Kent Community Health
NHS Foundation Trust

BOARD OF DIRECTORS MEETING IN PUBLIC

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Invicta Suite, Orida Hotel, Bearsted Road, Maidstone, Kent ME14 5AA

Supporting papers

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Infection prevention and control board assurance framework

September 2022 Version 1.11

Updates from version 1.8, November 30 are highlighted in yellow

Foreword

NHS staff should be proud of the care being provided to patients and the way in which services adapted and responded during the COVID-19 pandemic.

Effective infection prevention and control must continue and to support service recovery we have updated this board assurance framework (BAF) to support all healthcare providers to effectively self-assess their compliance with the National infection prevention and control manual (NIPCM) and other related infection prevention and control guidance to identify risks associated with infectious agents and provide an additional level of assurance to the Board. The general principles can be applied across all settings; acute and specialist hospitals, community hospitals, mental health and learning disability, and locally adapted. The framework can be used to assure directors of infection prevention and control, medical directors, and directors of nursing by assessing the measures taken in line with the NIPCM or existing local policies whilst the NIPCM is being implemented. It can be used to provide evidence and as an improvement tool to optimise actions and interventions. The framework can also be used to assure trust boards.

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

Ruth May
Chief Nursing Officer for England

1. Introduction

The application of infection prevention and control (IPC) measures has been key in the response to the SARS-CoV-2 pandemic.

The UKHSA guidance was archived at the end of April 2022, the proposal is that NIPCM combined with this version of the Board Assurance Framework (BAF) will support this transition.
This will continue to ensure organisations can respond in an evidence-based way to maintain the safety of patients, services users, and staff.

The update of the BAF helps providers to assess against the NIPCM as a source of internal assurance. It will also identify any areas of risk and the corrective actions required in response. The BAF provides assurance to trust boards that organisational compliance has been systematically reviewed.

The BAF is intended to support local organisations with decision making and be used by directors of infection prevention and control, medical directors, and directors of nursing if required unless alternative internal assurance mechanisms are 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.
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. Local risk assessments should be based on the measures as prioritised in the hierarchy of controls. In the context of infectious agents, 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 January 2023

1. Systems 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 their environment and other users may pose to them

Key lines of enquiry	Evidence	Gaps in assurance	Mitigating actions
Systems and processes are in place to ensure that: • A respiratory plan incorporating respiratory seasonal viruses that includes: – point of care testing (POCT) methods for infectious patients known or suspected to have a respiratory infection to support patient triage/placement according to local needs, prevalence, and care services – segregation of patients depending on the infectious agent taking into account those most vulnerable to infection eg clinically immunocompromised – a surge/escalation plan to manage increasing patient/staff infections – a multidisciplinary team approach is adopted with hospital leadership, operational teams, estates and facilities, IPC teams and clinical and non-clinical staff to assess and plan for creation of adequate isolation rooms/cohort units as part of the plan. • Organisational /employers risk assessments in the context of managing infectious agents are: – based on the measures as prioritised in the hierarchy of controls – applied in order and include elimination; substitution, engineering, administration and PPE/RPE – communicated to staff – further reassessed where there is a change or new risk identified eg. changes to local prevalence. • The completion of risk assessments have been approved through local governance procedures, for example integrated care systems. • Risk assessments are carried out in all areas by a competent person with the skills, knowledge, and experience to be able to recognise the hazards associated with the infectious agents. • Ensure that transfers of infectious patients between care areas are minimised	• Pausing of asymptomatic COVID testing of patients and staff implemented at the beginning of September in line with national guidance. • An admission COVID-19 LFT is undertaken for all negative patients admitted into a community hospital • Where COVID-19 outbreaks identified, contact tracing using LFT tests • Patients with respiratory symptoms tested for COVID, influenza A, B and RSV where indicated on onset		

and made only when necessary for clinical reasons. • Resources are in place to monitor and measure adherence to the NIPCM. This must include all care areas and all staff (permanent, flexible, agency and external contractors). • The application of IPC practices within the NIPCM is monitored e.g. 10 elements of SICPs. • The IPC Board Assurance Framework (BAF) is reviewed, and evidence of assessments are made available and discussed at trust board level. • The trust board has oversight of incidents/outbreaks and associated action plans. • The trust is not reliant on a single respirator mask type and ensures that a range of predominantly UK made FFP3 masks are available to users as required.	of symptoms. • Patients with the same respiratory virus are cohorted together if there are insufficient single rooms available • COVID PCR swab for discharge to care home • Patients are isolated/cohorted according to results. • Patients most vulnerable to infection e.g. clinically immunocompromised are cared for in a single room when possible. • COVID positive patients are Isolated/cohorted until 2 negative LFD (day 6 and 7) are received (flow chart on intranet – and IPC team daily records of all swabs. • Whilst in system extremis all COVID		

	and Flu A positive patients are isolated until they are 48 hours asymptomatic. • MDT approach is in place with estates and facilities. This includes discussions regarding isolation facilities where indicated. • Hierarchy of controls reflected in current risk assessment. • Operational capacity to care for patients are considered as part of the admission criteria and the twice weekly safer staffing reviews, this includes acuity monitoring. • The DIPC and IPC team receive the daily PHE communicable disease reports for Kent Surrey and Sussex which		

	details variant related outbreak activity. We also participate in system networks • When unacceptable risk of transmission is identified further risk assessment is undertaken to consider any alternative/extended RPE equipment required. A trigger and escalation tool is in development in response to recent guidance for the implementation of RPE. • All outpatient departments MIU/UTC, clinics and home visits assessed prior to admission/visit • Staff risk assessments in place to support management of staff which was developed as a system. • National guidance		

	has been implemented as published. • Patients only moved if deteriorate and require admission to Acute OR if their infectious status changes • Director level approval of COVID-19 sitreps in place. • The Board and Governors are visible in operational and infrastructure services and are able to challenge as necessary. • There is a monthly audit of performance with IP&C guidance and facilities management. • The IP&C BAF is presented at the quality committee which is reported to each Board meeting. • The Quality		

