Royal United Hospitals Bath
NHS Foundation Trust

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| **Report to:** | **Public Board** | **Agenda item:** | **14** |
| **Date of Meeting:** | **27th January 2021** | | |

| | |
|---|---|
| **Title of Report:** | **Infection Prevention and Control Board Assurance Framework and outbreaks update** |
| **Status:** | **For review** |
| **Board Sponsor:** | **Lisa Cheek, Director of Nursing and Midwifery** |
| **Author:** | **Rob Eliot, Quality Assurance and Clinical Audit Lead**<br>**Sarah Merritt, Deputy Director of Nursing and Midwifery** |
| **Appendices** | **Appendix A: Self-Assessment and Action Plan: Infection Prevention and Control** |

## 1. Executive Summary of the Report

The purpose of this report is to update the Trust Board on the self-assessment (Appendix A) completed to ensure the Trust is meeting key Infection Prevention and Control requirements for COVID-19. This includes an assessment of adherence to the following key guidance:

- Infection Prevention and Control (IPC) Board Assurance Framework. This framework has been developed by NHS England and is structured around the ten criteria of the code of practice on the prevention and control of infections (Hygiene Code). This links directly to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
- CQC infection prevention and control inspection prompts. Whilst the prompts are for care homes the CQC plan to adapt them for use with other services.
- NHS England: Key Actions: infection prevention and control and testing (last updated 23 December 2020). This guidance outlines key actions on infection prevention and control for organisations and systems including board responsibilities, staff testing and patient testing
- NHS England: Checklist and monitoring tool for the management of COVID-19 (based on COVID-19 Guidance for the remobilisation of services with health and care settings: IPC recommendations)

Where gaps in assurance have been identified, an action plan has been developed. The action plan identifies the relevant KLOEs or guidance prompts which are not being met and details the actions that have or will be taken to address these gaps. Delivery of the action plan is monitored by the COVID Action Plan Monitoring Group on a weekly basis. This group reports to the Operational Infection Prevention and Control Committee.

This report also provides an update on the outbreaks, which were first reported on 4 November 2020.

## 2. Recommendations (Note, Approve, Discuss)

The Trust Board is requested to discuss the completed self-assessments against key Infection Prevention and Control guidance and note the outbreaks update.

| 3. | Legal / Regulatory Implications |
|---|---|
| Health and Safety at Work Act 1974.<br>Code of Practice on the prevention and control of infection (linked directly to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. | |

| 4. | Risk (Threats or opportunities, link to a risk on the Risk Register, Board Assurance Framework etc) |
|---|---|
| Datix 180 Lack of isolation facilities<br>A failure to demonstrate adherence to infection prevention and control requirements could risk the Trust's registration with the Care Quality Commission (CQC). | |

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

| 6. | Equality and Diversity |
|---|---|
| No issues identified. Equality and Diversity legislation is an integral component to registration with the CQC. | |

| 7. | References to previous reports |
|---|---|
| Clinical Governance Committee on 12th January 2021. | |

| 8. | Freedom of Information |
|---|---|
| Private | |

# Infection Prevention and Control (IPC) Board Assurance Framework

## 1 Introduction to the IPC Board Assurance Framework

1.1 NHS England have developed the IPC 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.

1.2 The framework is structured around the ten criteria of the code of practice on the prevention and control of infections (Hygiene Code). This links directly to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

1.3 Although the framework is not compulsory, it is recommended to be used as a source of internal assurance to help organisations to maintain quality standards for infection prevention and control.

1.4 The Care Quality Commission (CQC) also used the IPC Board Assurance Framework in conversations they hold with providers with a focus on ensuring that trusts can provide assurance that they are meeting key infection prevention and control guidance.

1.5 A self-assessment was completed against the Board Assurance Framework and submitted to the Board of Directors in July 2020. An action plan was also developed to address any gaps in compliance with IPC guidance identified from the self-assessment.

1.6 NHS England updated the IPC Board Assurance Framework with additional Key Lines of Enquiry in October 2020.

## 2 Other Infection Prevention and Control Guidance

2.1 In addition to the IPC Board Assurance Framework, the following key documents have also been reviewed:

- CQC infection prevention and control inspection prompts. Whilst the prompts are for care homes the CQC plan to adapt them for use with other services.

- NHS England: Key Actions: infection prevention and control and testing (last updated 23 December 2020). This guidance outlines key actions on infection prevention and control for organisations and systems including board responsibilities, staff testing and patient testing

- NHS England: Checklist and monitoring tool for the management of COVID-19 (based on COVID-19 Guidance for the remobilisation of services with health and care settings: IPC recommendations)

## 3 Self-assessment

3.1 A combined self-assessment tool (Appendix A) has been developed which includes a review of compliance with the requirements of the IPC Board Assurance Framework and the additional guidance outlined in Section 2.

3.2 This self-assessment is broken down into the following 8 sections:

- Visiting (and visitors)
- Social distancing (Shielding)
- Patient pathways (Admission)
- Personal Protective Equipment (PPE)
- Testing
- Estates and Facilities (Premises)
- Staffing
- Policies

3.3 Each section includes a guidance page that lists the applicable Key Lines of Enquiry (KLOEs) or guidance prompts from the IPC Board Assurance Framework, CQC inspection prompts and NHS England key actions.

3.4 A self-assessment has been completed for each section which details the processes in place to support compliance with the guidance, information on assurance and monitoring processes and details of any concerns identified. A Red, Amber, Yellow, Green (RAYG) rating has been assigned to each section to indicate the level of adherence to the guidance.

3.5 Table 1 provides an overview of the self-assessment ratings and includes details of any gaps in compliance with the guidance.

| Section | Rating (RAYG) | Summary of gaps identified |
|---|---|---|
| 1. Visiting (and visitors) | Green | Requirements are met. However, work continues to improve signage and information available for visitors. |
| 2. Social distancing (Shielding) | Yellow | Most of the requirements are met and mitigating actions are in place. Work continues on ensuring all staff are adhering to 2m IPC guidance for social distancing |
| 3. Patient pathways (Admission) | Yellow | Most of the requirements are met. Work continues on improving compliance for admission swabs. |
| 4. Personal Protective Equipment (PPE) | Green | Key requirements are met. |
| 5. Testing | Yellow | Most of the requirements are met, however the Trust is not 100% compliant for swabs taken on admission, day 3 and days 5-7. |

| Section | Rating (RAYG) | Summary of gaps identified |
|---|---|---|
| 6. Estates and Facilities (Premises) | Amber | Most of the requirements are met, however there are vacancies within the cleaning team which impacts on the ability to ensure all frequently touched surfaces are cleaned at least twice daily. Work continues to understand the impact of ventilation on virus transmission. |
| 7. Staffing | Yellow | The requirements are mainly met. Work continues on the review and implementation of training specific to COVID-19. |
| 8. Policies | Yellow | Requirements are mostly met. There are some gaps in completion of risk assessments for at risk staff and antimicrobial stewardship oversight. |

| | |
|---|---|
| Green | Evidence available at the time of assessment shows the lines of enquiry are met |
| Yellow | Evidence available at the time of assessment shows that the lines of enquiry are 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 lines of enquiry are 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 lines of enquiry are not being met. Impact on people who use services or staff is high/significant. Immediate action is required |

3.6 Where gaps in assurance have been identified for each section, an action plan has been developed. The action plan identifies the relevant KLOEs or guidance prompts which are not being met and details the actions that have or will be taken to address these gaps.

3.7 Each action has been RAGB (red, amber, green, blue) rated to indicate whether the actions are progressing according to the timescales identified in the action plan. The comments / action status column has been updated to reflect progress towards implementing the actions.

3.8 On completion of all actions under each section, the identified action leads will be responsible for providing examples or evidence of how the actions that have been implemented have led to improvements. Each section of the action plan will not be closed down unless there are demonstrable improvements to performance and evidence of adherence to the guidelines.

## 4 Next steps

4.1 Delivery of the improvement plan will be monitored by the COVID Action Plan Monitoring Group on a weekly basis. This group reports to the Operational Infection Prevention and Control Committee.

4.2 Additional documented evidence will be requested to support the statements contained with the self-assessment, such as Standard Operating Procedures (SOP), audit results and examples of monitoring processes.

## 5 Update on COVID-19 Outbreaks

5.1 18 outbreaks have been declared since the first outbreak was reported on 04/11/2020.

