Leicestershire Partnership NHS Trust

Managing a Covid-19 Increased incidence/Outbreak/Cluster within LPT (Patients and Staff)

This policy is to be followed alongside the clinical management of Covid-19 It identifies the escalation process to be followed when there is a suspected or known increased incidence/cluster/outbreak in both patient and staff groups.

Key Words:	Covid-19, Increased incidence, Outbreak, Cluster	
Version:	1	
Adopted by:	Infection Prevention and Control Group Quality Forum	
Date this version was adopted:	11 August 2020	
Name of Author:	Amanda Hemsley, Lead Infection Prevention and Control Nurse Mel Hutchings, Infection Prevention and Control Nurse	
Name of responsible committee:	Quality Assurance Committee	
Please state if there is a reason for not	N/A	
Date issued for publication:	July 2020	
Review date:	1 February 2021	
Expiry date:	1 August 2021	
Target audience:	All LPT Staff	
Type of Policy:	Clinical √	Non Clinical
Which Relevant CQC Fundamental Standards?	9,10,12,20	

Contents

Version Control and Summary of Changes

Version	Date	Comment
Version 1	26 June 2020	This policy has been developed as a result of the recent pandemic of Covid-19. It supports the trusts response in managing a suspected or known increased incident/cluster/outbreak for Nosocomial acquired infections of Covid-19 in patients and/or staff. This policy is in line with the requirements as laid out in the recently published document by Public Health England; COVID-19 Hospital Outbreak Pack
Version 1.1	23 July 2020	Further guidance issued regarding the management and reporting of a Covid-19 increased incident/outbreak/cluster

For further information contact: Infection Prevention and Control Team

Definitions that apply to this policy

Cluster	A disease **cluster** or infection cluster is a group of similar health events that have occurred in the same area around the same time. Cases of the current coronavirus may be described as "outbreak clusters."
Coronavirus	Coronaviruses are a family of viruses that cause disease in animals. Seven, including the new virus, have made the jump to humans, but most just cause cold like symptoms
Covid-19	Covid-19 is different to these two other coronaviruses in that the spectrum of disease is broad, with around 80 per cent of cases leading to a mild infection. There may also be many people carrying the disease and displaying no symptoms, making it even harder to control.
Consultant in Public Health	A consultant who is knowledgeable in Infectious Diseases
Health protection professional	A person suitably qualified in the field of health protection and registered with an appropriate body such as the Faculty of Public Health, the Chartered Institute of Environmental Health and/or the Nursing and Midwifery Council or the General Medical Council
Increased Incidence	The occurrence of two or more cases of the same infection linked in time or place or the situation when the observed number of cases exceeds the number expected.
Infection	An organism present at a site and causes an inflammatory response, or where an organism is present in a normally sterile site.
Infection control incident	This can be defined as an outbreak of infection or infectious disease requires a more in depth level of strategic management
Infectious	Caused by a pathogenic micro-organism or agent that has the capability of causing infection
Outbreak	The occurrence of two or more cases of the same infection that are linked in time or place or the situation when the observed number of cases exceeds the number expected.
Personal Protective Equipment (PPE)	PPE is equipment that will protect the user against health or safety risks at work in relation to health care.
Social distancing	An effort to reduce your interaction with other people to slow the spread of an infectious disease. Covid-19 primarily spreads via respiratory droplet from close contact or contaminated surfaces. This may be by keeping a specific distance from others and the wearing of PPE or face coverings, dependent on the situation where it is being implemented

1.0 Purpose of the policy

The purpose of this policy is to ensure that all staff employed by LPT is aware of the processes to be followed with regards to the reporting process and management of an increased incidence/cluster/outbreak of Covid-19 within the community hospitals, inpatient settings, community teams, or groups of staff that work together. This policy relates to patients or staff.

2.0 Summary and Key Points

This policy provides trust wide guidance for the management of an increased incident, cluster or outbreak of Covid-19. It identifies clear and concise roles and responsibilities and the procedures that must be put into place to ensure a situation that has identified a number of patients or staff with the same infection is controlled and managed with the minimal risk to patient, staff and public safety. It gives a clear escalation process to be followed where necessary.

It is recognised that with the emergence of the Covid-19 pandemic, the management of patients, staff processes and care delivery is constantly changing as more about the virus is understood. In order to ensure that the virus does not spread further both within inpatient settings and the wider healthcare economy specific process must be adhered to.

