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Date	09.07.20	Agenda item	Bo.7.20.34

INFECTION PREVENTION AND CONTROL BOARD ASSURANCE FRAMEWORK FOR COVID-19

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Lead Director	Karen Dawber, Chief Nurse/Director Infection Prevention and Control				
Purpose of the paper	<p>This Infection Prevention and Control Board Assurance Framework has been developed by NHSE/I to assess against the Covid-19 guidance as a source of internal assurance that quality standards are being maintained. It will also help 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.</p> <p>This will in addition provide assurance on compliance with:</p> <ul style="list-style-type: none"> • NHS Outcomes Framework– domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm. • Health & Social Care Act 2008: Code of Practice for the NHS on the prevention and control of healthcare associated infections and related guidance (commonly known as The Hygiene Code). 				
Key control	This paper is a key control for the Board Assurance Framework				
Action required	To note				
Previously discussed at/ informed by	Silver & Gold Clinical Reference Group and Infection Prevention & Control Committee				
Previously approved at:	Committee/Group	Date			
Key Options, Issues and Risks					
<p>This Infection Prevention and Control Board Assurance Framework (BAF) has been developed by NHS England/Improvement (NHSE/I) to assess against the Covid-19 guidance as a source of internal assurance that quality standards are being maintained. It will also help 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.</p> <p>The BAF has been completed to demonstrate progress against national guidance for Covid-19 and subsequently support compliance with:</p> <ul style="list-style-type: none"> • The Health and Social Care Act (H&SCA) 2008: Code of Practice for the NHS on the prevention and control of healthcare associated infections and related guidance. • Regulation 12(2) (h) and 21(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 					
Analysis					
<p>The report presents assurances for progress against the National Standards for Infection Prevention and Control in relation to Covid-19 current guidance. The report also highlights any gaps in compliance and</p>					

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current mitigations in systems and processes which impact on the prevention and control of healthcare associated infections.

Recommendation

The report provides assurance to the Board by monitoring the activity of infection prevention and control against current National Covid-19 guidance as a source of internal assurance that quality standards are being maintained.

It highlights any gaps in compliance or areas of risk and shows the corrective actions taken in response. The Board is also requested to consider the gaps in compliance and the actions to improve compliance going forward.

The Board is asked to note the BAF tool as a process to provide assurance that organisational compliance has been systematically reviewed.

Risk assessment

Strategic Objective	Appetite (G)					
	Avoid	Minimal	Cautious	Open	Seek	Mature
To provide outstanding care for patients			g			
To deliver our financial plan and key performance targets			g			
To be in the top 20% of NHS employers					g	
To be a continually learning organisation				g		
To collaborate effectively with local and regional partners					g	
The level of risk against each objective should be indicated. Where more than one option is available the level of risk of each option against each element should be indicated by numbering each option and showing numbers in the boxes.	Low		Moderate	High	Significant	
	Risk (*)					
Explanation of variance from Board of Directors Agreed General risk appetite (G)						

Benchmarking implications (see section 4 for details)	Yes	No	N/A
Is there Model Hospital data relevant to the content of this paper?	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Is there any other national benchmarking data relevant to the content of this paper?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is the Trust an outlier (positive or negative) for any benchmarking data relevant to the content of this paper?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

Risk Implications (see section 5 for details)	Yes	No
Corporate Risk register and/or Board Assurance Framework Amendments	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Quality implications	<input checked="" type="checkbox"/>	<input type="checkbox"/>

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Resource implications	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Legal/regulatory implications	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Diversity and Inclusion implications	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Performance Implications	<input checked="" type="checkbox"/>	<input type="checkbox"/>

Regulation, Legislation and Compliance relevance
NHS Improvement: (please tick those that are relevant) <input type="checkbox"/> Risk Assessment Framework <input checked="" type="checkbox"/> Quality Governance Framework <input type="checkbox"/> Code of Governance <input type="checkbox"/> Annual Reporting Manual
Care Quality Commission Domain: Safe
Care Quality Commission Fundamental Standard: Safety (Regulation 12(2)(h) and 21(b) of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014
NHS Improvement Effective Use of Resources: Clinical Services
Other (please state): NICE [QS61] Infection prevention and control

Relevance to other Board of Director's Committee: (please select all that apply)					
Workforce	Quality	Finance & Performance	Partnerships	Major Projects	Other (please state)
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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1 PURPOSE/ AIM

- 1.1 The purpose of this report is to assess compliance against the Covid-19 guidance using the Board Assurance Framework (BAF) developed by NHSE/I as a source of internal assurance that quality standards are being maintained. The BAF has been completed and identified any areas of risk and demonstrates the corrective actions taken in response. The tool therefore provides an assurance process to the Board that organisational compliance has been systematically reviewed.
- 1.2 This will in addition provide assurance on compliance with:
- NHS Outcomes Framework– domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm.
 - Health & Social Care Act 2008: Code of Practice for the NHS on the prevention and control of healthcare associated infections and related guidance (commonly known as The Hygiene Code).