5.2 The following actions have been taken:

- **Environmental review**
  - Ventilation, declutter and cleanliness
  - Additional facility for staff breaks to support social distancing
  - Increased vigilance around PPE provision, use of hand gel and social distancing

- **Communication and signage**
  - Increased signage at all entrances, on corridors and on wards and IT solutions
  - Suspended visiting except in exceptional circumstances

- **Visibility**
  - Marshals in clinical areas to support IPC and PPE compliance
  - Clinical Walkabouts by senior nursing team
  - Reduced staff and public entrances to the RUH, staffed to support compliance

- **Patient Care**
  - Weekly patient screening
  - Careful rostering of staff to avoid sharing across clinical areas
  - Inpatients encouraged to wear face masks
  - Screens between beds to support social distancing
  - Careful close management of patient placement

5.3 A comprehensive review into all the deaths is underway to identify the degree of any possible attribution. An overarching Serious Incident investigation into the ward outbreaks is also being undertaken.

5.4 Daily outbreak meetings have been held since 4 November 2020. These have been more recently attended by CCG, B&NES and Public Health England (PHE) (Epidemiologist and Virologist).

5.5 An external peer review was undertaken on 3 December 2020 by the Associate Director of Infection Prevention and Control, Great Western Hospital and the Senior Infection Prevention and Control Nurse for NHSE/I SW. No breaches were identified from the external visit.

5.6 As of 4 January 2021, there is one final outbreak area but this is due to end shortly. PHE consider their support no longer required.

## 6 Recommendations

6.1 The Board of Directors is requested to discuss the completed self-assessments against key Infection Prevention and Control guidance and note the outbreaks update.

# Appendix A:
# Self-Assessment and Action Plan: Infection Prevention and Control
## Contents



WWW.CQC.ORG.UK | www.england.nhs.uk/coronavirus | GOV.UK | NHS.UK



Author: Rob Eliot, Quality Assurance and Clinical Audit Lead
Version 5 (5 January 2021)

# 1 Visiting (and visitors)

**Guidance**

**Description: In this area, we assess whether all types of visitors are prevented from catching and spreading infection**

**CQC Inspection Prompts:**

When we're inspecting, we look at:

- The measures in place to prevent relatives and friends, professionals and others visiting from spreading infection at the entrance and on entering the home
- The procedures people have to follow during the visit, how they're explained and how well they're followed by visitors
- The alternatives to visiting in person that the home has put in place

**NHS England: Checklist and monitoring tool for the Management of COVID-19**

- All entrances have signs directing patients with respiratory symptoms where to proceed
- Signs on respiratory hygiene and cough etiquette are displayed at all entrances, waiting areas and by all lifts catch-bin-kill.pdf
- Hand hygiene stations are available at all entrances
- Face mask stations are available at all entrances

**Infection Prevention and Control Board Assurance Framework:**

- KLOE 4a: implementation of national guidance on visiting patients in a care setting
- KLOE 4b: 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
- KLOE 4c: information and guidance on COVID-19 is available on all Trust websites with easy read versions
- KLOE 4d: infection status is communicated to the receiving organisation or department when a possible or confirmed COVID-19 patient needs to be moved
- KLOE 4e: there is clearly displayed and written information available to prompt patients' visitors and staff to comply with hands, face and space advice.
- KLOE 6h: hygiene facilities (IPC measures) and messaging are available for all patients/individuals, staff and visitors to minimise COVID-19 transmission such as:
  - hand hygiene facilities including instructional posters
  - good respiratory hygiene measures
  - maintaining physical distancing of 2 metres wherever possible unless wearing PPE as part of direct care
  - frequent decontamination of equipment and environment in both clinical and non-clinical areas
  - clear advice on use of face coverings and facemasks by patients / individuals, visitors and by staff in non-patient facing areas
- KLOE 6k: guidance on hand hygiene, including drying, should be clearly displayed in all public areas as well as staff areas



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# Appendix A:
# Self-Assessment and Action Plan: Infection Prevention and Control
## Visiting (and visitors) Self-Assessment:

Royal United Hospitals Bath
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| Processes (policies/SOPs) | Assurance / monitoring processes |
|---|---|
| • Trust-wide visiting guidance in place (updated regularly in line with national guidance) including restrictions on visiting (and available through the RUH website) - https://www.ruh.nhs.uk/patients/services/wards/visiting.asp?menu_id=1<br>• Information for patients and the public is available and regularly updated on the Trust website.<br>• Information leaflets available on visiting<br>• Signage in place for isolation rooms<br>• Restricted access in place for high risk areas<br>• Infection status is recorded on Patient Flow for internal transfers<br>• SBAR in place for internal transfers which includes infection status<br>• Infections recorded in depart summary<br>• Posters providing guidance on hand hygiene and drying of hands are in all staff and public areas. There are closed ward signs in place and the number of public and staff entrances have been reduced down to 3 entrances. There are manned hand hygiene / PPE stations at these entrances. | • Rota held for hand hygiene / PPE stations.<br>• Any issues raised are discussed at Gold / IPC Reference Group. |
| | **Concerns identified (gaps in assurance)** |
| | • Easy read versions of Trust COVID-19 patient information leaflets is not available. However, easy read versions of PHE guidance are available on the gov.uk website and these can be printed for patients<br>• Shortage of posters in public areas instructing how to use hand gel and hand wash<br>• More posters on respiratory hygiene are required throughout the Trust<br>• There is no signage informing patients that the environment is cleaned frequently both in clinical and non-clinical areas. |

| How would you rate performance for this section? | | Rationale for rating |
|---|---|---|
| ☒Green | Evidence available at the time of assessment shows the lines of enquiry are met | Requirements are met. However, work continues to improve signage and information available for visitors. |
| ☐Yellow | Evidence available at the time of assessment shows that the lines of enquiry are 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 lines of enquiry are 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 lines of enquiry are not being met. Impact on people who use services or staff is high/significant. Immediate action is required | |



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# 2 Social distancing (Shielding)

**Guidance**

**Description: In this area, we assess whether shielding and social distancing rules are followed**

**CQC Inspection Prompts:**

When we're inspecting, we look at:

- How staff and people using services socially distance and shield
- The impact on wellbeing of people using the service. How they have been supported and enabled to go out and return safely
- The measures in place for when it's not possible to socially distance
- The measures in place (for example isolation) for when there is infection or an outbreak

**NHS England: Key actions for infection prevention and control and testing**

- Key action 2: Staff maintain social distancing (2m+) in the workplace, when travelling to work (including avoiding car sharing) and remind staff to follow public health guidance outside of the workplace

**Infection Prevention and Control Board Assurance Framework:**

- KLOE 5g: ideally segregation should be with separate spaces, but there is potential to use screens, e.g. to protect reception staff
- KLOE 7a: restricted access between pathways if possible, (depending on size of the facility, prevalence/incidence rate low/high) by other patients/individuals, visitors or staff
- KLOE 7b: areas/wards are clearly signposted, using physical barriers as appropriate to patients/individuals and staff understand the different risk areas
- KLOE 7c: patients with suspected or confirmed COVID-19 are isolated in appropriate facilities or designated areas where appropriate
- KLOE 7d: 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
- KLOE 7e: patients with resistant/alert organisms are managed according to local IPC guidance, including ensuring appropriate patient placement
- KLOE 10m: all staff adhere to national guidance on social distancing (2 metres) if not wearing a face mask and in non-clinical areas
- KLOE 10n: consideration is given to staggering staff breaks to limit the density of healthcare workers in specific areas
- KLOE 10o: health and care settings are COVID-19 secure workplaces as far as practical, that is, that any workplace risk(s) are mitigated maximally for everyone



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# Appendix A:
# Self-Assessment and Action Plan: Infection Prevention and Control
## Social distancing (Shielding) Self-Assessment:

Royal United Hospitals Bath
NHS Foundation Trust

| Processes (policies/SOPs) | Assurance / monitoring processes |
|---|---|
| • Risk assessments carried out to identify any gaps in social distancing practice and mitigating actions. Any areas that require segregation to operate safely have screens. Changes include segregation of waiting areas, installation of screens on reception and beds separated with curtain tracks adjusted and screens installed in inpatient areas<br>• Low, medium and high risk pathways identified in line with national guidance. SOPs in place for low risk pathways to avoid mixing of staff and patients with other pathways<br>• High risk areas identified, e.g. COVID cohort wards. These have restricted access for patients with COVID only. Staffing of each pathway is maintained separately wherever possible<br>• Doors installed on all bays. Designated bay toilets used<br>• Standard signage developed for cohort areas<br>• Staff workplaces reviewed to allow for social distancing. COVID secure risks assessments completed. Staff breaks are staggered. Staff rooms and offices clearly indicate maximum number of people allowed at any time<br>• Senior nurse visibility and presence. Spot check of areas to ensure social distancing rules are maintained (completed by Director / Deputy Director of Nursing and Midwifery and Senior Nurses within the divisions)<br>• A marquee has been erected to provide additional staff break area | IPC Assurance Checklist Audit monitors where staff are maintaining social distancing in clinical areas (new checklist launched 30 November 2020).<br><br>Health & Safety undertake spot checks on COVID secure workplaces<br><br>Social distancing posters including:<br>https://webserver.ruh-bath.nhs.uk/staff_resources/COVID-19/posters.asp<br>• Keep Your Distance – Reception<br>• Keep Your Distance – Meeting Room<br>• Keep Your Distance – General Areas<br>• Keep Your Distance – Staircases<br>• Keep Your Distance – Children's Tiger Colouring<br><br>Staff shielding guidance (see Staff Brief 11/12/20) |
| | **Concerns identified (gaps in assurance)** |
| | Not all staff are adhering to 2m IPC guidance for social distancing in staff and clinical rooms.<br><br>Lack of suitable space for staff to take breaks (Social distancing requirements has reduced staff rest rooms to minimal).<br><br>Whilst appropriate measures have been taken to minimise risks to patients (e.g. ventilation and screens) the 2m social distancing rule cannot be adhered to in all inpatient areas. |

| How would you rate performance for this section? | | Rationale for rating |
|---|---|---|
| ☐Green | Evidence available at the time of assessment shows the lines of enquiry are met | Most of the requirements are met and mitigating actions are in place. |
| ☒Yellow | Evidence available at the time of assessment shows that the lines of enquiry are 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 lines of enquiry are 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 lines of enquiry are not being met. Impact on people who use services or staff is high/significant. Immediate action is required | |



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# 3 Patient pathways (Admission)

## Guidance

**Description: In this area, we assess whether people are admitted into the service safely**

### CQC Inspection Prompts:

When we're inspecting, we look at:

- The measures in place to prevent people from spreading infection when admitting a person to the service (from another service or the community)
- Whether the process for the most recent admission follows current guidance

### NHS England: Key actions for infection prevention and control and testing

- Key action 4: Moving patients increases their risk of transmission of infection. For urgent and emergency care, hospitals should adopt pathways that support minimal or avoid patient bed/ward transfers for the duration of their admission (unless clinically imperative). The exception will be patients who need a period of care in a side room or other safe bed while waiting for their COVID test results. On occasions when it is necessary to cohort COVID or non-COVID patients because of bed occupancy, then reliable application of IPC measures must be implemented. It is also imperative that any vacated areas are cleaned as per guidance.

### Infection Prevention and Control Board Assurance Framework:

- KLOE 1a: infection risk is assessed at the front door and this is documented in patient notes
- KLOE 1b: patients with possible or confirmed COVID-19 are not moved unless this is essential to their care or reduces the risk of transmission
- KLOE 1c: compliance with the national guidance around discharge or transfer of COVID-19 positive patients
- KLOE 5a: screening and triaging of all patients as per IPC and NICE Guidance within all health and other care facilities must be undertaken to enable early recognition of COVID-19 cases
- KLOE 5b: 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
- KLOE 5c: staff are aware of agreed template for triage questions to ask
- KLOE 5d: triage undertaken by clinical staff who are trained and competent in the clinical case definition and patient is allocated appropriate pathway as soon as possible
- KLOE 6a: separation of patient pathways and staff flow to minimise contact between pathways. For example, this could include provision of separate entrances/exits (if available) or use of one-way entrance/exit systems, clear signage, and restricted access to communal areas



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# Appendix A:
# Self-Assessment and Action Plan: Infection Prevention and Control
## Patient pathways (Admission) Self-Assessment:

Royal United Hospitals Bath NHS Foundation Trust

| Processes (policies/SOPs) | Assurance / monitoring processes |
|---|---|
| • All ED attendances have a COVID-19 proforma completed (COVID screening)<br>• 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<br>• Paediatrics has specific area for Red and Green patients<br>• Maternity utilise appropriate bays and side rooms<br>• Direct admit Surgery triage in Surgical Assessment Unit and place in appropriate side rooms and allocated bays<br>• Medical direct Admits are triaged. Possible and confirmed patients are isolated or segregated in the socially distanced bays<br>• 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. Patient's infection risk is also assessed and documented on Aramis upon non elective arrival.<br>• Patients that are possible or confirmed COVID-19 are placed in a dedicated side room on a dedicated ward or cohort<br>• COVID-19 patients are identified on the electronic site board and patient placement is reviewed 3 times a day<br>• Admission swabs, and where required rapid swabs, are used to support safe patient placement. Use of Lateral Flow Tests (LFT) in ED (and maternity for birthing partners) are being considered for introduction as soon as possible<br>SOPs:<br>COVID admission swabbing v4 (2).docx<br>Patient Transfer SOP.DOCX | • Any unauthorised transfers are escalated and investigated via the Trust Datix system and learning shared. These are also discussed at the daily outbreak meeting (attended by the site team).<br>• Any exceptions to compliance with national guidance around discharge or transfer of COVID-19 positive patients are reported daily at Silver Command.<br>• Performance for patient testing on admission, day 3 and day 5-7 for all wards is monitored through the weekly COVID action plan monitoring group (chaired by the Director of Nursing and Midwifery).<br><br>**Concerns identified (gaps in assurance)**<br>• The trust is not 100% compliant for admission swabs<br>• Facilities for point of care testing are not yet available |

| How would you rate performance for this section? | | Rationale for rating |
|---|---|---|
| ☐Green | Evidence available at the time of assessment shows the lines of enquiry are met | Most of the requirements are met. Work continues on improving compliance for admission swabs. |
| ☒Yellow | Evidence available at the time of assessment shows that the lines of enquiry are 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 lines of enquiry are 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 lines of enquiry are not being met. Impact on people who use services or staff is high/significant. Immediate action is required | |



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# 4 Personal Protective Equipment (PPE)

## Guidance

**Description: In this area, we assess whether the service uses PPE effectively to safeguard staff and people using the service**

**CQC Inspection Prompts:**

When we're inspecting, we look at:

- Where and how staff are putting on and taking off PPE
- How PPE is disposed of after use
- If the amount of PPE used complies with current guidance
- What specific PPE training has been provided during the pandemic
- How people who are fearful or anxious seeing staff wear PPE are reassured (for example people who are deaf, autistic people, people with dementia

**NHS England: Key actions for infection prevention and control and testing**

- Key action 3 (first part): Staff wear the right level of PPE when in clinical settings, including use of face masks in non-clinical settings, with systems in place to monitor adherence.

**Infection Prevention and Control Board Assurance Framework:**

- KLOE 1e: monitoring of compliance with PPE, consider implementing the role of PPE guardians / safety champions to embed and encourage best practice
- KLOE 1j: all staff (clinical and non-clinical) are trained in putting on and removing PPE; know what PPE they should wear for each setting and context; and have access to the PPE that protects them for the appropriate setting and setting as per national guidance
- KLOE 2b: designated cleaning teams with appropriate training in required techniques and use of PPE, are assigned to COVID-19 isolation or cohort areas.
- KLOE 5e: face coverings are used by all outpatients and visitors face masks are available for patients with respiratory symptoms
- KLOE 5f: provide clear advice to patients on use of face masks to encourage use of surgical facemasks by all inpatients in the medium and high-risk pathways if this can be tolerated and does not compromise their clinical care
- KLOE 6b: 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
- KLOE 6c: 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
- KLOE 6d: a record of staff training is maintained
- KLOE 6e: appropriate arrangements are in place that any reuse of PPE in line with the CAS alert is properly monitored and managed
- KLOE 6f: any incidents relating to the re-use of PPE are monitored and appropriate action taken
- KLOE 6g: adherence to PHE national guidance on the use of PPE is regularly audited
- KLOE 9d: PPE stock is appropriately stored and accessible to staff who require it
- KLOE 10c: staff required to wear FFP reusable respirators undergo training that is compliant with PHE national guidance and a record of this training is maintained
- KLOE 10d: staff who carry out fit test training are trained and competent to do so
- KLOE 10e: all staff required to wear an FFP respirator have been fit tested for the model being used and this should be repeated each time a different model is used
- KLOE 10f: a record of the fit test and result is given to and kept by the trainee and centrally within the organization
- KLOE 10g: for those who fail a fit test, there is a record given to and held by trainee and centrally within the organisation of repeated testing on alternative respirators and hoods

# Appendix A:
# Self-Assessment and Action Plan: Infection Prevention and Control
## Personal Protective Equipment (PPE) Self-Assessment:

Royal United Hospitals Bath NHS Foundation Trust

| Processes (policies/SOPs) | Assurance / monitoring processes |
|---|---|
| • 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<br>• Fit testing records held centrally and monitored through the IPC Reference Group to ensure COVID readiness<br>• PPE champions established to support staff in all inpatient areas<br>• Patients and staff issued with a surgical mask on arrival to the hospital (stations at the entrances to the hospital)<br>• Surgical face masks worn in all areas and corridors (face masks can be removed in COVID secure areas when members of staff are sat at their desk)<br>• Posters and signage in place across the site for use of face masks (including donning and doffing of surgical face masks), hand hygiene and social distancing<br>• PPE stock stored centrally and delivered to areas as required. Daily updates of PPE stock levels are reported<br><br>1e PPE Guide.pdf | • FIT testing records kept on a central database - \\tatooine\Facilities\Fit testing\FIT TESTING RESULTS<br>• Weekly IPC Assurance checklist audit undertaken by wards and departments (daily for outbreak areas). This includes assessment of use of PPE<br>• IPC Audits and assurances schedule developed which details the frequency of all IPC audits and how the results from these audits are monitored<br><br>RUH IPC Audits and assurances v4.docx<br>IPC Assurance Checklist - Audit Pro |
| | **Concerns identified (gaps in assurance)** |
| | Some issues identified around use of goggles. This has been addressed through communication messages and through senior nurse clinical visits. |

| How would you rate performance for this section? | | Rationale for rating |
|---|---|---|
| ☒Green | Evidence available at the time of assessment shows the lines of enquiry are met | Key requirements are met. |
| ☐Yellow | Evidence available at the time of assessment shows that the lines of enquiry are 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 lines of enquiry are 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 lines of enquiry are not being met. Impact on people who use services or staff is high/significant. Immediate action is required | |

# 5 Testing

**Guidance**

**Description: In this area, we assess whether there is enough access to testing for staff and people using the service**

**CQC Inspection Prompts:**

When we're inspecting, we look at:

- How staff and people using the service access regular testing
- How often they are tested
- What the service does when someone shows symptoms or returns a positive test
- What the service does if someone refuses a test

**NHS England: Key actions for infection prevention and control and testing**

- Key action 7a: Implementation of twice weekly lateral flow antigen testing for NHS patient facing staff. Whilst lateral flow technology is the main mechanism for staff testing, this can continue to be used alongside PCR and LAMP testing.
- Key action 7b: If your trust has a high nosocomial rate you should undertake additional targeted testing of all NHS staff, as recommended by your local and regional infection prevention and control/Public Health team. Such cases must be recorded, managed and reported using agreed regional/national escalation systems.
- Key action 8a: All emergency patients must be tested at admission, whether or not they have symptoms.
- Key action 8b: Those who go on to develop symptoms of COVID-19 after admission must be retested at the point symptoms arise.
- Key action 8c: Those who test negative on admission must have a retest on day 3 of admission, and again between 5-7 days post admission.
- Key action 8d: Sites with high nosocomial rates should consider testing COVID negative patients daily.
- Key action 8e: Patients being discharged to a care home must be tested 48 hours prior to discharge and must only be discharged when their test result is available. Care homes must not accept discharged patients unless they have that person's test result and can safely care for them.
- Key action 8f: Elective patients must be tested within 3 days before admission and must be asked to self-isolate from the day of their test until the day of admission.

**Infection Prevention and Control Board Assurance Framework:**

- KLOE 1f: staff testing and self-isolation strategies are in place and a process to respond if transmission rates of COVID-19 increase
- KLOE 5h: for patients with new onset symptoms it is important to achieve isolation and instigation of contact tracing as soon as possible
- KLOE 5i: patients with suspected COVID-19 are tested promptly
- KLOE 5j: patients that test negative but display or go on to develop symptoms of COVID-19 are segregated and promptly re-tested and contacts traced appropriately
- KLOE 5k: patients that attend for routine appointments who display symptoms of COVID-19 are managed appropriately
- KLOE 6n: a rapid and continued response through ongoing surveillance of rates of infection transmission within the local population and for hospital / organisation onset cases (staff and patients/individuals)
- KLOE 6o: positive cases identified after admission who fit the criteria for investigation should trigger a case investigation. Two or more positive cases linked in time and place trigger an outbreak investigation and are reported
- KLOE 8a: ensure screens taken on admission given priority and reported within 24hrs
- KLOE 8b: regular monitoring and reporting of the testing turnaround times with focus on the time taken from the patient to time result is available
- KLOE 8c: testing is undertaken by competent and trained individuals
- KLOE 8d: patient and staff COVID-19 testing is undertaken promptly and in line with PHE and other national guidance
- KLOE 8e: regular monitoring and reporting that identified cases have been tested and reported in line with the testing protocols (correctly recorded data)
- KLOE 8f: screening for other potential infections takes place



Author: Rob Eliot, Quality Assurance and Clinical Audit Lead
Version 5 (5 January 2021)

# Appendix A:
# Self-Assessment and Action Plan: Infection Prevention and Control
## Testing Self-Assessment:

Royal United Hospitals Bath NHS Foundation Trust

| Processes (policies/SOPs) | Assurance / monitoring processes |
|---|---|
| Patient testing:<br>• Patients that are possible or confirmed COVID-19 are placed in a dedicated side room on a dedicated ward or cohort.<br>• Urgent clinical need transfers are only authorised by Consultants. SOPs have been reviewed through the IPC Reference Group and the outbreak meeting has oversight of patient placement where COVID is a consideration<br>• COVID-19 patients are identified on the electronic site board and patient placement is reviewed 3 times a day.<br>• Testing takes place on admission, day 3 and days 5-7 and thereafter weekly<br>• Patients are swabbed following new onset of symptoms and isolated. Senior nurse on the ward identifies ward based contacts in-line with government guidance.<br>SOPs:<br>COVID admission swabbing v4 (2).docx<br>COVID 5 SWAB OCTOBER 2020.docx<br>COVID 3 DAY SWAB November 2020.docx<br>200619 Helena covid 19 Positive SOP v4 O<br>Patient Transfer SOP.DOCX<br>Staff testing:<br>• Twice weekly lateral flow antigen testing in place for all staff working on site.<br>• Staff testing pathways are in place, managed by ICC Staffing Command and Occupational Health | Performance for patient testing on admission, day 3 and day 5-7 for all wards is monitored through the weekly COVID action plan monitoring group (chaired by the Director of Nursing and Midwifery).<br><br>Any unauthorised transfers are escalated and investigated via the Trust Datix system and learning shared and is discussed at the outbreak meeting.<br><br>Form set up for staff to report results of their lateral flow antigen testing: https://www.surveymonkey.co.uk/r/RUHstafftesting<br><br>**Concerns identified (gaps in assurance)**<br>• The trust is not 100% compliant for swabs taken on admission, day 3 and days 5-7<br>• Unable to provide full assurance that the required staff are adhering to twice weekly lateral flow antigen testing |

| How would you rate performance for this section? | | Rationale for rating |
|---|---|---|
| ☐Green | Evidence available at the time of assessment shows the lines of enquiry are met | Most of the requirements are met, however the Trust is not 100% compliant for swabs taken on admission, day 3 and days 5-7. |
| ☒Yellow | Evidence available at the time of assessment shows that the lines of enquiry are 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 lines of enquiry are 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 lines of enquiry are not being met. Impact on people who use services or staff is high/significant. Immediate action is required | |

# 6 Estates and Facilities (Premises)

## Guidance

**Description: In this area, we assess whether the layout of the premises, the use of space and the hygiene practice promotes safety**

### CQC Inspection Prompts:

When we're inspecting, we look at:

- Whether the premises looks clean and hygienic
- Whether cleaning is scheduled and sustained
- The cleaning products used
- How the layout and facilities of the premises have been changed to support IPC and good ventilation
- How communal indoor and outdoor spaces been optimised to use safely

### NHS England: Key actions for infection prevention and control and testing

- Key action 1: Staff consistently practice good hand hygiene and all high touch surfaces and items are decontaminated multiple times every day, with systems in place to monitor adherence
- Key action 6: Where bays with high numbers of beds are in use, they must be risk assessed and where 2 metres cannot be achieved, means of physical segregation of patients are strongly considered. The concept of 'bed, chair, locker' should be implemented. All wards should be effectively ventilated.

