

Item 1.6a

Infection prevention and control board assurance framework

22 May 2020, Version 1.2

Updates since version 1, published on 4 May 2020, are highlighted in yellow.

Foreword

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

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

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

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

A handwritten signature in black ink, appearing to read 'Ruth May', is positioned above a thin vertical yellow line.

Ruth May

Chief Nursing Officer for England

1. Introduction

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

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

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

2. Legislative framework

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

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

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

Infection prevention and control board assurance framework

1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users			
Key lines of enquiry	Evidence	Gaps in assurance	Mitigating actions
<p>Systems and processes are in place to ensure:</p> <ul style="list-style-type: none"> infection risk is assessed at the front door and this is documented in patient notes patients with possible or confirmed COVID-19 are not moved unless this is essential to their care or reduces the risk of transmission compliance with the national guidance around discharge or transfer of COVID-19 positive patients all staff (clinical and non-clinical) are trained in putting on and removing PPE; know what PPE they should wear for each setting and context; and have access to the PPE that protects them for the appropriate setting and context as per national guidance national IPC guidance is regularly checked for updates and any changes 	<p>Elective patients assessed prior to admission. Emergency patients e.g PPCI patients assessed on presentation to the Cath Lab.</p> <p>Documented in the patient notes. Patients moved to cohort areas according to COVID 19 status. Positive patient movements tracked on ICNET</p> <p>Protocols in place</p> <p>Patient discharge information leaflet produced.</p> <p>Guidance and posters available regarding PPE for different zones/cohorts of patients. Information and educational materials available on the intranet. Training delivered by the education team and Critical Care and Theatre staff.</p> <p>Updates circulated to group emergency planning email and communicated via Trust command structure. Daily COVID 19</p>	<p>Unable to audit easily as documented in different places</p>	<p>Documentation to be reviewed and standardised</p>

<p>are effectively communicated to staff in a timely way</p> <ul style="list-style-type: none"> • changes to guidance are brought to the attention of boards and any risks and mitigating actions are highlighted • risks are reflected in risk registers and the board assurance framework where appropriate • robust IPC risk assessment processes and practices are in place for non COVID-19 infections and pathogens 	<p>briefing on corporate communications. Regular briefing to department heads/Bronze command. (Now changed to twice weekly)</p> <p>IPN is enrolled to receive updates from PHE website. Changes to guidance highlighted via Silver Command to Gold Command.</p> <p>Protocols and policies in place for prevention of other infections. Audit programme in place and data available.</p>		
2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections			
Key lines of enquiry	Evidence	Gaps in assurance	Mitigating actions
<p>Systems and processes are in place to ensure:</p> <ul style="list-style-type: none"> • designated teams with appropriate training are assigned to care for and treat patients in COVID-19 isolation or cohort areas • designated cleaning teams with appropriate training in required techniques and use of PPE are assigned to COVID-19 isolation or cohort areas • decontamination and terminal decontamination of isolation rooms or cohort areas is carried out in line with PHE and other national guidance 	<p>Teams assigned on a daily basis for COVID 19 isolation areas</p> <p>Hygiene staff allocated to COVID-19 areas. Training provided.</p> <p>Terminal decontamination carried out according to PHE guidelines and is logged on a database. Additional decontamination using UV-C of single rooms and HPV also used</p>		