	Committee receives updates on outbreaks and reports to the board. • Where cohorting is required, all IPC measures implemented, and when 'stepped down' terminal cleans undertaken – evidenced on deep clean checklist • Discharge letters include information on patient results and length of isolation requirements if positive or exposed. All patients screened 48 hours prior to discharge if going to care home / vulnerable people at home • IPC team supporting teams, inpatient visits – checklists and monitoring and		

	audits • Reviewed by IPC team on visits – team leads reviewing • Periodic checks by H&S teams through safer space champions. • Mandatory training programme – current compliance 95% • Training in place for donning and doffing PPE and COVID information pages on flo • Comms campaign targets hand hygiene, equipment cleaning, spacing and PPE and links to national resources and posters for local print and display • IPC training provided both electronic and face to face where required. Full PPE info on Flo, and posters available		

	• Fit-testing training programme in place on multiple masks for all staff. • All guidance reviewed, discussed at IMM, and changes implemented where required, through internal cascade system, as well as on internal intranet. • Risks highlighted on Datix and discussed through IMM, any high risks, on Trust BAF • The NIPC manual is available for all staff on Flo, and has been communicated at clinical visits, through the IPC link worker network, at national IPC week and through the comms team. The IPC team are systematically working through all policies and changing them into		

	organism specific standard operating procedures as much of the standard IPC is incorporated in the manual. • Director level approval of COVID-19 sitreps in place. • Outbreak management team is minuted and common themes reported to DIPC and bimonthly to IPCAS. • Overarching data provided to performance team daily, presented through IPCAS and in daily exec sitrep. Reported to Quality committee and to board. • IP&C audit programme in place. Evidence of compliance assessed bi-monthly • Chief Nurse hosts weekly calls with		

	ward Matrons. • Ward huddles and key focus areas include PPE awareness and key risk information. • Comms remains live to changes in guidance for NHS staff and reiteration of expectations for all work-related activity		

2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections

Key lines of enquiry	Evidence	Gaps in assurance	Mitigating actions
Systems and processes are in place to ensure that: • The Trust has a plan in place for the implementation of the National Standards of Healthcare Cleanliness and this plan is monitored at board level. • The organisation has systems and processes in place to identify and communicate changes in the functionality of areas/room. • Cleaning standards and frequencies are monitored in clinical and non-clinical areas with actions in place to resolve issues in maintaining a clean environment. • Enhanced/increased frequency of cleaning should be incorporated into environmental decontamination protocols for patients with suspected/known infections as per the NIPCM (section 2.3) or local policy and staff are appropriately trained. • Manufacturers' guidance and recommended product 'contact time' is	• IPC training updated to incorporate COVID-19 information, donning and doffing, viral swabbing, and face to face fit test training including domestic staff have received training, and where appropriate have been fit tested. • Non-infectious areas cleaned and visited prior to infectious areas.		

followed for all cleaning/disinfectant solutions/products. • For patients with a suspected/known infectious agent the frequency of cleaning should be increased particularly in: patient isolation rooms – cohort areas – donning and doffing areas – if applicable – 'frequently touched' surfaces e.g., door/toilet handles, chair handles, patient call bells, over bed tables and bed/trolley rails – where there may be higher environmental contamination rates, including: toilets/commodes particularly if patients have diarrhoea and/or vomiting. • The responsibility of staff groups for cleaning/decontamination are clearly defined and all staff are aware of these as outlined in the National Standards of Healthcare Cleanliness • A terminal clean of inpatient rooms is carried out: – when the patient is no longer considered infectious – when vacated following discharge or transfer (this includes removal and disposal/or laundering of all curtains and bed screens) – following an AGP if clinical area/room is vacated (clearance of infectious particles after an AGP is dependent on the ventilation and air change within the room). • Reusable non-invasive care equipment is decontaminated: – between each use – after blood and/or body fluid contamination – at regular predefined intervals as part of an equipment cleaning protocol before inspection, servicing, or repair equipment. • Compliance with regular cleaning regimes is monitored including that of reusable patient care equipment. • Ventilation systems, should comply with HBN 03:01 and meet national recommendations for minimum air changes. • Ventilation assessment is carried out in conjunction with organisational estates teams and or specialist advice from the ventilation group and/or the organisations, authorised engineer and plans are in place to improve/mitigate inadequate ventilation systems wherever possible.	• Patient information available and the offer of masks for patients is risk assessed. • Terminal clean checklists - utilising Chlorine 1000 ppm in place • Implemented – daily cleaning sheets in place and undertaken twice daily if outbreaks are declared. • Chlorclean/titan chlorine-based cleaning solutions are in place • National cleaning standards are measured and audited in all areas. • Area cleaned in line with National cleaning standards (April 2021). • Frequent touch areas cleaned as part of daily schedules and in addition when visibly contaminated. • Ward checklist for daily equipment - evidenced on IPC team checklist • Linen and laundry		

• Where possible air is diluted by natural ventilation by opening windows and doors where appropriate.	handled in line with national guidance and checked on all observational audits • Where possible equipment is single use • Equipment cleaning protocols in place – evidenced on checklists by IPC team • Monthly audits by facilities and presented at IPCAS • Mechanical ventilation, air flow and air change compliance has been reviewed and is currently subject to discussions with landlords for any remedial works. • Specialist ventilation is in place at QVMH only. Reviewed in line with HTM. Window opening regime in place. • Policy and protocols in place for decontamination of all equipment. Check lists are located on all clinical units and IPC		

	check these as part of their clinical visits. As part of the safer space programme staff are required to clean all IT equipment and desk spaces before and after use.		