### Infection Prevention and Control Board Assurance Framework:

- KLOE 2c: decontamination and terminal decontamination of isolation rooms or cohort areas is carried out in line with PHE and other national guidance
- KLOE 2d: 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
- KLOE 2e: attention to the cleaning of toilets/bathrooms, as COVID-19 has frequently been found to contaminate surfaces in these areas
- KLOE 2f: 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 effective against enveloped viruses
- KLOE 2g: manufacturers' guidance and recommended product 'contact time' must be followed for all cleaning/disinfectant solutions/products as per national guidance
- KLOE 2h: '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
- KLOE 2i: Electronic equipment, e.g. mobile phones, desk phones, tablets, desktops and keyboards should be cleaned at least twice daily
- KLOE 2j: Rooms/areas where PPE is removed must be decontaminated, timed to coincide with periods immediately after PPE removal by groups of staff (at least twice daily)
- KLOE 2k: linen from possible and confirmed COVID-19 patients is managed in line with PHE and other national guidance and the appropriate precautions are taken
- KLOE 2l: single use items are used where possible and according to Single Use Policy
- KLOE 2m: reusable equipment is appropriately decontaminated in line with local and PHE and other national policy
- KLOE 2n: ensure cleaning standards and frequencies are monitored in non-clinical areas with actions in place to resolve issues in maintaining a clean environment
- KLOE 2o: ensure the dilution of air with good ventilation e.g. open windows, in admission and waiting areas to assist the dilution of air
- KLOE 2p: there is evidence organisations have reviewed the low risk COVID-19 pathway, before choosing and decision made to revert to general purpose detergents for cleaning, as opposed to widespread use of disinfectants
- KLOE 6j: 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

# Appendix A:
# Self-Assessment and Action Plan: Infection Prevention and Control

Royal United Hospitals Bath
NHS Foundation Trust

## Estates and Facilities (Premises) Self-Assessment:

| Processes (policies/SOPs) | Assurance / monitoring processes |
|---|---|
| • Special Clean SOP matches the PHE guidance for environmental decontamination (COVID-19 Flowchart SOP).<br>• Ward based patient toilets cleaned at least three times a day. Public toilets cleaned six times a day<br>• Cleaning is carried out using a chlorine containing tablet with detergent at strength of 1000ppm<br>• Manufacturer guidance is followed for contact times<br>• The nursing cleaning schedule has been updated to meet the new requirements of a twice daily clean<br>• Room/areas where PPE is removed are cleaned twice a day in line with daily cleaning schedule<br>• SOP for disposal of linen is in line with PHE guidelines, including using alginate bag and double bagging, and labelling outer bag.<br>• Decontamination policy sets out requirements for single use and reusable items<br>• All admission and waiting areas reviewed to ensure they have natural ventilation, or functioning mechanical ventilation. Doors installed on all bays.<br>• Risk assessments carried out to identify any gaps in social distancing practice and mitigating actions. Any areas that require segregation to operate safely have screens. Changes include segregation of waiting areas, installation of screens on reception and beds separated with curtain tracks adjusted.<br>• Ventilation of inpatient areas has been reviewed and where possible ventilation has been increased either mechanically or where naturally through guidance. | • Hand hygiene compliance by staff and decontamination of high touch surfaces and items is monitored through completion of the Infection Prevention and Control Audit (IPC) Programme. The programme includes audits on hand hygiene, cleaning audits, equipment cleaning and an IPC Assurance checklist audit which reviews key IPC standards including use of PPE, cleaning of high touch surfaces and social distancing.<br>• IPC Audits and assurances schedule developed which details the frequency of all IPC audits and how the results from these audits are monitored.<br>• Examples of audits and monitoring:<br>IPC Assurance Checklist (standards<br>IPC Assurance Checklist (weekly by<br>HCAI Report WE 20.12.2020.xlsx |
| **Concerns identified (gaps in assurance)** | |
| Insufficient resource to ensure all frequently touched surfaces are cleaned at least twice daily. Some gaps in completion of the audits for all areas.<br><br>Ventilation affecting air flow in the ward areas. Due to colder weather windows are open less and therefore naturally ventilated wards have less dilution of air. Guidance has been issued to open windows more frequently in naturally ventilated wards although this increases risk of hypothermia to patients. Screens were installed around bed bays to reduce transmission of covid and increase available bed base, however, this may be having a detrimental effect on air flow to these areas. The Estates team are investigating the feasibility of installing CO2 monitors into these areas to give an indication of poor airflow although currently there is no national guidance on this subject. | |

| How would you rate performance for this section? | | Rationale for rating |
|---|---|---|
| ☐Green | Evidence available at the time of assessment shows the lines of enquiry are met | Most of the requirements are met, however there are vacancies within the cleaning team which impacts on the ability to ensure all frequently touched surfaces are cleaned at least twice daily. Work continues to understand the impact of ventilation on virus transmission. |
| ☐Yellow | Evidence available at the time of assessment shows that the lines of enquiry are 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 lines of enquiry are 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 lines of enquiry are not being met. Impact on people who use services or staff is high/significant. Immediate action is required | |



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# 7 Staffing

## Guidance

**Description: In this area, we assess whether staff training, practices and deployment show the service can stop the transmission of infection and manage outbreaks**

### CQC Inspection Prompts:

When we're inspecting, we look at:

- How staff movement and transmission in and between care homes is minimised
- How staff rotas, shift patterns and handovers have changed to improve IPC
- If agency staff are used, how it's checked that they follow IPC measures and don't work between other services
- What recent IPC training has been given to support staff to provide safer care
- How staff wellbeing is supported, including becoming unwell, sick leave and returning to work safely

### NHS England: Key actions for infection prevention and control and testing

- Key action 3 (second part): Movement of staff between COVID and non-COVID areas is minimised.

### Infection Prevention and Control Board Assurance Framework:

- KLOE 1g: training in IPC standard infection control and transmission-based precautions are provided to all staff
- KLOE 1h: IPC measures in relation to COVID-19 should be included in all staff Induction and mandatory training
- KLOE 1i: all staff are regularly reminded of the importance of wearing face masks, hand hygiene and maintaining physical distance both in and out of work
- KLOE 2a: designated teams with appropriate training are assigned to care for and treat patients in COVID-19 isolation or cohort areas
- KLOE 6i: staff regularly undertake hand hygiene and observe standard infection control precautions
- KLOE 6l: staff understand the requirements for uniform laundering where this is not provided for on site
- KLOE 6m: 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
- KLOE 9a: staff are supported in adhering to all IPC policies, including those for other alert organisms
- KLOE 10h: for members of staff who fail to be adequately fit tested a discussion should be had, regarding redeployment opportunities and options commensurate with the staff members skills and experience and in line with nationally agreed algorithm
- KLOE 10i: a documented record of this discussion should be available for the staff member and held centrally within the organisation, as part of employment record including Occupational health
- KLOE 10j: following consideration of reasonable adjustments e.g. respiratory hoods, personal re-usable FFP3, staff who are unable to pass a fit test for an FFP respirator are redeployed using the nationally agreed algorithm and a record kept in staff members personal record and Occupational health service record
- KLOE 10l: 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
- KLOE 10p: staff are aware of the need to wear facemask when moving through COVID-19 secure areas
- KLOE 10q: staff absence and well-being are monitored and staff who are self-isolating are supported and able to access testing staff are aware of the need to wear facemask when moving through COVID-19 secure areas
- KLOE 10r: staff who test positive have adequate information and support to aid their recovery and return to work.

# Appendix A:
# Self-Assessment and Action Plan: Infection Prevention and Control

Royal United Hospitals Bath
NHS Foundation Trust

## Staffing Self-Assessment:

| Processes (policies/SOPs) | Assurance / monitoring processes |
|---|---|
| • The staff intranet features an extensive COVID-19 resource section (including PPE guides and training videos in donning and doffing), key message area and our communication brief for staff including our film provides useful updates on a daily basis.<br>• All IPC mandatory training is delivered online (accessed through ESR).<br>• Staff who are not able to work in an area requiring PPE due to fit testing failure will be deployed elsewhere in the trust.<br>• Daily staff briefs and comms messages frequently remind staff of IPC requirements. Posters and signage in place across the site.<br>• Designated teams in place for high, medium and low risk areas and clinical specialties (e.g. Critical Care, Oncology, Enhanced Respiratory Care)<br>• Additional changing facilities were provided during the first phase Covid response to support adherence with the Uniform Policy.<br>• 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 advice given as per washing instructions.<br>• 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.<br>• Planned/elective care pathways have designated daily staffing to ensure no cross-over with urgent/emergency care pathway staffing.<br>• Staff testing positive: 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. EAP support areas with high levels of COVID activity and those with long COVID symptoms<br>• Staffing command have oversight of all absences including all those related to COVID | • IPC training records on ESR. Training reported to IPCC Operational Group.<br>• Audit programme in wards and departments which includes staff adherence to IPC policies including hand hygiene practice, cleaning, equipment cleaning and an IPC Assurance checklist audit which reviews key IPC standards<br>• IPC Audits and assurances schedule developed which details the frequency of all IPC audits and how the results from these audits are monitored<br>  <br>RUH IPC Audits and assurances (process) |
| | **Concerns identified (gaps in assurance)** |
| | Training specific to COVID-19 is limited to nationally available programmes. IPC Team are working with the Education Team on an RUH specific COVID training package. Setting up the training package was delayed due to availability of staff however work is underway to have this in place. |

| How would you rate performance for this section? | | Rationale for rating |
|---|---|---|
| ☐Green | Evidence available at the time of assessment shows the lines of enquiry are met | The requirements are mainly met. Work continues on the review and implementation of training specific to COVID-19. |
| ☒Yellow | Evidence available at the time of assessment shows that the lines of enquiry are 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 lines of enquiry are 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 lines of enquiry are not being met. Impact on people who use services or staff is high/significant. Immediate action is required | |