<ul style="list-style-type: none"> 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 attention to the cleaning of toilets/bathrooms, as COVID-19 has frequently been found to contaminate surfaces in these areas cleaning is carried out with neutral detergent, a chlorine-based disinfectant, in the form of a solution at a minimum strength of 1,000ppm available chlorine, as per national guidance. 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 manufacturer's guidance and recommended product 'contact time' must be followed for all cleaning/ disinfectant solutions/products as per national guidance: <ul style="list-style-type: none"> 'frequently touched' surfaces, eg door/toilet handles, patient call bells, over-bed tables and bed rails, should be decontaminated at least twice 	<p>Cleaning Schedules available</p> <p>Cleaning audited and monitoring scores available</p> <p>1000ppm chlorine based disinfectant product used for terminal cleans.</p> <p>Frequently touched surfaces included as part of cleaning schedule- cleaned 3x daily. Monitored as part of Matrons'</p>		
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<p>contaminated with secretions, excretions or body fluids</p> <ul style="list-style-type: none"> ○ electronic equipment, eg mobile phones, desk phones, tablets, desktops and keyboards should be cleaned at least twice daily ○ 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) • linen from possible and confirmed COVID-19 patients is managed in line with PHE and other national guidance and the appropriate precautions are taken • single use items are used where possible and according to single use policy • reusable equipment is appropriately decontaminated in line with local and PHE and other national guidance • review and ensure good ventilation in admission and waiting areas to minimise opportunistic airborne transmission 	<p>Weekly audits</p> <p>Included in frequently touched surfaces schedule. Audit data available</p> <p>Cleaning schedules in place</p> <p>Linen policy in place</p> <p>Included in disinfection policy</p> <p>Cleaning and disinfection policy in place</p>	<p>No specific ventilation in admission and waiting areas</p>	<p>Social distancing measures in place. Masks available in all areas</p>
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3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance			
Key lines of enquiry	Evidence	Gaps in assurance	Mitigating actions
<p>Systems and processes are in place to ensure:</p> <ul style="list-style-type: none"> • arrangements around antimicrobial stewardship are maintained • mandatory reporting requirements are adhered to and boards continue to maintain oversight 	<p>Normal antimicrobial ward rounds suspended. Remote review taking place for Critical Care Antimicrobial audits for Q4 (19/20) during COVID completed and presented to drug and therapeutics</p>	<p>Stewardship data not available</p>	<p>Stewardship programme to be reviewed by antimicrobial pharmacist and microbiologist in July.</p>
4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/medical care in a timely fashion			
Key lines of enquiry	Evidence	Gaps in assurance	Mitigating actions
<p>Systems and processes are in place to ensure:</p> <ul style="list-style-type: none"> • implementation of national guidance on visiting patients in a care setting • areas in which suspected or confirmed COVID-19 patients are being treated are clearly marked with appropriate signage and have restricted access • information and guidance on COVID-19 is available on all trust websites with easy read versions • infection status is communicated to the receiving organisation or department when a possible or confirmed COVID-19 patient needs to be moved 	<p>Visiting currently restricted. Exceptions detailed in the End of Life protocol and assessed on individual basis. Signage displayed for individual areas/zones</p> <p>Resources available on website. Easy read versions available on website</p> <p>Included on discharge planning information for external transfers. Alerts in place for all inpatients</p>		

5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people			
Key lines of enquiry	Evidence	Gaps in assurance	Mitigating actions
<p>Systems and processes are in place to ensure:</p> <ul style="list-style-type: none"> frontdoor areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed COVID-19 symptoms and to segregate them from non COVID-19 cases to minimise the risk of cross-infection, as per national guidance mask usage is emphasized for suspected individuals ideally segregation should be with separate spaces, but there is potential to use screens, eg to protect reception staff for patients with new-onset symptoms, it is important to achieve isolation and instigation of contact tracing as soon as possible patients with suspected COVID-19 are tested promptly patients who test negative but display or go on to develop symptoms of COVID-19 are segregated and promptly re-tested and contacts traced 	<p>Emergency arrivals are screened for symptoms in the ambulance or on arrival and placed in the appropriate area.</p> <p>Information in guidelines</p> <p>Screens in place at all reception areas</p> <p>Patients with new symptoms are cohorted promptly and immediately tested.</p> <p>Negative swabs in symptomatic patients still suspected are isolated and retested</p> <p>Contact tracing initiated on positive result or negative result with strong clinical suspicion</p>		

<ul style="list-style-type: none"> patients who attend for routine appointments and who display symptoms of COVID-19 are managed appropriately 	Guidance available for Outpatients. Screening questions asked of patients for scheduled appointments. Temperature checks for outpatients		
6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection			
Key lines of enquiry	Evidence	Gaps in assurance	Mitigating actions
<p>Systems and processes are in place to ensure:</p> <ul style="list-style-type: none"> all staff (clinical and non-clinical) have appropriate training, in line with latest PHE and other guidance, to ensure their personal safety and working environment is safe all staff providing patient care are trained in the selection and use of PPE appropriate for the clinical situation, and on how to safely don and doff it a record of staff training is maintained appropriate arrangements are in place so that any reuse of PPE in line with the CAS alert is properly monitored and managed any incidents relating to the re-use of PPE are monitored and appropriate action taken adherence to PHE national guidance on the use of PPE is regularly audited 	<p>Training provided by education team and also by individual departments e.g. critical care education practitioners regarding PPE and correct donning/doffing. Donning and doffing videos on intranet and staff app. Included in corporate induction</p> <p>Training records held by Education Team</p> <p>Only visors currently reused – automated process in place</p> <p>Incidents reported via usual incident management system</p> <p>Guidance on intranet</p>	No audit data available	Audit to be undertaken in Critical Care by end of July 2020. To add to Matron's audit tool - To be reviewed by Silver command