3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**
Systems and process are in place to ensure that: • Arrangements for antimicrobial stewardship (AMS) are maintained and a formal lead for AMS is nominated. • NICE Guideline NG15 is implemented – antimicrobial stewardship: systems and processes for effective antimicrobial medicine use. • The use of antimicrobials is managed and monitored: – to optimise patient outcomes – to minimise inappropriate prescribing – to ensure the principles of Start Smart, Then Focus are followed. • Contractual reporting requirements are adhered to, and boards continue to maintain oversight of key performance indicators for prescribing including: – total antimicrobial prescribing – broad-spectrum prescribing – intravenous route prescribing. • Resources are in place to support and measure adherence to good practice and quality improvement in AMS. This must include all care areas and staff (permanent, flexible, agency and external contractors).	• IPCAS held bimonthly, antimicrobials Task and Finish group for antimicrobial stewardship in place. • PGD audit programme in place undertaken by pharmacy. • Pharmacy techs on wards weekly support prudent prescribing.		

4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion.

Key lines of enquiry	Evidence	Gaps in assurance	Mitigating actions
Systems and processes are in place to ensure that: • IPC advice/resources/information is available to support visitors, carers, escorts, and patients with good practices e.g. hand hygiene, respiratory etiquette, appropriate PPE use. • Visits from patient's relatives and/or carers (formal/informal) should be encouraged and supported whilst maintaining the safety and wellbeing of patients, staff and visitors. • National principles on inpatient hospital visiting and maternity/neonatal services will remain in place as an absolute minimum standard. National guidance on visiting patients in a care setting is implemented. • Patients being accompanied in urgent and emergency care (UEC), outpatients or primary care services, should not be alone during their episode of care or treatment unless this is their choice. • Restrictive visiting may be considered by the incident management team during outbreaks within inpatient areas This is an organisational decision following a risk assessment and should be communicated to patients and relatives. • There is clearly displayed, written information available to prompt patients' visitors and staff to comply with handwashing, respiratory hygiene and cough etiquette. The use of facemasks/face coverings should be determined following a local risk assessment. • If visitors are attending a care area to visit an infectious patient, they should be made aware of any infection risks and offered appropriate PPE. • Visitors, carers, escorts who are feeling unwell and/or who have symptoms	• Guidance on Intranet, reflect national guidance. This has been updated on flo in response to recent updated guidance in June 2022 and includes patients attending urgent and emergency care (UEC) being accompanied by a visitor unless they choose not to. • Visiting in outbreak situations has been updated to facilitate daily visiting outside of compassionate reasons for non-symptomatic patients. All visitors are informed of the risk and PPE required. • All patients in inpatient units cohorted or in side-rooms as per IP&C guidance. In non-inpatient areas, specific rooms / streaming in place for segregation of		

of an infectious illness should not visit. Where the visit is considered essential for compassionate (end of life) or other care reasons (e.g., parent/child) a risk assessment may be undertaken, and mitigations put in place to support visiting. • Visitors, carers, escorts should not be present during AGPs on infectious patients unless they are considered essential following a risk assessment eg carer/parent/guardian. • Implementation of the supporting excellence in infection prevention and control behaviours Implementation toolkit has been adopted where required.	potential respiratory / non-respiratory patients, and SOP's in local services for this • Available on Internet and Intranet – easy read version in process for most information • Patients and visitors accessing our buildings are asked to wear PPE based on a local risk assessment • The toolkit has been roiled out in line with national guidance. The Trust actively strives to ensure a culture of wellbeing, leadership development and speaking up.		

5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**
Systems and processes are in place to ensure that: • All patients are risk assessed, if possible, for signs and symptoms of infection prior to treatment or as soon as possible after admission, to ensure appropriate placement and actions are taken to mitigate identified infection risks (to staff and other patients).	• All services have triage questions and SOPs in place • In wave 1 joint work implemented between primary care and		

• Signage is displayed prior to and on entry to all health and care settings instructing patients with symptoms of infection to inform receiving reception staff, immediately on their arrival (see NIPCM). • The infection status of the patient is communicated prior to transfer to the receiving organisation, department or transferring services ensuring correct management /placement. • Triaging of patients for infectious illnesses is undertaken by clinical staff based on the patients' symptoms/clinical assessment and previous contact with infectious individuals, the patient is placed /isolated or cohorted accordingly whilst awaiting test results. This should be carried out as soon as possible following admission and a facemask worn by the patient where appropriate and tolerated. • Patients in multiple occupancy rooms with suspected or confirmed respiratory infections are provided with a surgical facemask (type II or type IIR) if this can be tolerated. • Patients with a suspected respiratory infection are assessed in a separate area, ideally a single room, and away from other patients pending their test result and a facemask worn by the patient where appropriate and tolerated (unless in a single room/isolation suite). • Patients with excessive cough and sputum production are prioritised for placement in single rooms whilst awaiting test results and a facemask worn by the patient where appropriate and tolerated only required if single room accommodation is not available. • Patients at risk of severe outcomes of infection receive protective IPC measures depending on their medical condition and treatment whilst receiving healthcare eg priority for single room protective isolation. • If a patient presents with signs of infection where treatment is not urgent consider delaying this until resolution of symptoms providing this does not impact negatively on patient outcomes. • The use of facemasks/face coverings should be determined following a local risk assessment.	KCHFT to identify vulnerable patients. KCHFT assessments and flow charts identify the appropriate pathways for these patients (e.g. home visit, clinic or virtual assessment). • Inpatients who are identified at risk of severe outcomes of infection are placed in a side room as appropriate. • Triage questions at entrance to hospitals / services / prior to domiciliary visits • Services have own questions – based on national triage form • Initial triage for allocation of waiting room etc. undertaken by receptionist – clinical staff triage in MIU/UTC as appropriate. • Direct inpatient admissions are isolated until assessed for risk of infection. • Inpatients are		