3.0 Introduction

The general public and staff have a right to expect that any potential hazards in a healthcare environment are adequately controlled. All staff must possess an appropriate awareness of their role in the prevention and control of infection in their areas of work. Not only is this part of their processional duty of care to the patients with whom they are involved (NMC 2015), but it is also their responsibility to themselves, to other patients and members of staff under the Health and Safety at Work Act (1974).

Coronaviruses are a family of viruses that cause disease in animals. Seven, including the new virus (Covid-19), have made the jump to humans, but most just cause cold like symptoms

Covid-19 is different to these two other coronaviruses in that the spectrum of disease is broad, with around 80 per cent of cases leading to a mild infection. There may also be many people carrying the disease and displaying no symptoms, making it even harder to control.

3.1 What are the symptoms of coronavirus?

Initial symptoms include fever, dry cough, tiredness and a general feeling of being unwell. Other symptoms have been identified such as loss of taste and sense of smell.

In most cases, individuals are usually considered infectious while they have symptoms. How infectious individuals are, depends on the severity of their symptoms and stage of their illness. The average time from symptom onset to clinical recovery in mild cases is approximately 2 weeks and is 3-6 weeks for severe or critical cases.

3.2 How is it transmitted?

COVID-19 is thought to be transmitted through respiratory droplets and not by airborne transmission. The small droplets which are expelled from the nose or mouth are spread when a person with Covid-19 coughs or exhales.

These droplets land on objects and surfaces around the person. Other people then become infected with the Covid-19 virus by touching these objects or surfaces, in turn touching their eyes, nose or mouth. People can also become infected with the virus if they breathe in droplets from a person with Covid-19 who coughs out or exhales droplets (advised as within 2 metres).

Individuals can be asymptomatic, whilst being infected with the virus. This means that transmission can occur without the person knowing and can make it difficult to prevent or control cross contamination.

Limiting transmission of COVID-19 in the healthcare setting requires a range of infection prevention and control measures.

4.0 Case definitions for investigation of hospital increased incidents/clusters/outbreaks of Covid-19

4.1 Case Response

In responding to a disease cluster or outbreak it is important to agree a case definition including a description of time, place, person and clinical features early on in the investigation and reviewed throughout. This enables the incident or outbreak control committee members to gather, analyse and present relevant information to inform decisions on effective outbreak control measures.

It is often helpful to devise a hierarchical set of case definitions depending upon certainty of diagnosis in the individual, moving from a highly specific case-definition (high certainty that the patient has the disease, but with recognition that not all cases will meet this definition) to a high sensitivity definition (high certainty that all cases have been detected, but with the recognition that some identified cases may have a different cause of illness). This hierarchy will usually have 2-3 levels.

Case-definitions are usually based on clinical and/or laboratory criteria, but may also have an epidemiological (e.g. contact with a confirmed case), geographical or setting component (e.g. a specific hospital site, block or ward) and/or a time component (e.g. from a specific date).

4.2 Case definition

Category	**Criteria**
Confirmed	Laboratory confirmed diagnosis of COVID-19 in a patient who is or has been in a healthcare setting.

	Laboratory confirmed diagnosis of Covid-19 in a member of LPT staff who works at or has been working in a healthcare setting
Probable	A hospital inpatient (*or staff member*) who has one of the following without an alternative diagnosis*: • clinical or radiological evidence of pneumonia; ***or*** • acute respiratory distress syndrome; ***or*** • Fever (≥37.8°C) ***and*** at least one of the following respiratory symptoms, which must be of acute onset: persistent cough (with or without sputum), hoarseness, nasal discharge or congestion, shortness of breath, sore throat, wheezing, sneezing; ***or*** • a loss of, or change in, normal sense of taste or smell (anosmia) in isolation or in combination with any other symptoms
Possible	Any acute respiratory symptoms or fever, without other identified cause*, or worsening of a pre-existing respiratory condition

For any increased incident/cluster/outbreak, each patient should be classified using the above definitions; **Confirmed, Probable and Possible** by how likely each case is to be a nosocomial (hospital acquired) case, based on the duration of time between admission and symptom onset:

- 0-2 days: Unlikely
- 3-7 days: Indeterminate
- 8-14 days: Probable
- >14 days: Definite

Any patients who are diagnosed with Covid-19, 7 days from admission to an LPT inpatient setting will require a Hospital Onset Covid-19 (HOC) root cause analysis to be carried out. This should be commenced by the ward staff and supported by the IPCT. It should be completed within the identified timescale and reported by the IPC team as a Healthcare Acquired Infection (HAI).

