	Data capture of those offered but declined to complete risk assessment	23/07/2020	Victoria Downing-Burn, Deputy Director for People	Green	Managers asked to inform HR of BAME staff who decline a RA
5	Ward/Department Managers to refer BAME staff to Occupational Health for advice as appropriate	Ongoing	Ward/Department Managers	Green	Engagement of OHS Lead Doctor in process.

On completion of all actions above, please provide examples / evidence of how these actions have led to improvements. Include any relevant KPIs (Process and Outcome Measures)
Daily improvement seen of RAs completed for BAME Staff. Anticipated experience of staff to feel safe and supported within the workplace.

Do the actions taken and the evidence provided give sufficient assurance that the gaps identified for the KLOE has been addressed and can be closed down?
Yes **If No, please state why this recommendation cannot be closed down and what further actions are required to ensure the recommendations are met:**

Status	
Red	Cause for concern. No progress towards completion. Needs evidence of action being taken
Amber	Delayed, with evidence of actions to get back on track
Green	Progressing to time, evidence of progress
Blue	Action complete