2 BACKGROUND/CONTEXT

- 2.1 Effective infection prevention and control is fundamental to the control and containment of Covid-19. NHSE/I have developed the board assurance framework to support all healthcare providers to effectively self-assess their compliance with PHE and other COVID-19 related infection prevention and control guidance and to identify risks.

The purpose of the framework is to assure the Board by assessing the measures taken in line with current guidance and also as an improvement tool to optimise actions and interventions.

3 PROPOSAL

- 3.1 This report will confirm continued assurance systems for compliance against the statutory requirements which will support assurance with corporate strategic objective 1 - To provide outstanding care for our patients.

4 BENCHMARKING IMPLICATIONS

- 4.1 Summary up to 23.6.20 provided by Performance Team:
- BTHFT have just under 10% of all the acute open bed stock across West Yorkshire and Harrogate (WY&H).
 - BTHFT have over 33% of all the Covid in-patients in the region.
 - 8.6% of our bed base is occupied by a Covid patient (over 4 times higher than the regional average).
 - More than half of all the new in-patient Covid diagnosis across the region are in BTHFT.

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	WY&H Total	BTHFT	BTHFT as % of region
Total beds open	6285	608	9.7
Total Covid in-patients	157	52	33.1
Covid patients on Mechanical ventilation	12	9	75.0
New admissions diagnosed with Covid	4	3	75.0
New in-patients diagnosed with Covid	5	2	40.0
Total new Covid diagnosis	9	5	55.6
% beds occupied with Covid patients	2	8.6	N/A

- 4.2 Figure 2 provides benchmarking data provided below by PHE Regional Team on 25.6.20 identifies that Bradford city have had high testing - higher than anywhere else in NEY for over 4 weeks, but the positive test return is also high. Looking at individual data for the past 4 weeks, the majority of cases are working age and some school age people with significant household contact cases - possibly due to the combination of large multi-generational families living in tight accommodation.

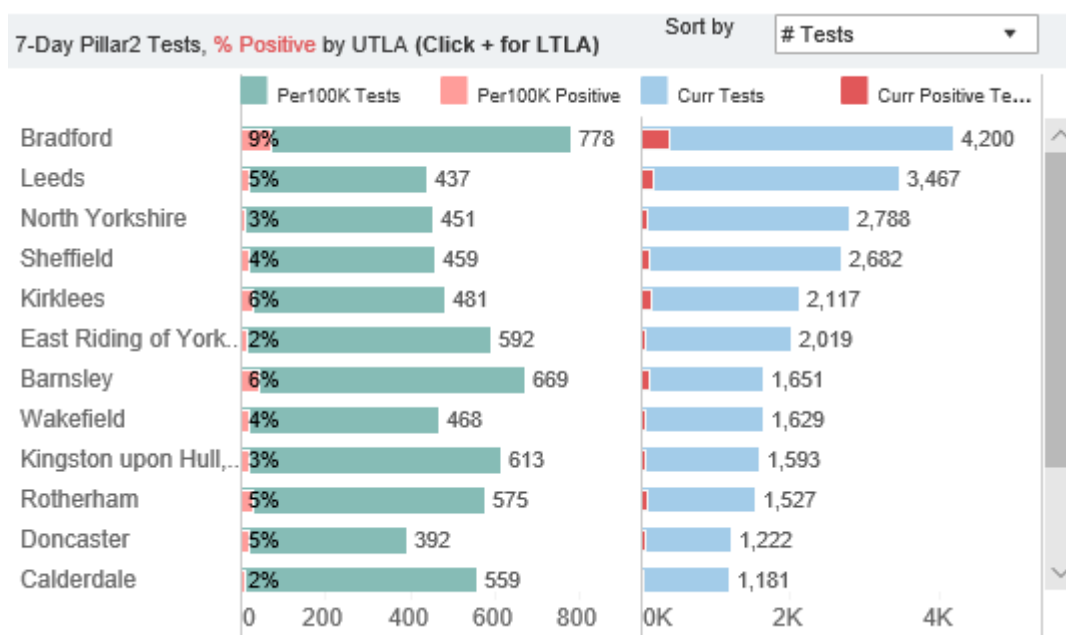


Figure 2

5 RISK ASSESSMENT

- 5.1 The report presents assurances for progress against the National Standards for Infection Prevention and Control in relation to Covid-19 current guidance. The report also highlights

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any gaps in compliance and current mitigations in systems and processes which impact on the prevention and control of healthcare associated infections.