Exposure levels of staff contact with a case should be considered, depending upon whether:

- The staff member wore appropriate personal protective equipment (PPE) and/or
- The staff member was exposed to an aerosol-generating procedure.
- The staff member has been identified through the track and trace system

- The staff member has been self-isolating previously due to a family/household contact testing positive

If an increased incident/outbreak/cluster of Covid-19 within a staff group is identified then the root cause analysis tool (for staff) should be commenced by the manager of the service with support from the IPC team.

5.0 Reporting and Management of increased incidents/clusters/outbreaks of Covid-19

5.1 Stage 1

The risk of increased incidences/clusters or outbreaks needs to be reduced to a minimum and subsequent organisation disruption through local surveillance and detections of organisms.

Prompt recognition and reporting of symptomatic patients and/or staff to the Infection Prevention and Control team, enables prompt closure of bays or ward areas as a containment measure, whilst identifying the possibility of an investigation into the cause, and ensuring all the correct infection prevention and precaution measurements are in place (appendix 1 and 2).

Staff who receive a positive Covid-19 test result, either from community testing or the employees testing portal must be sent home from work immediately. If they are not currently at work when they receive the result they must contact their line manager at the earliest stage to discuss the next steps.

The IPCT will advise on the immediate management of the patients/staff.

If there are 2 or more patients or staff who have been identified as linking in time and place (as above) then the algorithm for the reporting of an increased incidence/outbreak/cluster should be followed (appendix 3).

If it is found that there is an increased incidence of staff positive results for Covid-19; who all work or who have recently worked within the same area then Occupational health should be informed to support the requirements for swabbing staff for Covid-19. As staff members receive their results, they should inform both their manager and occupational health (appendix 4) and fill out an E-irf.

The infection prevention and control team (IPCT) should be informed on a daily basis (or as soon as possible) for patients or staff who are displaying symptoms or have tested positive for Covid-19.

If the IPCT cannot be contacted, then the senior nurse on duty must contact the Director on Call

Where a number of patients or staff (larger than a cluster) are identified, an outbreak meeting is required. This will be convened and led by the DIPaC. Decisions such as the need to swab further patients or staff will be made at this meeting (appendix 5).

5.2 Stage 2

- Identification of 2 or more patients or staff with a positive Covid-19 result (linked in time and place) should be communicated to the IPC team as soon as possible.

- The IIMARCH form should be completed by the IPC team in conjunction with the service manager.

- The form should be submitted to the Midlands CVICC via the Single Point of Communication (SPOC) at england.mids-incident@nhs.net

- The IPC team should inform PHE East Midlands regional group of the potential outbreak at icc.eastmidlands@phe.gov.uk

- Outside the operating hours of the CV19 Incident Centre (08.00 – 17.00 Monday to Friday and 09.00 – 16.00 Saturday and Sunday), the EPRR on-call manager must be notified by a call and the IIMARCH form sent to them via email.

- Should any outbreak present a material threat to the organisations ability to maintain services it is likely that an urgent meeting should be convened to discuss the outbreak and mitigating actions using the agenda attached (appendix 3).

- An updated IIMARCH from must be submitted to the ICC every subsequent day by 12.00 mid-day (including weekends and bank holidays).

5.3 Transfer of patients between care settings (NHSEI/PHE Outbreak Cell)

Inter-facility Transfers: Good Practice Guidance

Transferring patients between care settings to meet patient medical or nursing need during Covid-19 might be required in patients, either as part of step-down or rehabilitation arrangements or change in clinical need.

This may include the need for a specialist procedure or treatment for example, cardiac angioplasty or renal dialysis.

Where possible, patients should be deemed clinically fit for discharge or transfer to other clinical settings.

As far as possible, transfer should be avoided if the patient is:

- Pyrexial or acutely unwell
- Currently on a ward where there is an ongoing Covid outbreak

If transfer is essential, **the ambulance service/patient transport service and receiving hospital must be advised in advance of the infectious status of the patient.**

The Covid risk of a patient is based on:

- The length of time they have already been an inpatient
- Their testing schedule and outcomes
- Their symptomatology

The Covid status of a patient should be known prior to their transfer (see below for transfer of patients in an emergency)

IPC measures should continue for COVID-19 patients until 14 days have elapsed since their first positive SARS-CoV-2 test. This is due to uncertainties about the duration of infectiousness for patients with more severe illness or immunosuppression which may increase the time of viral shedding.