• Patients that attend for routine appointments who display symptoms of infection are managed appropriately, sensitively and according to local policy. • Staff and patients are encouraged to take up appropriate vaccinations to prevent developing infection • Two or more infection cases linked in time, place and person trigger an incident/outbreak investigation and are reported via reporting structures.	screened using LFT on admission. • If patient develops respiratory symptoms a viral PCR is taken at onset of symptoms • Patients with a respiratory viral infection are isolated / cohorted until they meet the criteria to be stepped down for the infection they have in line with the SOP for the management of respiratory viruses. • SOP for the management of respiratory viruses has now been ratified and published on Flo. • Staff wear FFP3 masks when caring for patients with suspected or confirmed respiratory infections spread by the airborne route. • TIIR masks are worn based on an IP&C risk assessment for all other patients, in respiratory outbreak settings or if staff		

	personal choice. • Patients with respiratory symptoms, or when an area is experiencing a respiratory outbreak are requested to wear a FRSM when unable to socially distance, and when mobilising around the area as tolerated. Posters and leaflets available to encourage this. • Dual COVID-19 and flu vaccinations for eligible staff run according to the JCVI guidance. OH provide employment vaccinations according to role. • Entrances to all hospitals have signage displayed advising relatives not to visit if they are unwell with respiratory or diarrhoea and vomiting symptoms • When two or more infection cases linked in time, place and person are identified		

	outbreak measures and investigation is implemented including national reporting of it.		

6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**
Systems and processes are in place to ensure that: • IPC education is provided in line with national guidance/recommendations for all staff commensurate with their duties. • training in IPC measures is provided to all staff, including: the correct use of PPE. • All staff providing patient care and working within the clinical environment are trained in hand hygiene technique as per the NIPCM and the selection and use of PPE appropriate for the clinical situation and on how to safely put it on and remove it (NIPCM). • Adherence to NIPCM, on the use of PPE is regularly monitored with actions in place to mitigate any identified risk. • Gloves and aprons are worn when exposure to blood and/or other body fluids, non-intact skin or mucous membranes is anticipated or in line with SICP's and TBP's. • Hand hygiene is performed: – before touching a patient – before clean or aseptic procedures – after body fluid exposure risk – after touching a patient	• Full IP&C guidance on Flo, shared through communication channels. • IPC training continues, Fit-testing continues, records held centrally by EWD and reported monthly to IPC team • PPE not re-used unless re-usable or sessional • Decontamination options available (visors) • The NIPCM will replace many of the IPC policies and a link on Flo has been added which takes	• Hand hygiene audits from in patient areas are focussed on before and after patient contact and not the 5 moments	• The IP&C team observe hand hygiene compliance against the 5 moments on their clinical visits.

– after touching a patient's immediate surroundings. • The use of hand air dryers should be avoided in all clinical areas. Hands should be dried with soft, absorbent, disposable paper towels from a dispenser which is located close to the sink but beyond the risk of splash contamination (NIPCM). • Staff understand the requirements for uniform laundering where this is not provided for onsite.	staff directly to the government page. • The IP&C team are actively promoting the wearing of PPE based on risk assessment as per the NIPCM, SICP and TBP • In system extremis the wearing of Type II fluid resistant masks within 2M of patients is in place in the community hospitals. • IPC team visit wards and provide feedback twice per month • 6 steps hand hygiene posters, respiratory hygiene posters. PPE poster prompts in place • Documented cleaning checked in IPC audits / checklists • Clear guidance on intranet, posters and through Trust comms • Hand Hygiene assessments formally reported monthly through IPC team for inpatient areas, non-		

	inpatient service report locally and report issues and risks to IPCAS twice per year • Hand air-dryers in non-clinical areas (offices) have these, none in clinical settings • Posters / soap dispensers have hand hygiene technique in toilets and bathrooms • Staff guidance on intranet and policy for uniform laundering		

7. Provide or secure adequate isolation facilities			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**
Systems and processes are in place to ensure: • That clear advice is provided; and the compliance of facemask wearing for patients with respiratory viruses is monitored (particularly when moving around the ward or healthcare facility) providing it can be tolerated and is not detrimental to their (physical or mental) care needs. • Patients who are known or suspected to be positive with an infectious agent where their treatment cannot be deferred, care is provided following the NIPCM. • Patients are appropriately placed ie infectious patients are ideally placed in	• Patients with a confirmed respiratory infection are nursed in a single room where possible or are cohorted together with the same respiratory organism.	• Limited single rooms in some settings	• Single rooms prioritised, and cohorting of patients implemented. • IPC team review placement daily with clinical staff and bed management

a single isolation room. If a single/isolation room is not available, cohort patients with confirmed respiratory infection with other patients confirmed to have the same infectious agent. • • Standard infection control precautions (SIPC's) are applied for all, patients, at all times in all care settings. • Transmission based precautions (TBP) may be required when caring for patients with known/suspected infection or colonization.	• Appropriate facilities, PPE and precautions are in place to manage patients who have a suspected or confirmed infectious agent when their treatment cannot be delayed. • IPC team review placement daily with clinical staff • IPC team meet daily (Monday – Friday) with the bed management team to discuss placement of patients from the acute to maximise patient flow • All patients are managed with SICP and TBP are used for all patients with a suspected or confirmed infection/ colonisation. • There is signage on area doors when a patient is being nursed with TBP in		team • IP&C team undertake observational audit when visiting clinical areas.

	place.		