<ul style="list-style-type: none"> • staff regularly undertake hand hygiene and observe standard infection control precautions • hand dryers in toilets are associated with greater risk of droplet spread than paper towels. Hands should be dried with soft, absorbent, disposable paper towels from a dispenser which is located close to the sink but beyond the risk of splash contamination, as per national guidance • guidance on hand hygiene, including drying, should be clearly displayed in all public toilet areas as well as staff areas • staff understand the requirements for uniform laundering where this is not provided on site • 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 displays any of the symptoms 	<p>Hand hygiene and standard infection control precautions observed and audit results available</p> <p>No Hand dryers in situ</p> <p>Hand hygiene posters displayed</p> <p>No uniform laundering available (other than scrubs). Information on requirements is on the Trust intranet</p> <p>Guidance available on intranet. Communicated frequently through safety huddles.</p>	<p>Require refreshing in some areas</p>	<p>Audit to be undertaken by Infection Prevention by end of July 2020 -To be reviewed by Silver command</p>
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7. Provide or secure adequate isolation facilities			
Key lines of enquiry	Evidence	Gaps in assurance	Mitigating actions
<p>Systems and processes are in place to ensure:</p> <ul style="list-style-type: none"> patients with possible or confirmed COVID-19 are isolated in appropriate facilities or designated areas where appropriate areas used to cohort patients with possible or confirmed COVID-19 are compliant with the environmental requirements set out in the current PHE national guidance patients with resistant/alert organisms are managed according to local IPC guidance, including ensuring appropriate patient placement 	<p>Patients with Covid 19 are isolated or cohorted in appropriate areas. Designated as red/yellow zones or individual rooms</p> <p>Defined areas agreed by Gold Command. Limited availability of isolation rooms (negative pressure)</p> <p>Patients with alert organisms managed according to IPC guidance, as usual. Monitored and data available</p>		
8. Secure adequate access to laboratory support as appropriate			
Key lines of enquiry	Evidence	Gaps in assurance	Mitigating actions
<p>Systems and processes are in place to ensure:</p> <ul style="list-style-type: none"> testing is undertaken by competent and trained individuals patient and staff COVID-19 testing is undertaken promptly and in line with PHE and other national guidance screening for other potential infections takes place 	<p>Protocol and competency framework in place</p> <p>Screening undertaken for inpatients and pre-admission patients</p> <p>Staff screening records held by test and trace team</p> <p>Screening for MRSA, VRE, CPE in place.</p>	<p>Audit data available for competency</p> <p>Audit data is being collated for patients and staff</p> <p>Data on screening outcomes sent to execs and board</p>	<p>Learning and Development to manage competencies and auditing</p> <p>Audits to be performed by end of July 2020 – Reviewed by Silver command</p>

9. Have and adhere to policies designed for the individual's care and provider organisations that will help prevent and control infections			
Key lines of enquiry	Evidence	Gaps in assurance	Mitigating actions
<p>Systems and processes are in place to ensure:</p> <ul style="list-style-type: none"> staff are supported in adhering to all IPC policies, including those for other alert organisms any changes to the PHE national guidance on PPE are quickly identified and effectively communicated to staff all clinical waste related to confirmed or possible COVID-19 cases is handled, stored and managed in accordance with current national guidance PPE stock is appropriately stored and accessible to staff who require it 	<p>Training and education undertaken. Records held by education team</p> <p>PHE updates communicated via command structure</p> <p>Waste policy in place</p> <p>PPE supplies managed by dedicated team who supply individual areas</p>		
10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection			
Key lines of enquiry	Evidence	Gaps in assurance	Mitigating actions
<p>Systems and processes are in place to ensure:</p> <ul style="list-style-type: none"> staff in 'at-risk' groups are identified and managed appropriately, including ensuring their physical and psychological wellbeing is supported staff required to wear FFP reusable respirators undergo training that is compliant with PHE national guidance 	<p>Robust staff welfare systems in place including at risk groups</p> <p>Protocol in place for reusable respirators- ad hoc training. Register of staff maintained</p>		

<p>and a record of this training is maintained</p> <ul style="list-style-type: none"> 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 all staff adhere to national guidance on social distancing (2 metres) wherever possible, particularly if not wearing a facemask and in non-clinical areas consideration is given to staggering staff breaks to limit the density of healthcare workers in specific areas staff absence and wellbeing are monitored and staff who are self-isolating are supported and able to access testing staff who test positive have adequate information and support to aid their recovery and return to work 	<p>Unable to completely segregate planned and elective care pathways and urgent and emergency care patients</p> <p>Reviews have been undertaken and risk assessments in place to enable social distancing where possible. Facemasks available in all areas</p> <p>Regular update reports provided to Bronze Command</p> <p>Staff testing guidance / FAQs produced by swabbing team Staff who test positive supported as per normal sickness process by line managers with additional support provided by HR/OH as required</p>		
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