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# 8 Policies

**Guidance**

**Description: In this area, we assess whether IPC policy is up to date and implemented effectively to prevent and control infection**

**CQC Inspection Prompts:**

When we're inspecting, we look at:

- Whether infection risks to people are thoroughly assessed and managed
- The action taken to consider and reduce any impact to people or staff who may be disproportionately at risk of COVID-19 (for example, people with learning disabilities or dementia or BAME people)
- The changes made following the most recent audit
- The plans in place to address future coronavirus and other infection outbreaks and winter pressures

**NHS England: Key actions for infection prevention and control and testing**

- Key action 5: Daily data submissions have been signed off by the Chief Executive, the Medical Director or the Chief Nursing Officer, and the Board Assurance Framework is reviewed and evidence of reviews is available
- Key action 9: Local systems must assure themselves, with commissioners, that a trust's infection prevention and control interventions (IPC) are optimal, the Board Assurance Framework is complete, and agreed action plans are being delivered.
- Key action 10: Local systems must review system performance and data; offer peer support and take steps to intervene as required.

**Infection Prevention and Control Board Assurance Framework:**

- KLOE 1d: monitoring of IPC practices, ensuring resources are in place to enable compliance with IPC practice
- KLOE 1k: national IPC guidance is regularly checked for updates and any changes are effectively communicated to staff in a timely way
- KLOE 1l: changes to guidance are brought to the attention of boards and any risks and mitigating actions are highlighted
- KLOE 1m: risks are reflected in risk registers and the Board Assurance Framework where appropriate
- KLOE 1n: robust IPC risk assessment processes and practices are in place for non COVID-19 infections and pathogens
- KLOE 1o: that Trust CEOs or the executive responsible for IPC approve and personally signs off, all data submissions via the daily nosocomial sitrep. This will ensure the correct and accurate measurement and testing of patient protocols are activated in a timely manner.
- KLOE 1p: ensure Trust Board has oversight of ongoing outbreaks and action plans.
- KLOE 3a: arrangements around antimicrobial stewardship are maintained
- KLOE 3b: mandatory reporting requirements are adhered to and boards continue to maintain oversight (antimicrobial use)
- KLOE 6p: robust policies and procedures are in place for the identification of and management of outbreaks of infection
- KLOE 9b: any changes to the PHE national guidance on PPE are quickly identified and effectively communicated to staff
- KLOE 9c: all clinical waste related to confirmed or suspected COVID-19 cases is handled, stored and managed in accordance with current national guidance
- KLOE 10a: staff in 'at-risk' groups are identified and managed appropriately including ensuring their physical and psychological wellbeing is supported
- KLOE 10b: that risk assessment(s) is (are) undertaken and documented for any staff members in an at risk or shielding groups, including Black, Asian and Minority Ethnic (BAME) and pregnant staff
- KLOE 10k: boards have a system in place that demonstrates how, regarding fit testing, the organization maintains staff safety and provides safe care across all care settings. This system should include a centrally held record of results which is regularly reviewed by the board

# Appendix A:
# Self-Assessment and Action Plan: Infection Prevention and Control

Royal United Hospitals Bath
NHS Foundation Trust

## Policies Self-Assessment:

| Processes (policies/SOPs) | Assurance / monitoring processes |
|---|---|
| • 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 meets weekly to ensure Trust compliance.<br>• Data submissions are submitted by the Senior Nurse for Infection Prevention and Control. The submissions are also reviewed by the Director of Nursing and Midwifery.<br>• Daily IPC update is provided to Gold which includes an update on any new national guidance, an overview of any outbreaks and any key decisions to be taken (e.g. visiting)<br>• All COVID-19 risks are added to the Trust Risk Register on Datix<br>• 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 investigations are carried out for hospital onset infections.<br>• The IPC BAF self-assessment was submitted to Board of Directors in July 2020. An action plan to address gaps was completed and is being monitored through the weekly IPC COVID Action Plan Monitoring Group.<br>• Clinical advice on appropriate use of antimicrobials is available 24/7 from the consultant microbiology team who also provide daily virtual ICU ward rounds.<br>• Guidelines are in place for appropriate prescribing of antibiotics. COVID section added to antibiotic prescribing app 'Microguide'.<br>• PHE Healthcare Associated Infection DSC Mandatory Surveillance ongoing. All AMR local indicators (PHE Fingertips) Laboratory reporting of infections to PHE has continued.<br>• A Trust guideline for the management of outbreaks of infection is available to all staff via the intranet which has been utilised in all COVID-19 outbreaks. External reporting of outbreaks is carried out in line with national guidance.<br>• Risk assessments for BAME staff and staff that have been identified in an "at risk category" held by line managers. Central records held of all completed risk assessments<br>• 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. | • Daily visits to wards by IPC Team to monitor practice. Any non-compliance is fed back at the time and training opportunities undertaken.<br>• IPC and PPE champions are also in place on the wards and they also monitor local IPC practices.<br>• Increased remote live auditing of prescribing practice via ePMA<br>• Review of risks through monthly risk register report to Management Board and quarterly report to Board of Directors. This includes discussion and consideration of COVID-19 risks<br>• Daily IPC update to Gold – escalated to Board of Directors where necessary<br>• Weekly HCAI report widely circulated showing infection rate, and audit results.<br>• Framework developed which describes the different committees and groups that meet to monitor IPC performance<br>  <br>IPC Assurance - Framework v4.docx |
| | **Concerns identified (gaps in assurance)** |
| | • Capacity for microbiology Consultant input into AMS reduced is reduced from July 2020 onwards due to critical microbiology staff shortages. Some gaps in antimicrobial stewardship<br>• Some gaps in completion of risk assessments for at risk staff |

| How would you rate performance for this section? | | Rationale for rating |
|---|---|---|
| ☐Green | Evidence available at the time of assessment shows the lines of enquiry are met | Requirements are mostly met. There are some gaps in completion of risk assessments for at risk staff and antimicrobial stewardship oversight. |
| ☒Yellow | Evidence available at the time of assessment shows that the lines of enquiry are 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 lines of enquiry are 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 lines of enquiry are not being met. Impact on people who use services or staff is high/significant. Immediate action is required | |



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# Infection Prevention and Control (IPC) Combined Action Plan

**The IPC combined action plan details the actions taken to address any gaps identified from this self-assessment. The action plan is grouped into the following 8 areas of the self-assessment:**

1. Visiting (and visitors)
2. Social distancing (Shielding)
3. Patient pathways (Admission)
4. Personal Protective Equipment (PPE)
5. Testing
6. Estates and Facilities (Premises)
7. Staffing
8. Policies

**Where there are gaps in compliance, these are likely to be identified from the following sources / guidance:**

- Guidance on the CQC Infection Prevention and Control Inspection process (CQC inspection prompts)
- NHS England Key actions: infection prevention and control and testing
- Infection Prevention and Control Board Assurance Framework (BAF)
- Local outbreaks
- Audits

# Appendix A:
# Self-Assessment and Action Plan: Infection Prevention and Control

| Action Plan *(complete this section where gaps in assurance are identified)* | | |
|---|---|---|
| **Gap Ref No** | **1** | |
| **Section** | **Visiting (and visitors)** | |
| **Gap identified from** | **CQC prompts** | **1** |
| | **IPC BAF** | **4** |
| **Prompt** | CQC: In this area, we assess whether all types of visitors are prevented from catching and spreading infection<br><br>IPC BAF KLOE 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<br>• 4e: there is clearly displayed and written information available to prompt patients' visitors and staff to comply with hands, face and space advice<br><br>IPC BAF KLOE 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<br>• 6h: hygiene facilities (IPC measures) and messaging are available for all patients/individuals, staff and visitors to minimise COVID-19 transmission | |
| **Summary of gaps** | Inability to police IPC behaviours of all staff and patients entering the hospital<br>Lack of adherence to hand gel and mask wearing on arrival to hospital<br>Staff and patients not gelling hands on entrance to clinical areas - Lack of prompts and reminders to follow best practice<br>Our communication with staff and patients has not supported our outbreak management<br>Signage is not direct enough in ask and actions | |

| **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 | IPC stations on main entrances to the hospital to be staffed using a rota to provide additional check and challenge | 11/12/2020 | Helen Back, Divisional Director of Operations – Women & Children<br><br>Specialty Teams | Blue | • IPC stations now have a staffing rota<br>• Recorded telephone guidance on main switchboard number<br>• Reduced numbers of hospital entry points for staff and visitors<br>• Entry points staffed to support verbal guidance and advice<br>• Maternity services supporting a partner presence across all pathway points |
| 2 | Review and minimise number of entrances into the hospital for staff and patients | 11/12/2020 | Jamie Caulfield, HIP 2 Business Change Manager – Estates & Facilities | Blue | Completed. 3 entrances (Atrium, PAW and Lansdown) |