The flow diagram is a visual aid for the process to be followed for safe inter-facility transfer. (Appendix 6)

Transferring patients in an emergency scenario

If a patient has an emergency clinical need for transfer the patient's current infectious status and a risk assessment of the patient's **current infectious status** should be shared with the ambulance service and the receiving unit.

5.4 Community Outbreak in LPT tenant buildings

The actions identified below should be carried out when a confirmed increased incident/outbreak or cluster of Covid-19 has occurred within a community health building delivering care during daytime (no overnight stays).

- LPT representative to advise the Landlord there are staff/patient positive Covid-19
- LPT to request a deep clean via the facilities help desk (various depending on which building staff occupy).
- IPCT to review space/risk and advise if the building can be accessed and/or areas that LPT staff should avoid.
- Landlord to confirm to LPT representative if building access is affected, and to advise once the clean is complete.
- LPT representative to advise services to re-instate use/access.

References

Management of an increased incident/outbreak policy 2018, Leicestershire Partnership Trust

www.gov.uk/coronavirus

www.nhsimprovement.nhs.uk

Appendix 1

Checklist of activities that should be instigated by ward on initial suspicion

- Inform the IPCT
- Isolation of affected patients
- Increased cleaning and disinfection of affected areas
- Alerting managers of other departments (if relevant)
    - Occupational therapy
    - Physiotherapy
    - Hotel services
    - Speech and language therapy
    - Dieticians
    - Other
- Consideration of closing affected areas to admissions
- Consideration of swabbing patients within the same area
- Stopping transfers of affected patients out of the affected area
- Opening of affected area (if closed)
- Communication Strategy
- Staff surveillance, immunisation and exclusion from ward
- Consideration of swabbing staff and self-isolation
- Incident reporting
- Appropriate paperwork to be completed

Appendix 2

Cleaning Algorithm for an increased incidence/cluster/outbreak of infection for environmental cleaning

Affected Area defined as affected single room, bay or ward

- Ensure disposable gloves and aprons are removed and hands are washed using liquid soap and water before leaving the Affected Area.
- Alcohol sanitiser to be used immediately on leaving the Affected Area.
- All patient toilets and bathrooms within an Affected Area during an increased incidence/outbreak must be cleaned twice daily