6	RECOMMENDATIONS
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- 6.1 The report provides assurance to the Board by monitoring the activity of infection prevention and control against the Covid-19 guidance as a source of internal assurance that quality standards are being maintained.
- 6.2 It highlights any gaps in compliance or areas of risk and shows the corrective actions taken in response. The Board is also requested to consider the gaps in compliance and the actions to improve compliance going forward.
- 6.3 The Board is asked to note the BAF tool as a process to provide assurance that organisational compliance has been systematically reviewed.

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7	Appendices
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Appendix 1: 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 patients and staff are protected with PPE, as per the PHE national guidance national IPC guidance is regularly checked for updates and any changes are effectively 	<ul style="list-style-type: none"> Process in place and embedded. EPR flag system Cohorting policy is updated on a regular basis to identify areas dependent on numbers Our local SOP's reflect national guidance and are tracked through the command structures in place Local PPE guidance has been updated in line with changes to national guidance, PPE is managed through a centralized hub with expert clinical advice available Risk registers updated and monthly update to Board members via regulation committee or Board 	<ul style="list-style-type: none"> Staff, in some areas, remain confused over the level of PPE to wear – this is primarily in relation to the new guidance to wear a surgical mask at all times unless in a non-clinical area which is approved as “Covid secure”. Although ad hoc observation audits are being undertaken, routine audits not being undertaken on Meridian. 	<ul style="list-style-type: none"> Continue to update communications in relation to PPE. Informative videos developed with Communications team. PPE hub in place to give advice in relation to PPE, this includes coordinated deliveries of the correct PPE to all clinical and non- clinical areas. Audit schedule to recommence from the 1st July 2020. Infection control matron spot check to be recommenced

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<p>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 	<ul style="list-style-type: none"> Board Assurance Framework updated June 2020 IPC risk for non COVID continues as per our policies and procedures in place 		
2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections			
Key lines of enquiry	Evidence	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 	<ul style="list-style-type: none"> Staff training and / or information in place for all front line staff (including porters / domestics / temporary workers) Dedicated cleaning teams in place with HPV / Chlorine and UV in place. PPE training and advice given 	<ul style="list-style-type: none"> Lack of resources to support deep cleaning on sites other than BRI, relating the availability of the HPV machine. Limited capacity to provide a programme of deep cleaning for all wards on a regular basis above and 	<ul style="list-style-type: none"> Case of need for an additional machine has been escalated to Gold, approval received 19/5/2020. Ad hoc deep cleaning being provided. Business case under development by the facilities team to deliver a regular programme of deep cleaning

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<p>assigned to COVID-19 isolation or cohort areas.</p> <ul style="list-style-type: none"> decontamination and terminal decontamination of isolation rooms or cohort areas is carried out in line with PHE and other national guidance increased frequency of cleaning in areas that have higher environmental contamination rates as set out in the PHE and other national guidance 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 policy 	<ul style="list-style-type: none"> National guidance is followed and SOP's are in place for all staff Where an item is for single use only and is being reused (Visor / Goggles and respirators) this has been risk assessed and a process in place. Reusable equipment is appropriately decontaminated and policies are in place 	<p>beyond the normal cleaning schedules.</p> <ul style="list-style-type: none"> Limited availability of routine disinfectant products (i.e. chlorox wipes) 	<p>for all areas.</p> <ul style="list-style-type: none"> Review of schedules and frequencies of ward and department routine cleaning to ensure compliance with National Cleaning standards and recommendations for enhancement of cleaning in high risk area will form part of Business case. IPC team working in collaboration with Procurement to source suitable alternatives.
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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 process 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 	<ul style="list-style-type: none"> • Anti- microbial pharmacist in place and continues to maintain some of the service. • Reporting continues to be signed off and reported to the national systems. Board dashboard in place 	<ul style="list-style-type: none"> • Consultant microbiologist not on site doing ward rounds 	<ul style="list-style-type: none"> • EPR virtual review • Failsafes within EPR for discontinuation of high risk drugs • Virtual MDT reviews in place
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 where possible being treated in areas clearly marked with appropriate signage and have restricted access 	<ul style="list-style-type: none"> • National guidance has been implemented and uploaded onto website, SOP in place • Signage in place 	<ul style="list-style-type: none"> • Although documented we have had a concern raised that we did not notify a care home of potential COVID status (on discharge from AED) • Easy read information not yet available on the external website. 	<ul style="list-style-type: none"> • Written information being provided to care homes for all patients who are assessed in a 'non-green area' • Easy read documents under development with the support of Bradford Talking Media. • Written information available and communication via Silver tactical to remind ward clinical