# Appendix A:
# Self-Assessment and Action Plan: Infection Prevention and Control

| 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.)* |
|---|---|---|---|---|---|
| 3 | Hygiene Stations – purpose built dispensers for gel and mask including patient information | 11/12/2020<br><br>**Revised completion date:** 28/02/2021 | Jamie Caulfield, HIP 2 Business Change Manager – Estates & Facilities | Amber | Progress delayed over Christmas period (company closed until 4 January 2021). |
| 4 | Hand gel on all handles into ward areas | 31/01/2021 | Sarah Merritt, Deputy Director of Nursing and Midwifery | Amber | On order. Surveys to be completed on doors to check gel is not damaging the wood. |
| 5 | Update the discharge summary template to include infection status | 30/09/2020 | Jessica Flower, Change Lead | Blue | Where infections are recorded as a problem they are included in the depart summary. |
| 6 | Communication Strategy to include practical measures, local ward/clinical area and staff level messaging and signage. Corporate communication and working with partners. | 11/12/2020 | Lucy Kearney | Blue | Completed. |
| 7 | Clear communication message for staff as they arrive on site as well as greater visibility of information to raise awareness to staff and patients. Digital as well as banners etc. | 11/12/20 | David McClay Caroline Kenny Helen Back | Blue | Interim signage is in place and digital element completed. |

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**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

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| | |
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Author: Rob Eliot, Quality Assurance and Clinical Audit Lead
Version 5 (5 January 2021)

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| Action Plan *(complete this section where gaps in assurance are identified)* | | |
|---|---|---|
| **Gap Ref No** | **2** | |
| **Section** | **Social distancing (Shielding)** | |
| **Gap identified from** | **IPC BAF** | **7** |
| | **NHS England Key Actions** | **2** |
| **Prompt** | IPC BAF: KLOE 7: Provide or secure adequate isolation facilities.<br>• 7b: areas/wards are clearly signposted, using physical barriers as appropriate to patients/individuals and staff understand the different risk areas<br><br>NHS England Key Action 2: Staff maintain social distancing in the workplace, when travelling to work (including avoiding car sharing) and to remind staff to follow public health guidance outside of the workplace | |
| **Summary of gaps** | There is no standard signage in place for defining cohort areas<br>Consistency and visibility of signage poor<br>Not all staff are adhering to 2m IPC guidance for social distancing in staff and clinical rooms.<br>Lack of suitable space for staff to take breaks (Social distancing requirements has reduced staff rest rooms to minimal). | |

| **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 | Banners for closed wards to be ordered to provide clear signage to staff and patients | 11/12/2020 | Sarah Merritt, Deputy Director of Nursing and Midwifery<br><br>Yvonne Pritchard, Senior Nurse, Infection Control | Blue | In place |
| 3 | Director and Deputy for Nursing & Midwifery to undertake clinical walkabouts to ensure standards on social distancing and PPE are maintained | 11/12/2020 | Lisa Cheek, Director of Nursing and Midwifery<br><br>Sarah Merritt, Deputy Director of Nursing and Midwifery | Blue | In place |
| 4 | IPC Marshal/Warden rota to be rolled out using a tabard approach in public areas and entrances to raise visibility and give staff greater authority to challenge | 31/01/2021 | Helen Back, Divisional Director of Operations – Women & Children<br><br>Specialty Teams | Green | Awaiting tabards. IPC Marshals are in place. |

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|---|---|---|---|---|---|
| 5 | Staff marquee to be made fully operational to give staff a better space for breaks | 09/12/2020 | Jamie Caulfield, HIP 2 Business Change Manager – Estates & Facilities | Blue | Completed |

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| **Gap Ref No** | **3** | |
| **Section** | **Patient pathways (Admission)** | |
| **Gap identified from** | **IPC BAF** | **5** |
| **Prompt** | KLOE 5a: screening and triaging of all patients as per IPC and NICE Guidance within all health and other care facilities must be undertaken to enable early recognition of COVID-19 cases | |
| **Summary of gaps** | Facilities for point of care testing are not yet available | |

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|---|---|---|---|---|---|
| 1 | Introduce lateral flow testing for patients admitted through ED | 31/01/2021 | Nicky Ashton, Divisional Director of Operations, Surgery | Amber | Logistical challenges. Task and Finish Group needs to be set up to develop SOPs and procure consumables. |

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# Appendix A:
# Self-Assessment and Action Plan: Infection Prevention and Control

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| **Gap Ref No** | **4** | |
| **Section** | **Personal Protective Equipment (PPE)** | |
| **Gap identified from** | **IPC BAF** | **5** |
| | **NHS England Key Actions** | **3** |
| | **Audits** | **IPC Assurance Checklist** |
| **Prompt** | IPC BAF: 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.<br><br>NHS England Key Action 3: Staff wear the right level of PPE when in clinical settings, including use of face masks in non-clinical settings | |
| **Summary of gaps** | PPE guidance to be updated<br>Some issues identified around use of goggles (from IPC Assurance Checklist Audit). | |

| **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 | Yvonne Pritchard, Senior Nurse Infection Control | Blue | Guidance updated. |
| 2 | PPE Ward champion on each shift to provide additional focus on IPC adherence and provide staff with greater authority to challenge | 10/12/2020 | Matrons (Champions)<br><br>Yvonne Pritchard, Senior Nurse, Infection Control | Blue | PPE champions in place on all wards.<br><br>PPE champions have developed information boards in ward areas. |

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Version 5 (5 January 2021)

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| **Gap Ref No** | **6** | |
| **Section** | **Estates & Facilities (Premises)** | |
| **Gap identified from** | **IPC BAF** | **KLOE 2** |
| | **NHS England Key Actions** | **KLOE 1** |
| | **NHS England Key Actions** | **KLOE 6** |
| **Prompt** | IPC BAF: Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.<br><br>NHS England Key Actions 1: Staff consistently practice good hand hygiene and all high touch surfaces and items are decontaminated multiple times every day – once or twice a day is insufficient<br><br>NHS England Key Actions 6: Where multiple occupancy estate (e.g. 10 bedded bays) are in use for unplanned care, these must be risk assessed, and where 2m can't be achieved, physical segregation of patients is considered, and wards are effectively ventilated | |
| **Summary of gaps** | IPC BAF<br>• Designated cleaning teams are not consistently provided as cleaning bank staff are used to cover annual leave and sickness<br>• Existing cleaning staff resource does not allow for twice daily cleaning in wards<br>• Records of twice daily nurse equipment cleaning held locally and no audit in place<br>• Less than 100% compliance with cleanliness of re-usable equipment<br><br>NHS England Key Actions 6:<br>Ventilation affecting air flow in the ward areas | |