8. Secure adequate access to laboratory support as appropriate			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**
There are systems and processes in place to ensure: • Laboratory testing for infectious illnesses is undertaken by competent and trained individuals. • Patient testing for infectious agents is undertaken promptly and in line with national guidance. • Staff testing protocols are in place for the required health checks, immunisations and clearance. • There is regular monitoring and reporting of the testing turnaround times, with focus on the time taken from the patient to time result is available. • Inpatients who go on to develop symptoms of infection after admission are tested/retested at the point symptoms arise. **COVID-19 specific** • Patients discharged to a care home are tested for SARS-CoV-2, 48 hours prior to discharge (unless they have tested positive within the previous 90 days), and result is communicated to receiving organisation prior to discharge. Coronavirus (COVID-19) testing for adult social care services. • For testing protocols please refer to: COVID-19: testing during periods of low prevalence	• All tests for infectious illnesses are processed by external laboratories. No delays in results. • All patients are tested on admission or when symptoms start for an infectious agent. Staff are aware of the required clinical specimen for the patient's condition and how to collect the required sample. • OH undertakes pre employment checks including vaccination status depending on role. • Lateral flow testing in place for staff who develop symptoms		

	and for those staff that meet the national criteria for asymptomatic twice weekly lateral flow testing. • Twice weekly reporting of staff positive cases via IMM and for executive sitrep. • All screening protocols implemented, and audited outbreak screening discussed at outbreak meetings • IPC team review results, and chase labs if delays of > 48 hours. • Specialist clinical advice is available from both Acute trusts via clinical microbiologists/virologists. • All patients screened 48 hours prior to discharge if going to care home and the result is communicated to the receiving care home. • Elective Podiatric		

	surgery – In line with the updated guidance for pausing asymptomatic COVID swabbing from 1st September 2022 patients are no longer COVID swabbed prior to their surgery unless they are severely immunocompromised. Symptomatic patients or those with a known respiratory infection are deferred until they have recovered.		

9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**
Systems and processes are in place to ensure that • Resources are in place to implement, measure and monitor adherence to good IPC and AMS practice. This must include all care areas and all staff (permanent, flexible, agency and external contractors). • Staff are supported in adhering to all IPC and AMS policies. • Policies and procedures are in place for the identification of and management of outbreaks of infection. This includes the documented recording of an outbreak. • All clinical waste and infectious linen/laundry used in the care of known or suspected infectious patients is handled, stored and managed in accordance with current national guidance as per NIPCM. • PPE stock is appropriately stored and accessible to staff when required as per NIPCM. --	• Checklist and audit by IPC team, data reporting for alert organisms • All Guidance reviewed regularly, and updated when national changes occur within 24-48 hours. Immediate risks are communicated via Flo • Dedicated PPE team in place to manage stock and logistics. • Stocks of correct PPE available, information on stock levels reported via Flo for staff. Stored within multiple locations/hubs for ease of access. • Waste audit in place compliant with national guidance. • Linen and laundry handled in line with national guidance and checked on all		

	observational audits • When two or more infection cases linked in time, place and person are identified outbreak measures and investigation is implemented including national reporting of it. • The IP&C team visit clinical areas when an outbreak is declared and regularly throughout the outbreak to ensure appropriate precautions are in place. • Outbreaks meetings are held at least weekly and more often if required. • Notes and actions from outbreak meetings are recorded and sent to all stakeholders.		

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

Systems and processes are in place to ensure that:
• Staff seek advice when required from their occupational health department/IPCT/GP or employer as per their local policy.
• Bank, flexible, agency, and locum staff follow the same deployment advice as permanent staff.
• Staff understand and are adequately trained in safe systems of working commensurate with their duties.
• A fit testing programme is in place for those who may need to wear respiratory protection.
• Where there has been a breach in infection control procedures staff are reviewed by occupational health. Who will:
  ○ lead on the implementation of systems to monitor for illness and absence
  ○ facilitate access of staff to treatment where necessary and implement a vaccination programme for the healthcare workforce as per public health advice
  ○ lead on the implementation of systems to monitor staff illness, absence and vaccination
  ○ encourage staff vaccine uptake.
• Staff who have had and recovered from or have received vaccination for a specific respiratory pathogen continue to follow the infection control precautions, including PPE, as outlined in NIPCM.
• A risk assessment is carried out for health and social care staff including pregnant and specific ethnic minority groups who may be at high risk of complications from respiratory infections such as influenza or severe illness from COVID-19
	• Managerial support, OH only for management referrals, not routine OH monitoring.
	• Individual risk assessments completed for ALL staff, including those in at risk groups
	• Risk assessments undertaken and completed for ALL BAME and pregnant staff. Updated guidance communicated to managers via Infrastructure divisional meeting.
	• Fit-testing in place – recorded through EWD
	• Trained dedicated fit-testers through fit-test programme utilising approved resources and competency assessments.
	• Portacount training by company rep and Fit – to – FIT company		

○ a discussion is had with employees who are in the at-risk groups, including those who are pregnant and specific ethnic minority groups ○ that advice is available to all health and social care staff, including specific advice to those at risk from complications ○ bank, agency, and locum staff who fall into these categories should follow the same deployment advice as permanent staff ○ a risk assessment is required for health and social care staff at high risk of complications, including pregnant staff. • Testing policies are in place locally as advised by occupational health/public health. • NHS staff should follow current guidance for testing protocols. • Staff required to wear fit tested FFP3 respirators undergo training that is compliant with HSE guidance and a record of this training is maintained by the staff member and held centrally/ESR records. • Staff who carry out fit test training are trained and competent to do so. • Fit testing is repeated each time a different FFP3 model is used. • All staff required to wear an FFP3 respirator should be fit tested to use at least two different masks. • Those who fail a fit test, there is a record given to and held by employee and centrally within the organisation of repeated testing on alternative respirators or an alternative is offered such as a powered hood. • That where fit testing fails, suitable alternative equipment is provided. Reusable respirators can be used by individuals if they comply with HSE recommendations and should be decontaminated and maintained according to the manufacturer's instructions.	completed and two machines purchased. • Fit-test results reported and recorded locally and centrally. • Working towards identified staff groups being fit tested on multiple masks, as per resilience principles, to enable choice and responsiveness to changes in push stock • FFP3 mask fit testing compliance reported monthly at PSCRG and Bi-monthly at IPCAS and no longer reported weekly at IMM. IPCT work closely with EWD on the accuracy of the figures. • HR processes in place ensure risk assessments are acted upon to limit occupational exposure to COVID-19. • Voluntary staff vaccination programme in place for COVID and Flu with uptake reported to		