1st clean of the day

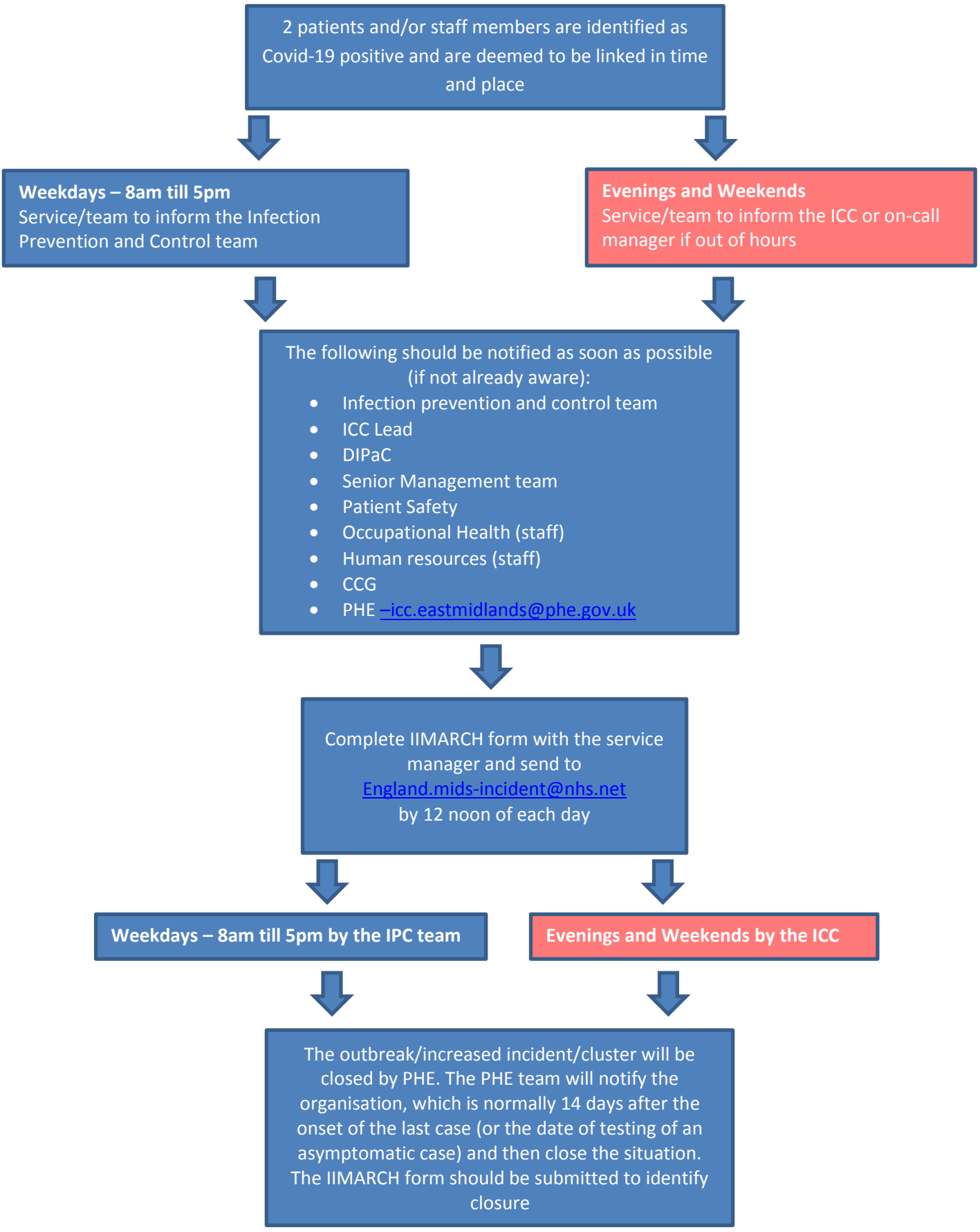
Affected Area to been cleaned after Unaffected Areas. Ensure all cleaning equipment is dedicated to the Affected Area. Chlor-clean to be used for all equipment, toilets, horizontal surfaces, etc.

2nd clean of the day

Check and clean en suite facilities (if available). Empty bins, clean all horizontal surfaces and clean designated toilets (if not en-suite). Ensure all cleaning equipment is dedicated to the Affected Area. Chlor-clean to be used for all equipment, toilets, horizontal surfaces, etc.

Appendix 3

Algorithm for the reporting of an increased incidence/cluster/outbreak for Covid-19



Guidance for Contact Tracing –Occupational Health

Public Health England (PHE) advice has changed to coincide with 'test and trace'. This means contacts of people who have tested positive for Covid-19 now need to self-isolate for 14 days.
Full guidance can be found here:
https://www.gov.uk/government/publications/covid-19-management-of-exposed-healthcare-workers-and-patients-in-hospital-settings/covid-19-management-of-exposed-healthcare-workers-and-patients-in-hospital-settings

It states:

5.4 If staff have been notified that they are a contact of a co-worker who is a confirmed case

If a staff member has been notified that they are a contact of a co-worker who has been confirmed as a COVID-19 case, and contact with this person occurred while not wearing PPE, the 14-day isolation period applies

To help us meet the requirements of this, the following process has been agreed:

A

1. PHE notify OH that a staff member tested positive for Covid-19 via secure email.
2. Covid nurse / duty nurse fills in the initial section of the contact tracing form (Appendix A).
3. Send the form to their manager for completion of staff contacts (copy to the CMG lead).
4. Set a reminder for 8 hours to check it has been returned (chase and escalate if required).
5. Covid nurse / duty nurse calls named contacts and excludes them as required.
6. Create a COHORT record for each person contacted – ensure it as recorded as 'appointment reason Covid-19' 'Excluded'.

B

1. OH receives notification of a positive swab result that we have taken.
2. OH rings the staff member.
3. Inform them of the result and seek information about work related contacts in past 48 hours (advising that test and trace will also be in touch in relation to social contacts).
4. Complete details on tracing form (appendix A).
5. Liaise with manger for contact details if required.
6. Covid nurse / duty nurse calls named contacts and excludes them as required.
7. Create a COHORT record for each person contacted – ensure it as recorded as 'appointment reason Covid-19' 'Excluded'.