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|---|---|---|---|---|---|
| 1 | Implementation of monthly audit for wards/department to audit cleanliness of non-clinical equipment | 13/07/2020 | Simon Andrews Divisional Director of Nursing, Surgery | Blue | New audit schedule and audit proforma (IPC assurance checklist) introduced 30 November 2020. High touch point cleaning checklist also introduced.<br><br>Monthly audit replaced with weekly audit for all areas – escalating to daily for an area during an outbreak (commenced November 2020). |
| 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<br>Lisa Brown, Matron<br>Di Dorrington, Matron | Blue | Clinical equipment cleanliness is now completed weekly (in accordance with schedule identified in Action 1).<br>Audit framework for infection control completed |
| 3 | Individual ward/department action plans with weekly review for those areas less than 90%. | Ongoing | Anita West, Matron<br>Lisa Brown, Matron | Blue | Process for weekly review of audit results included within the audit schedule. Results to |

| 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.)* |
|---|---|---|---|---|---|
| | | | Di Dorrington, Matron | | be reviewed through the IPC COVID Action Plan Monitoring Group (meeting weekly) from w/c 30 November 2020. |
| 4 | Increase cleaning resource to allow for twice daily cleaning | 31/08/2020 | Philip Watson, Head of Facilities | Amber | Update 03/01/2021 – Business case approved for recruitment of 67.05 WTE fixed term cleaners. Recruitment has started with first 29 interviews arranged within 2 weeks of advert. Agency staff continue to be used, and recruited to maintain cleaning frequency. 75% of agency shifts recruited to with regular agency staff. |
| 5 | Create dedicated cleaning teams for COVID isolation/cohort wards to cover leave/sickness | 31/07/2020 | Philip Watson, Head of Facilities | Blue | Update 03/01/21 – Dedicated cleaning teams created for each risk level, based on staff risk assessments. If there is a requirement to move staff from red to blue areas, process in place for daily lateral flow tests for 14 days as agreed with IPC |
| 6 | Working with facilities team to ensure increased cleaning of high touch areas and toilets and bathrooms and assurances around cleaning of high touch areas under the ward staff responsibility. | 08/01/2021 | Philip Watson, Head of Facilities | Amber | A large team of agency cleaners are employed especially to ensure increased touch point cleaning. They start at 11.00am and re-clean the areas the early staff have cleaned to ensure these have increased frequency of cleaning. There is a designated supervisor to ensure this is happening. The cleaners have a revised work schedule to reduce cleaning for low risk areas such as walls and to concentrate more on the high touch areas, doors, rails, toilets etc. The toilet sheets have been revised to include all areas on the wards and are now found in the cleaning file in the cleaning cupboards rather than on the toilet doors. These are signed off at the end of the shift and the supervisors check on their rounds.<br><br>The cleaning team leader meets with her staff daily. Staff are allocated taking into account the grading of the ward, age of the staff and the number of patients on the ward. Cleaning |

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|---|---|---|---|---|---|
| | | | | | staff are generally not moved between wards but may sometimes be moved to cover priority areas as staffing levels change. |
| 7 | Declutter of corridors and wards. Ensure suitable bed storage on and off site and beds remaining stored on site are clean and protected. | 18/12/2020 | Sarah Merritt, Deputy Director of Nursing and Midwifery<br><br>Brian Johnson, Director of Estates & Facilities<br><br>Phillip Watson, Head of Facilities<br><br>Divisional Directors of Nursing and Midwifery | Blue | 03/01/2021 – Additional 40 beds removed from corridors for storage off-site. Sample bed cover ordered for protection of remaining beds. Daily corridor inspection to remove items from corridors implemented. |
| 8 | Review of current ventilation levels in ward areas and options available to improve | 09/12/2020 | Sarah Merritt, Deputy Director of Nursing and Midwifery<br><br>Matt Taylor, Interim Head of Estates<br><br>Emma Boldock, Consultant Microbiologist & Infection Control Doctor | Blue | Ventilation levels have been reviewed. Levels known. Mechanical and natural. Where possible mechanical adjustments have been made. For natural, communication messages have been provided around opening windows for 5-10 minutes every hour, however thermal regulation in winter is a concern. |

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|---|---|---|
| **Gap Ref No** | **7** | |
| **Section** | **Staffing** | |
| **Gap identified from** | **NHS England Key Actions** | **2** |
| | **IPC BAF** | **1** |
| **Prompt** | NHS England Key Actions 2: Staff maintain social distancing in the workplace, when travelling to work (including avoiding car sharing) and to remind staff to follow public health guidance outside of the workplace.<br><br>IPF BAF KLOE 1h: IPC measures in relation to COVID-19 should be included in all staff Induction and mandatory training | |
| **Summary of gaps** | Staff not always adhering to social distancing<br>Training specific to COVID-19 is limited to nationally available programmes | |

| **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 | Work with HR regarding conduct if a staff member is not compliant with PPE or IPC practices | 30/11/2020 | HR Business Partners | Blue | Importance of correct PPE conversations. Refer to conduct policy if continued non-compliance. Conduct route is pursued for staff that are persistently non-compliant |
| 2 | Implement training packages | 28/02/2021 | Mariska Oddy, Infection Control Nurse | Green | In progress |

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| **Gap Ref No** | **8** | |
| **Section** | **Policies** | |
| **Gap identified from** | **IPC BAF** | **KLOE 1m, 3a, 3b, 10** |
| **Prompt** | KLOE 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.<br>• 1m: risks are reflected in risk registers and the Board Assurance Framework where appropriate<br><br>KLOE 3: Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.<br>• 3a: arrangements around antimicrobial stewardship are maintained<br>• 3b: mandatory reporting requirements are adhered to and boards continue to maintain oversight (antimicrobial use)<br><br>KLOE 10: Have a system in place to manage occupational health needs and obligations of staff in relation to infection.<br>• 10a: staff in 'at-risk' groups are identified and managed appropriately including ensuring their physical and psychological wellbeing is supported<br>• 10b: that risk assessment(s) is (are) undertaken and documented for any staff members in an at risk or shielding groups, including Black, Asian and Minority Ethnic (BAME) and pregnant staff | |
| **Summary of gaps** | KLOE 1:<br>• Separate risk log which is currently not on Datix.<br><br>KLOE 3:<br>• Capacity for microbiology Consultant input into AMS reduced is reduced from July onwards due to critical microbiology staff shortages<br>• AFS CQUIN has not been supported due to staff shortages<br>• AMS pharmacist capacity reduced<br>• Quarterly TRUST AMS and medical Director meetings to review progress (cancelled)<br>• A3 on antimicrobial stewardship and ARK not presented to CGC<br><br>KLOE 10:<br>• Percentage of BAME staff risk assessments completed below 80% | |

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|---|---|---|---|---|---|
| 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<br>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<br><br>**Next review: 31 December 2020** | Fiona Abbey, Transformation Programme Manager<br><br>Rob Eliot, Quality Assurance and Clinical Audit Lead<br><br>Fiona Barnard, Head of Risk and Assurance | Amber | Separate risk log for COVID-19 risks now no longer in place. Process agreed on 30/11/2020 to move all relevant existing COVID-19 risks from the risk log to Datix. Divisions notified and Datix is being updated. Not all risks have been moved across yet. |
| 3 | Business case for 5th Consultant pending. Locums being actively sourced | July 2020 | Moya O'Doherty Clinical Director Pathology<br>Nicky Ashton Surgical Divisional Manager | Amber | BC re-submitted 24/5/20, reviewed at TIG. Further discussions at TIG have taken place. Further changes agreed on 11/11/20. Awaiting feedback from Board. |
| 4 | AFS CQUIN has been postponed until April 2021 | April 2021 | Katia Montella | Green | Postponed until next year. |
| 5 | Discussions have taken place with Pharmacy Director who is supportive of increasing hours for AMS pharmacist. | September 2020 | Uzoma Ibechukwu Chief Pharmacist | Blue | Increased AMS pharmacy resource until April 21 out of current pharmacy budget. A business case will be required for future funding. |
| 6 | AMS quarterly Trust meetings and meeting with medical director to be re-instated | July 2020 | Bernie Marden, Medical Director | Amber | Trust meetings occurred in July and November Meetings with Medical Director have not occurred as Microbiologist AMS lead on maternity leave. Medical Director has met with Clinical Director of Pathology and Pharmacy to discuss A3 |

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| 7 | 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 though objective to reduce hospital acquired infections with AMS being contributory to this | September 2021 | Uzo Ibechukwu Chief Pharmacist Moya O'Doherty Pathology Director | Amber | Clinical Director of Pathology, AMS team, OPU clinicians and Coach House have completed the A3. Key 4 high impact countermeasures were to increase pharmacy AMS resource, increase microbiology resource, explore a mandatory 72hour antibiotic stop and improve AMS governance within the Trust (introduce an AMS policy and review AMS working group ToR and Chair). OPU has been chosen as a target area to commence actions but many high impact ones will be hard to close without increased resource. |
| 8 | Central collation of BAME risk assessments completed in divisions and departments | 23/07/2020 | Victoria Downing-Burn, Deputy Director for People | Blue | Complete. Compliance figures submitted to NHSE/I 23.7.20 and subsequent reporting periods. Daily updates are available. |
| 9 | Line managers to be made aware of outstanding risk assessments | Daily | Andrew Howse, Senior Workforce Analyst | Blue | Names of those without RAs circulated to Ward/Department Manager. All staff invited / able to conduct assessment on line. |
| 10 | 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 | |
| 11 | Data capture of those offered but declined to complete risk assessment | 23/07/2020 | Victoria Downing-Burn, Deputy Director for People | Blue | Managers asked to inform HR of BAME staff who decline a RA. |
| 12 | 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. Covid risk assessments in place for all staff. Referral to OH for advice as appropriate. |

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