• Members of staff who fail to be adequately fit tested: a discussion should be had, regarding re deployment opportunities and options commensurate with the staff members skills and experience and in line with nationally agreed algorithm. • 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. • Boards have a system in place that demonstrates how, regarding fit testing, the organisation maintains staff safety and provides safe care across all care settings. This system should include a centrally held record of results which is regularly reviewed by the board. • Staff who have symptoms of infection or test positive for an infectious agent should have adequate information and support to aid their recovery and return to work.	Board and committees. • Guidance information on Flo, shared internally, implemented through SOP's and challenged on IPC team walkabouts, and H&S walkabouts • E-roster reporting tool in place. HR policy on Flo for testing through national portal • As per the national guidance for pausing of asymptomatic testing. Lateral flow testing is in place for symptomatic staff and those that meet the criteria for asymptomatic twice weekly LFD testing.		

KCHFT EDI REFRESH PROJECT PLAN - 15.02.23 UPDATE

All milestones subject to assumptions (see note at bottom of plan)

OWNERS: KCHFT

TASK LEADS: Person(s) responsible for overseeing/ensuring task is completed

LEGEND: COMPLETED ON TRACK AT RISK

Week commencing: November 1, 7, 14, 21, 28 | December 5, 12, 19, 26 | January 2, 9, 16, 23, 30 | February 6, 13, 20, 27 | March 6, 13, 20, 27 | April 3, 10, 17, 24 | May 1, 8, 15, 22, 29 | June 1, 8, 15, 22, 29 | July 3, 10, 17, 24, 29

ID	TASK	TASK LEAD	STATUS	
ACTIVITY	**1. Programme structure and management**			
1.1..	Agree communication, management and reporting structure	KCHFT/ PEA		
1.2.	Identify key stakeholders to engage with - first iteration through stakeholder mapping session	KCHFT/ PEA		6
1.3.	Agree methods of engaging with different stakeholder groups/individuals, so that the review approach and objectives are understood and co-design is being created across the organsation	KCHFT/ PEA		
1.4.	Undertake initial desk research to explore any specific themes from existing materials - e.g. staff survey, Red Quadrant feedback, WDES/WRES, other equality reports and previous consultancy work - that may be used in this programme of staff engagement	PEA		
1.5.	Agree Terms of Reference and establish a task and finish group to oversee delivery of the programme, set outputs, milestones and review progress	KCHFT/ PEA		
1.6.	Work with EDI leads and analysts to further explore organisation-specific issues that may be used to underpin staff engagement activities outlined in Activity 2- Activity 7			
1.7.	Create a driver diagram that provides an overview of the goal: 'to engage widely with KCHFT staff, so their lived experiences, views and suggestions contribute to the revised EDI plan'			
1.8.	Create an engagement log, to record all engagement activities, who has been involved/engaged throughout the programme and key themes			
1.9.	Early engagement with key stakeholders - including interviews with network chairs and attendance at existing networks - to discuss programme methodology and build ownership	PEA		
1.10.	Agree Terms of Reference and establish a Critical Friend Group to act as a sounding board for agreed engagement activities and hold the EDITFG to account	KCHFT/ PEA		27
1.11.	Create early core narrative to go out to staff explaining the main aim of the programme and the importance of staff engagement and feedback in refreshing the EDI plan	KCHFT/ PEA		
1.12.	Extended Task and Finish Group meeting to co-design what staff will be engaged on	KCHFT/ PEA		24
1.13.	Test the proposed engagement with broader stakeholders, on a one-to-one basis or in small virtual groups (see Activity 2 & 5)	PEA		
1.14.	With the task and finish group agree the best ways to build internal capacity so that engagement and dialogue with staff continues to develop so NLF ambitions are met	PEA		
ACTIVITY	**2. Initial exploratory interviews**			
2.1.	Idenitfy a sample of 20 staff - including 5 middle managers (Bands 5-7) - to be interviewed to test early theme ideas	KCHFT		
2.2.	Create invite and semi-structured discussion guide for manager interviews, based on intelligence gathered in 1.3-1.8 above	PEA		
2.3..	Conduct semi-structured interviews	PEA		
2.4.	Extrapolate key themes from the interviews, particularly issues/concerns, blockages, support and development needs	PEA		
2.5.	Share key themes and proposed steps to address these with task and finish group, for discussion and agreement regarding managers' support and development	PEA		
2.6.	Share draft report from all completed interviews with TFG	PEA		
ACTIVITY	**3. Virtual workshops**			