The Covid nurse / duty nurse should also update the track and trace data sheet.

C

1. Manager informed by their staff member that they have had a positive swab result for Covid-19.
2. Manager accesses the 'Guidance for contact Tracing' from the FAQ on INsite.
3. Manager completes the contact tracing form (appendix A) and forwards this to OH via ohcovid@uhl-tr.nhs.uk
4. Create a COHORT record for each person contacted – ensure it as recorded as 'appointment reason Covid-19' 'Excluded'.

CONFIDENTIAL
OCCUPATIONAL HEALTH SERVICE

Name of positive staff member _____

Date of Test / Symptom onset _____

Ward / Work Area _____

CMG and Lead _____

Please identify:

1. Staff who have had face to face contact <1 metre of any duration, e.g. conversation, skin to skin contact or being coughed on, (with no PPE worn) **or** any contact within one metre for one minute or longer, (with no PPE worn) in the 48 hours before the test date / symptoms:

Name	Date of Birth	Mobile No.

These staff will need to be excluded from work for 14 days from their last contact with the staff member named above (**Manager must open Smart report)**.

2. Staff who have spent >15 minutes within 1 and 2 metres (with no PPE worn) in the 48 hours before the test was done / symptom onset:

Name	Date of Birth	Mobile No.

These staff will need to be excluded from work for 14 days from their last contact with the staff member named above **(manager must open Smart report)**.

Please confirm that all staff are following current IPC advice YES ☐ NO ☐

Please consider any potential **patient contacts** and liaise with the infection prevention team with regards to these and discuss with them any additional resources or training your area requires in relation to IPC

NB: THIS FORM MUST BE COMPLETED AND RETURNED TO ohcovid@uhl-tr.nhs.uk WITHIN 8 HOURS OF RECEIPT

https://www.gov.uk/government/publications/covid-19-management-of-exposed-healthcare-workers-and-patients-in-hospital-settings/covid-19-management-of-exposed-healthcare-workers-and-patients-in-hospital-settings