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<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> Information available on the website. Easy read versions have been commissioned from Bradford Talking Media Electronic patient record with alerts clearly in place for all patients at BTHFT. Discharge and transfer documentation clearly states infection status. 	<ul style="list-style-type: none"> Patient contacts for a confirmed Covid case not always provided with timely information that they have been a contact 	<ul style="list-style-type: none"> teams to notify patient that they have been a contact.
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"> 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 patients with suspected COVID-19 are tested promptly patients that test negative but display or go on to develop symptoms of COVID-19 are segregated and promptly re-tested 	<ul style="list-style-type: none"> Policies and procedures are in place and embedded. Specific SOPs developed and updated as appropriate. 	<ul style="list-style-type: none"> We are understanding more about the disease process on a daily basis, this means we need to change and review frequently – sometimes ahead of national guidance 	<ul style="list-style-type: none"> Command structure in place (including clinical reference group) to evaluate all new findings and decisions.

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<ul style="list-style-type: none"> patients that attend for routine appointments who display symptoms of COVID-19 are managed appropriately 			
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 that any reuse of PPE in 	<ul style="list-style-type: none"> Training in place for all staff including updated SOP, videos, posters web and face to face. In preparation education sessions aimed purely at COVID and treatment including Donning / Doffing and IPCC All staff trained but not embedded due to changing guidance Staff training records are maintained for all staff on a centralized database CAS alert reviewed and action 	<ul style="list-style-type: none"> Changing guidance Inconsistent recording of training records, with variable use of ESR and ability to pull 	<ul style="list-style-type: none"> Posters in all clinical areas, ongoing teaching and spot checks. Education content updated as per new guidance. Local records being kept. Need to revisit reporting arrangements.

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<p>line with the CAS alert is properly monitored and managed</p> <ul style="list-style-type: none"> 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 staff regularly undertake hand hygiene and observe standard infection control precautions staff understand the requirements for uniform laundering where this is not provided for on site All staff understands the symptoms of COVID-19 and takes appropriate action in line with PHE and other national guidance if they or a member of their household display any of the symptoms. 	<p>plan developed</p> <ul style="list-style-type: none"> Regular spot audits are being undertaken in relation to the wearing of PPE, any incidents reported in relation to PPE are reviewed by the infection control team. Hand hygiene audits have continued and observations taking place Staff have been advised on the correct temperature to wash uniforms, strict policy of no travelling to work in uniform enforced Evidence that staff understand the requirements to report / ask for advice / self-isolate 	<p>compliance reports.</p> <ul style="list-style-type: none"> Not always full compliance, separation and storage of clean and dirty visors. 	<ul style="list-style-type: none"> Spot checks and Chief Nurse Team/ IPN Team assurance visits in place to monitor compliance. Review existing audit programme and data and undertake a gap analysis which will then inform the training priorities, future audit programme and infection control annual plan. Alternative methods of providing training in development including training banners with assessment questions.
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7. Provide or secure adequate isolation facilities

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
Systems and processes are in place			