ID	TASK	TASK LEAD	STATUS	November	December	January	February	March	April	May	June	July
3.1.	Design and agree 4 generic focus groups with Task and Finish group	KCHFT/ PEA										
3.2.	Set up 4 online focus groups and send invitation out	KCHFT										
3.3.	Facilitate 4 generic focus groups (with T&F members, to build organisational capacity and ownership)	PEA						20 29	12 20			
3.4.	Notes to be pulled together and themes extrapolated and used to design survey	PEA										
3.5.	Facilitate 1 theme-based focus groups (with network leads and/or members, to build organisational capacity and ownership)	PEA										
ACTIVITY	**4. World Café(s)**											
4.1.	Identify and agree critical success factors emerging from all engagement activities that will be explored in more detail at World Café events	PEA										
4.2.	With the Task and Finish group, design a world café to address the agreed critical success factors	PEA/KCHFT										
4.3.	Agree and design materials for the day(s)	PEA/KCHFT										
4.4.	Invitations to be sent out to staff and patients and uptake monitored	KCHFT										
4.5.	Support and prepare table "hosts" (and other staff), beforehand	PEA										
4.6.	Facilitate the world café session(s)	PEA								24	19 21	
4.7.	Notes to be pulled together and themes extrapolated, to be included in final overarching report	PEA										
ACTIVITY	**5. Staff interviews**											
5.1.	Identify a cross-section of staff to be interviewed to scope possible survey questions	KCHFT										
5.2.	Create invitation and semi-structured discussion guide, based on intelligence gatherred to date	PEA										
5.3.	Guide to be signed off by Task and Finish group	KCHFT										
5.4.	Support and coach network chairs and task and finish group members to conduct interviews	PEA										
	Invite staff to take part in interviews	KCHFT										
5.5.	Conduct interviews	KCHFT/ PEA										
5.6.	Write up interviews and extrapolate key themes	PEA										
ACTIVITY	**6. Staff survey**											
6.1.	Use the feedback from all intelligence gathered to date, to create an online survey	PEA										
6.2.	Survey to be reviewed and agreed by Task and Finish Group	KCHFT										
6.3.	Survey put online	PEA										
6.4.	Link to survey sent out to all KCHFT staff	KCHFT										
6.5.	Provide weekly updates, to monitor uptake and any further promotions	PEA										
6.6.	Close survey and create a draft report, to include graphs and charts	PEA										
ACTIVITY	**Programme outputs and closure**											
7.1.	Produce an overarching report of the entire engagement programme, to include: themes and recommendations for ongoing staff engagement in EDI action planning; key themes and suggestions from staff engagement to be included in the EDI action plan refresh; potential resources required for both	PEA										
7.2.	Test emerging ideas, recommendations and actions with the Task and Finish group and other leads,	PEA										
7.3.	Support the Task and Finish group in developing an ongoing monitoring and review process, including how learning can be shared safely	PEA										
7.4.	Disseminate outcomes across KCHFT.so that the refreshed EDI action plan is understood and owned by Trust leaders, managers and staff	KCHFT										
7.5.	Review and evaluate the overall programme outcomes	KCHFT/ PEA										
	The above plan and timeline is based on certain assumptions, such as KCHFT setting up and managing online and face to face meetings, sending information/materials to agreed participant cohorts etc.											

ID	TASK	TASK LEAD	STATUS	November	December	January		February	March	April	May	June	July	
	The timeline reflects certain interdependancies - this means that slippage in one activity may have a knock-on effect on another													

Kent Community Health Foundation Trust. EDI Refresh - Engagement Log 4		
Date	**Activity**	**Comments**
8.11.22	Draft project plan ToRs 1 hr; initial reading of papers for desk research	Created by PEA
	Draft ToRs for Task and Finish Group	Created by PEA
	Begin desk research	PEA reviewing existing documents
29.11.22	EDI Task and Finish Group	Arranged by KCHFT. First meeting. Initial introduction to the project and PEA + introduction to Draft Project Plan and ToRs
1.12.22	LGBTQi Network Meeting	PEA invited to attend and update
5.12.22	Early desk research	Draft initial exploratory desk research paper table and narrative
	Critical Friend ToRs	Created by PEA
	Driver Diagram	Created by PEA
6.12.22	Engagement Log	Created by PEA. To be update weekly
12.12.22	BAME Staff Network/PEA introductory meeting	Intro meeting to be rearranged. Next BAME staff network meeting: 11.1.23
13.12.22	EDI Team	Introductory meeting.Project plan, stakeholder mapping and use of data discussed
	EDI Team follow up meeting	EDI discussion re. findings from desk research and key themes from EDI data
14.12.22	EDI Task and Finish Group	Agenda items: Actions from last meeting, updated project plan, initial engagement log, T&F Group Draft ToRs, Critical Friend Group Draft ToRs, findings from initial desk research and related questions, Driver Diagram,
6.1.23	EDI Refreh Stakeholder Mapping Session	2 hour session to identify stakeholders and map in 'influence/power' matrix
10.1.23	Meeting with Patricia Coleman	introductory meeting. Purpose of programme stakeholder mapping and use of data discussed
10.1.23	EDI Task and Finish Group	Agenda items: Approved ToRs, updated project plan and driver diagram, stakeholder mapping notes and matrix, Critical Friend Group Draft ToRs and initial suggestions re membership, engagement log, intro to extended session on 24th
11.1.23	**Disability and Carers Network**	Introductory meeting Purpose, stakeholder mapping and request for feedback and engagement cascade discussed
11.1.23	BAME Network	Agenda item to outline the programme
16.1.23	Staffside	Introductory meeting
	Staff Partnership Forum	Introductory meeting
23.1.23	Early comms briefing	PEA/Comms
24.1.23	Task and Finish Group Workshop	Session purpose: To provide the Task and Finish group with an opportunity to explore key lines of enquiry/questions to be covered through the engagement process PEA has been commissioned to support.
30.1.23	Menopause Network	Intrpductory meeting
30.1.23	Catch up meeting	Rview 24th Workshop and plan next steps