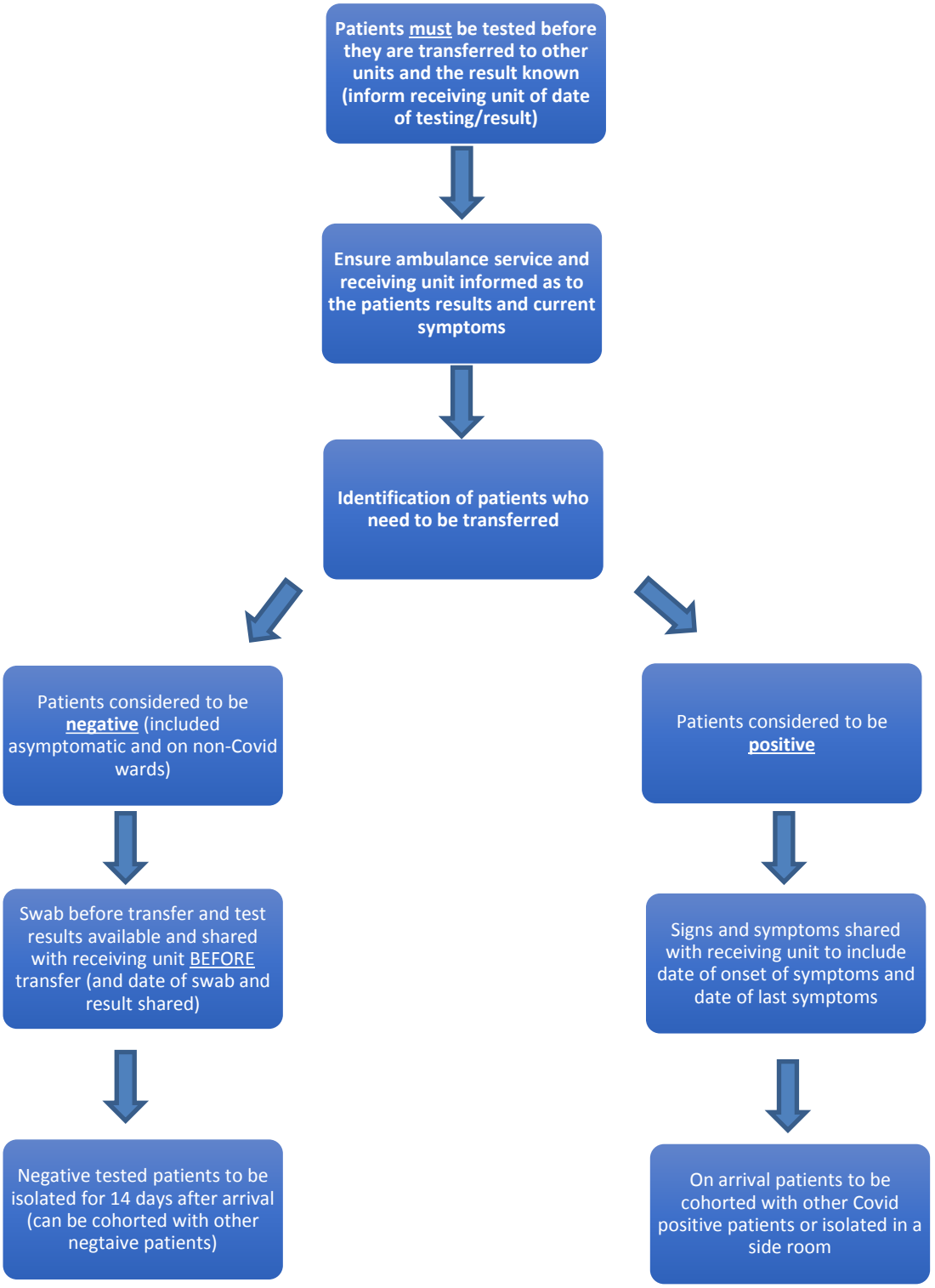
Infection Prevention and Control Team

Actions to be taken in the event of an outbreak
<Date, time and venue>

1. **Introductions & apologies**
2. **Minutes** – review of actions from previous meeting(s)
3. **Purpose** of the meeting
    a. At first meeting agree Chair and Terms of Reference
4. **Summary** of situation- situation updates (for subsequent meetings)
    a. Epidemiological
        a. Number of cases according to case-definitions and description by person, place and time
        b. Clinical management & outcome
    b. Patient movements on admission
    c. Suspected cases- patients and linked staff
    d. Patient pathway- from admission to discharge
5. **Microbiology**: testing regime in general, testing carried out, potential future testing needs,
6. **Infection Prevention and Control**
    a. Case isolation/cohorting facilities
    b. Environmental cleaning
7. **Current Risk assessment** -any evidence of hospital transmission
    a. Implication for finding further case(s) as per case definition
    b. Implications for current control measures
    c. Potential for review of control measures
8. **Contacts identification/management**
    a. Staff
    b. Patients
9. **Discharge Plans for cases**- returning to own or residential facilities and ability to self-isolate safely.
10. **Communications**
    a. Internal – staff, inpatients, students, volunteers, visitors
    b. Discharged patients – contacts of confirmed case
    c. External: NHSE, PHE, Media statement
11. **Agreed actions**
12. **Any other business**
13. **Date of the next meeting**

Appendix 6

Algorithm for safe inter-facility transfer of patients



The NHS Constitution

The NHS will provide a universal service for all based on clinical need, not ability to pay. The NHS will provide a comprehensive range of services

Shape its services around the needs and preferences of individual patients, their families and their carers	Yes
Respond to different needs of different sectors of the population	Yes
Work continuously to improve quality services and to minimise errors	yes
Support and value its staff	Yes
Work together with others to ensure a seamless service for patients	Yes
Help keep people healthy and work to reduce health inequalities	Yes
Respect the confidentiality of individual patients and provide open access to information about services, treatment and performance	Yes

DATA PRIVACY IMPACT ASSESSMENT SCREENING

Data Privacy impact assessment (DPIAs) are a tool which can help organisations identify the most effective way to comply with their data protection obligations and meet Individual's expectations of privacy.
The following screening questions will help the Trust determine if there are any privacy issues associated with the implementation of the Policy. Answering 'yes' to any of these questions is an indication that a DPIA may be a useful exercise. An explanation for the answers will assist with the determination as to whether a full DPIA is required which will require senior management support, at this stage the Head of Data Privacy must be involved.