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<p>to ensure:</p> <ul style="list-style-type: none"> patients with suspected or confirmed COVID-19 are isolated in appropriate facilities or designated areas where appropriate 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 patients with resistant/alert organisms are managed according to local IPC guidance, including ensuring appropriate patient placement 	<ul style="list-style-type: none"> Policies and procedures in place to monitor guidance Cohorting plans in place that are flexed to the different needs of patients and demands Environmental checks plus additional checks in place Existing policies in place and maintained – flagging system via EPR 	<ul style="list-style-type: none"> Not an exact science on how to cohort and this leads to differences in opinion – potentially impacting on practice Environmental checks are showing areas of concern Old estate, with paucity of side rooms (including side rooms with en-suite and/or appropriate ventilation), and adapted nightingale wards with limited hand wash facilities. Evidence that timely review of Covid-19 swab results not in place by Clinical teams so that a patient is not moved to a red ward or side room promptly. 	<ul style="list-style-type: none"> Command and control structure in place with consensus gained and reviewed as any concerns arise. MDT Review meetings for isolation and cohorting facilities in progress to establish where current estate can be adapted/or reconfigured to enhance isolation capacity. Established operational processes for communication between estates, facilities, infection control and the Clinical Site team to move patients to the most appropriate area in a timely manner.
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8. Secure adequate access to laboratory support as appropriate

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
<p>There are systems and processes in place to ensure:</p> <ul style="list-style-type: none"> testing is undertaken by competent and trained individuals 	<ul style="list-style-type: none"> Managed in collaboration with Airedale and any new guidance 	<ul style="list-style-type: none"> No established regular routine reporting in 	<ul style="list-style-type: none"> Regular report to be established through EPR for

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<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> is reviewed and implemented Staff testing uptake has increased as availability improved. Clear database of staff and rational for testing 	place to check compliance with MRSA /CPE screening.	MRSA/CPE screening.
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9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
<p>Systems and processes are in place to ensure that:</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 suspected 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 	<ul style="list-style-type: none"> As part of business as usual and ongoing checks, evidence is available that we are adhering to policies and addressing any changes Effective process in place to manage communication of changes to national guidance via command and control structure. PPE hub in place offering advice and supply of correct PPE 	<ul style="list-style-type: none"> Robust audit of waste disposal not in place during Covid 19 due to risk from contaminated waste 	<ul style="list-style-type: none"> Review with Waste Officer ward processes for waste disposal with spot-check visits to wards

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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>Appropriate 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 <ul style="list-style-type: none"> staff required to wear FFP reusable respirators undergo training that is compliant with PHE national guidance and a record of this training is maintained 	<ul style="list-style-type: none"> Risk assessment process in place for vulnerable groups of staff including guidance for managers and risk assessment checklist and template. Documents are regularly updated in line with national guidance. OH support available to staff/managers that have concerns about their vulnerabilities including signposting to psychological support. [local and national] Record of training. Staff trained to use respirators by IPC or specially trained staff. 	<ul style="list-style-type: none"> Changing guidance and advice re vulnerable groups. Risk assessments locally held so assurance re completion and follow up. Inconsistent recording of training. Staff remaining confused re when to wear FFP respirators due to conflicting guidance from PHE/NHSE and Professional bodies on 	<ul style="list-style-type: none"> Regular communications re risk assessments. Risk assessment checklist developed for BAME staff which can be used for all colleagues. Reporting functionality set up on ESR/OLM to record completion. Spot check audits to be instigated. Revisiting reporting arrangements. Advice/comms taking place when issue comes up via risk assessments. Discussion via Silver and Gold CRG to agree list of AGP and SOP amended as required.

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<ul style="list-style-type: none"> • staff absence and well-being are monitored and staff who are self-isolating are supported and able to access testing • Staff that test positive have adequate information and support to aid their recovery and return to work. 	<ul style="list-style-type: none"> • Staff absence is recorded via Health Roster/ESR; standard operating procedures are in place for all symptomatic staff/symptomatic household contacts to access staff testing. HR/Occupational health helpline in place. • In house staff testing results are returned via occupational health, individual staff and managers are provided with appropriate isolation, re-swabbing and return to work advice based on national guidance and local policies/SOPs. 	<p>what procedures are included as aerosol generating procedures (AGP)</p> <ul style="list-style-type: none"> • Timely reporting and recording of absence in all cases. • Staff who book tests in a different name means delays in getting results back to staff. • Staff who book outside the agreed process or via the government system get results directly and occupational health are not flagged to chase results. • Testing via Marley site reliant upon staff advising occupational health, again potential delays. 	<ul style="list-style-type: none"> • HR Helpdesk contact staff on days 1-3 of absence to check testing status and to book test for them if this has not happened. • Development of an on line booking system for staff testing. • Increase in in house testing capacity will negate the need for staff to use other services. • Occupational Health Service available over seven days. • Staff test and Trace in place with Occupational health and follow up by IPC Team if any clusters of staff identified. Investigation of potential outbreaks in place and notification processes compliant with NHSE/I requirements.
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