Date	Activity	Comments
31.1.23	OD and ED Online Meeting	Introductory meeting with Business Partners to outline the programme and involve in identifying early scoping interviewees
1.2.23	Individual confidential call	Confidential call at individual's request to share their personal experience
3.2.23	Telephone call - LD and DW	DW feedback was primarily that we need to get dates in diary for CFG recognising most people will be off on leave in March . She is happy with the process and efforts to reach into organisation. Wants the programme extended rather than rushed, to maximise engagement and demonstrate transparency
	Scoping interview brief	Brief written for business partners to recruit interviewees
7.2.23	Task and Finish Group	Agenda items: Key notes/actions from 24th workshop; Comms update; Critical Friends Group; Feedback from network and POD meetings; invitation for scoping interviews; planned workshops - dates and outline; risks and issues
8.2.23	PEA/KCHFT Project catch-up	Discuss and agree actions from T&F Group meeting
9.2.23	Draft discussion guide for scoping interviews	Created by PEA
	Telephone call - JVR and JS	Discussion with Health and Wellbeing Lead regarding the role of the programme groups, how to engage/involve health and wellbeing champions and how to capture 'soft intelligence' regarding mental health issues
10.2..23	PEA/VRC telephone call	Project update
	Scoping telephone interview	
12/13.2.23	Hold the date' narrative for first two workshops	Narrative created and sent out to staff to hold 20 and 29 March for online workshops: PEA/Comms
13.2.23	Scoping telephone interviews x2	Testing questions related to EDI strategy
14.2.23	Scoping telephone interviews x2	Testing questions related to EDI strategy
16.2.23	Staff Health and Wellbeing Meeting	Discussion with group regarding the complementary nature of both programmes of work and how feedback could be shared across both. Follow up meeting to be arranged with Health and Wellbeing Champions
20.2.23	Scoping telephone interviews x3	Testing questions related to EDI strategy
	Briefing calls with CFG members x3	The purpose of the Critical Friend Group explained through reference to the ToRs plus the relationship between CFG and TFG outlined
21.2.23	Scoping telephone interview	Testing questions related to EDI strategy
	Briefing call with CFG member	Talk through the CFG requirements and this person's contribution
	Task and Finish Group	Agenda items: project plan and engagement logs talked through; verbal report on themes emerging from scoping interviews; key messages to be cascade through comms
22.2.23	Scoping telephone interview	Testing questions related to EDI strategy
	Briefing call with CFG member	The purpose of the Critical Friend Group explained through reference to the ToRs plus the relationship between CFG and TFG outlined
24.2.23	Scoping telephone interview	Testing questions related to EDI strategy
	Briefing call with CFG member	Talk through the CFG requirements and this person's contribution

Date	Activity	Comments
	Created Critical Friend Group Agenda	Agenda included ToRs, project plan and engagement log, early themes from interviews, comms plan and themes to take back to TFG
27.2.23	Critical Friend Group	Inaugural CFG. 2 hours. 8 participants. Role, purpose of group discussed. Members shared personal experiences and views. Members said they welcomed the opportunity to speak openly and freely, to share and hear others' experiences, in a safe place. They identified key issues to take back to the TFG
	Scoping telephone interviews x3	Testing questions related to EDI strategy
28.2.23	Scoping telephone interviews x2	Testing questions related to EDI strategy
1.3.23	Programme update	PEA/VR-C catch up
	Scoping telephone interview	Testing questions related to EDI strategy
2.3.23	Created Critical Friend Group Agenda	Update on key actions and areas to take to TFG
	Created TFG Agenda	Update on key actions and areas for further discussion
7.3.23	Critical Friend Group	Agenda: Group to reflect on key themes from first CFG meeting; review of CFG ToRs v3;Key themes from scoping interviews to date - reflections and feedback; Stakeholder map - review and input from CFG; Engagement Log - feedback from SFG to Task and Finish Group; Engagement update: workshops and survey - comments from CFG; Communications - key messages; Group feedback for consideration by the Task and Finish Group
	Task and Finish Group	Taking stock: revisiting the Group's Terms of Reference; Critical Friend Group introductory meeting 27 February - membership and feedback; Scoping interviews - feedback/key themes; Generic workshops arranged for 20 and 29 March - recruitment and uptake; Timeline for all-staff survey - to be discussed/agreed; Agree key messages to go out to staff via communications team; Engagement log
9.3.23	Menopause Network	Follow up meeting to explore EDI related issues in more depth
	Scoping telephone interview	Final scroping interview
12.3.23	Interview report	Draft report on all 20 interviews created, pulling out key themes and suggestions for future actions
13.3.23	Workshop planning meeting	Outline programme structure and case studies discussed
16.3.23	Governors' Meeting	Role and purpose of EDI refresh engagement programme discussed and roles explored

KCHFT EDI REFRESH - Stakeholder groups/teams

Date(s)	Stakeholder Group	Members
29.11.22	EDI Task and Finish Group	KCHFT:Victoria Robinson-Collins, Sarah Cook, Nicola Rutter, Sharon Gradwell, Hasan Reza, William Anderson, Jaishree Narayanan, Thomas Fentem, Nataiie Parkinson, Funmi Balogun, Mark Anderson, Patricia Coleman, Denise Williams, Adam Lott, Peter Brook, Chloe Crouch, John Stone, Nigel Turner, Emma Darvill, Andrew Martin, Leanne Hately, Julie Jeffries, Kim Murphy, Stephen Grice, Jane Thackwray, Paul Hodson, Sharon Gradwell, William Anderson, Pilar Bustamente, Jill Day PEA: Lorraine Denoris, Julie Van Ruyckevelt
1.12.22	LGBTQi Network Meeting	
13.12.22	EDI Team	Hasan Reza, Jill Day
6.1.23	Stakeholder Mapping Session	KCHFT: Hasan Reza, Victoria Robinson-Collins, Peter Brook, Jill Day, Emma Darvill, Denise Williams, Andrew Martin, Stephanie Cooper, Pilar Bustamente, Mark Anderson, Leanne Hately, Gina Baines PEA: Lorraine Denoris, Julie Van Ruyckevelt
11.1.23	Disabiliy and Carers Network	Sacha Langfield, Helen Merrick, Joyce Masimba, Karen Millen, Jaishree Narayanan, John Stone, Tina Tarchetti, Denise Williams, PEA: Lorraine Denoris, Julie Van Ruyckevelt,
11.1.23	BAME Network	
16.1.23	Staffside	
16.1.23	Staff Partnership Forum	
24.1.23	Task and Finish Group Workshop	
30.1.23	Menopause Network	
31.1.23	OD and ED Online Meeting	Margaret Daly, Sam Clark, Emma Darvill, Kay Fox, Leanne Hately, Andrew Martin, Rachel Mulgrew, Nicola Rutter, Mary Williams

KCHFT EDI REFRESH: Individual stakeholders		
Date	**Stakeholder**	**Key points of/from discussion**
10.1.23	Pat Coleman	
11.1.23	Jaishree Narayanan	
31.1.23	Confidential	
9.2.23	John Stone	Health and Wellbeing Lead