Name of Document:	**Management of a cluster/increased incident/outbreak for Covid-19 Patients and Staff**	
Completed by:	**Amanda Hemsley**	
Job title	**Lead Infection Prevention and Control Nurse**	**Date 20 August 2020**

Screening Questions	**Yes / No**	**Explanatory Note**
1. Will the process described in the document involve the collection of new information about individuals? This is information in excess of what is required to carry out the process described within the document.	no	
2. Will the process described in the document compel individuals to provide information about them? This is information in excess of what is required to carry out the process described within the document.	no	
3. Will information about individuals be disclosed to organisations or people who have not previously had routine access to the information as part of the process described in this document?	no	
4. Are you using information about individuals for a purpose it is not currently used for, or in a way it is not currently used?	**no**	
5. Does the process outlined in this document involve the use of new technology which might be perceived as being privacy intrusive? For example, the use of biometrics.	no	
6. Will the process outlined in this document result in decisions being made or action taken against individuals in ways which can have a significant impact on them?	no	
7. As part of the process outlined in this document, is the information about individuals of a kind particularly likely to raise privacy concerns or expectations? For examples, health records, criminal records or other information that people would consider to be particularly private.	no	
8. Will the process require you to contact individuals in ways which they may find intrusive?	**no**	

If the answer to any of these questions is 'Yes' please contact the Data Privacy Team via Lpt-dataprivacy@leicspart.secure.nhs.uk
In this case, ratification of a procedural document will not take place until review by the Head of Data Privacy.

Data Privacy approval name:	Emma Wallis - Associate Director of Nursing and Professional Practice
Date of approval	E L Wallis

Acknowledgement: This is based on the work of Princess Alexandra Hospital NHS Trust

Due Regard Screening Template

Section 1	
Name of activity/proposal	Policy for the management of Covid-19 clusters/increased incidents/outbreaks for patients and staff
Date Screening commenced	20 August 2020
Directorate / Service carrying out the assessment	Infection Prevention and Control
Name and role of person undertaking this Due Regard (Equality Analysis)	Amanda Hemsley Lead Infection Prevention and Control Nurse
Give an overview of the aims, objectives and purpose of the proposal:	
AIMS: **The aim of the policy is support staff within LPT to identify, manage and report any increased incidences of Covid-19 in line with national requirements and direction**	
OBJECTIVES: To maintain patient and staff safety and prevent the increase of infection of Covid-19	

Section 2	
Protected Characteristic	**If the proposal/s have a positive or negative impact please give brief details**
Age	n/a
Disability	n/a
Gender reassignment	n/a
Marriage & Civil Partnership	n/a
Pregnancy & Maternity	n/a
Race	n/a
Religion and Belief	n/a
Sex	n/a
Sexual Orientation	n/a
Other equality groups?	n/a

Section 3			
Does this activity propose major changes in terms of scale or significance for LPT? For example, is there a clear indication that, although the proposal is minor it is likely to have a major affect for people from an equality group/s? Please <u>tick</u> appropriate box below.			
Yes		No	
High risk: Complete a full EIA starting click here to proceed to Part B		Low risk: Go to Section 4.	**X**

Section 4			
If this proposal is low risk please give evidence or justification for how you reached this decision:			
This policy is in line with national requirements and direction. It identifies reporting processes and management to maintain and promote patient and staff safety			
Signed by reviewer/assessor	D L Wallis	**Date**	20/08/20
Sign off that this proposal is low risk and does not require a full Equality Analysis			
Head of Service Signed		**Date**	

7.0 Stakeholders and Consultation

Key individuals involved in developing the document

Name	Designation
Amanda Hemsley, Mel Hutchings	Lead Infection Prevention and Control Nurse Infection Prevention and Control Nurse

Circulated to the following individuals for consultation

Name	Designation
Andy Knock	Infection Prevention and Control Nurse
Antonia Garfoot	Infection Prevention and Control Nurse
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Anne Scott	Director of Nursing
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Helen Walton	Estates and Facilities Property manager
Laura Belshaw	Head of Nursing, FYPC
Louise Evans	Deputy Head of Nursing, FYPC
Jude Smith	Head of Nursing, CHS
Michelle Churchard-Smith	Head of Nursing, AMH and MHSOP
Claire Armitage	Deputy Head of Nursing, AMH Community
ICC Clinical leads	LPT
Tracy Ward	Head of Patient Safety
Sue Arnold	Lead Nurse, Patient Safety