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Northumberland & North Tyneside Community Infection Prevention and Control Strategy (2023 to 2028)

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North Tyneside Council

Northumberland
County Council

Contents

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Summary

Background
The SARS-CoV-2 (COVID) pandemic has reinforced the importance of effective infection prevention and control (IPC) in community settings.

Aims
To minimise preventable incidents and outbreaks of harmful infection in community settings in Northumberland and North Tyneside through effective IPC interventions; and to ensure that Northumberland and North Tyneside are as prepared as possible to implement effective IPC measures in community settings in response to new or developing threats or pandemics.

Scope
Community settings or providers in Northumberland and North Tyneside, specifically: care homes; domiciliary care (homecare) including independent supported living; children's residential homes; educational settings; and general practices.

Where are we now?
The Northumbria Healthcare NHS Foundation Trust IPC team is currently made up of 10.1 whole time equivalent (WTE) nursing staff broken down into 5.3 WTE staff working in the acute and 4.8 WTE staff working in the community (covering Northumberland and North Tyneside). Activities span training, direct support, audit, and collaborative working.

Current guidance seeks to ensure that organisations and staff have the knowledge, skills, training, behaviours, values, support, monitoring, culture, and leadership to prevent infections.

A literature review, surveys, stakeholder focus groups, and a prioritisation exercise were undertaken. These identified opportunities for additional training, increased awareness of guidance, and monitoring of IPC behaviours. The surveys also found high levels of 'infectious presenteeism'. A high value is placed on the role of the IPC team, but the resource is stretched between multiple community settings and between prevention and control.

Where are we going and how will we get there?
We need to work as a whole system to improve IPC in community settings, and collectively prioritise deployment of the IPC team. There is need not only for additional resource, but also for approaches that build resilience and capacity within settings which are reflected in the strategy goals and how we will achieve them.

Our vision is for all health and care professionals working in the community to have the capability, opportunity, and motivation to implement IPC measures in their setting to protect those who use their services or live, work, or study in their settings.

How will we know we have arrived?
The strategy implementation group will meet quarterly to monitor implementation and report annually to the Health Protection Assurance Board.

1 Introduction

> *"Over the last decade, major outbreaks such as those due to the Ebola virus disease and the Middle East respiratory syndrome coronavirus (MERS-CoV), and the coronavirus disease 2019 (COVID-19) pandemic… have exposed the gaps in infection prevention and control (IPC) programmes that exist irrespective of the resources available or the national level of income."*
>
> WHO Global report on infection prevention and control (2022)[1]

Infection prevention and control (IPC) is about using practical, evidence-based approaches to prevent patients, residents, service users, visitors, and staff from being harmed by avoidable infections. Effective IPC must be part of everyday practice and be applied consistently by everyone.

The SARS-CoV-2 (COVID-19) pandemic reminded all of us of the threats that infectious diseases continue to pose. To date, more than 228,000 people in the United Kingdom have died with COVID-19 identified as a cause on their death certificate.[2] An estimated 1.9 million people living in private households in the UK (2.9% of the population) were experiencing self-reported long COVID (symptoms continuing for more than four weeks after the first confirmed or suspected COVID-19 infection that were not explained by something else) as of 5 March 2023.[3] By March 2022, it was estimated that the UK Government had spent an additional £310 to £410 billion on measures in response to the pandemic.[4]

In Northumberland and North Tyneside, the Northumbria Healthcare NHS Foundation Trust (NHCT) Infection Prevention and Control (IPC) team was crucial to this effort. As well as working to prevent and control outbreaks within hospital settings, the team supported care homes during hundreds of outbreaks, as well as providing advice and support to domiciliary care and independent supported living providers, schools, colleges, early years settings, children's residential homes, general practices, prisons, and many other settings where they could. They were the eyes and the ears, building relationships and trust with managers and staff, and working in collaboration with colleagues in Council public health, social care, and education teams, Clinical Commissioning Group (CCG) then Integrated Care Board (ICB) teams, and the Public Health England (PHE) then UK Health Security Agency (UKHSA) north east health protection team. They continue to provide training, advice, support, audit, and visits within a limited resource to prevent and control infections and outbreaks.

This strategy seeks not only to maximise and prioritise the resources available within limited budgets for a specialist IPC team to deliver activities in communities, but also to ensure that the wider systems and services across Northumberland and North Tyneside have the knowledge, skills, behaviours, and values to prevent and control harmful infections and be as prepared as possible for future threats.

2 Aims of the strategy

The aims of the strategy are:

- To minimise preventable incidents and outbreaks of harmful infection in community settings in Northumberland and North Tyneside through effective IPC interventions.
- To ensure that Northumberland and North Tyneside are as prepared as possible to implement effective IPC measures in community settings in response to new or developing threats or pandemics.

3 Objectives of the strategy

The objectives of the strategy are:

- To understand current IPC provision, activities, behaviours, and need within community settings (*Where are we now?*).
- To understand current guidance for community settings and interventions to influence behaviours.
- To agree and prioritise goals to promote IPC measures in community settings, including additional resources and capacity building approaches (*Where do we want to get to?*)
- To agree how we will achieve the goals (*How will we get there?*).
- To define how we will monitor achievement against the goals (*How we will know we have arrived?*).

4 Scope

This strategy covers Northumberland and North Tyneside because they share an acute hospital trust and IPC team. It focuses on IPC in community settings and providers only, and not hospital settings, specifically:

- Care homes.
- Domiciliary care (homecare) including independent supported living.
- Children's residential homes.
- Educational settings.
- General practices.

5 Governance

A strategy group was convened to oversee the development of this strategy: membership is described in the Acknowledgements section.

IPC is considered at a regional level by the Antimicrobial Resistance and Healthcare Associated Infection Subcommittee of the North East and North Cumbria (NENC) ICB Quality and Safety Committee. The subcommittee seeks to bring together key stakeholders across health and social care from the NENC Integrated Care System (ICS) to tackle antimicrobial resistance, reduce healthcare associated infections, share information and best practice, and achieve system-level assurance.

6 Where are we now?

6.1 Scale of the challenge

Table 1 outlines the number of potential community settings and providers across Northumberland and North Tyneside in which the NHCT IPC team might play a role.

Table 1. Scale of the challenge: numbers of settings and providers

	Northumberland	**North Tyneside**
Care sector	• 71 elderly care residential and nursing homes • 28 specialist learning disability/mental health care homes • 58 domiciliary care providers • 221 independent supported living (ISL) settings	• 31 elderly care residential and nursing homes • 14 learning disability/mental health care homes • 30 domiciliary care providers • 27 independent supported living providers with around 400 settings

Education	• Early years provision
	  ○ 174 childminders
	  ○ 95 day nurseries
	• 130 first and primary schools
	• 14 middle schools
	• 15 high and secondary schools
	• 13 special/alternative provision schools
	• One pupil referral unit
	• One further education college
		• Early Years Provision:
		  ○ 108 childminders
		  ○ 48 day nurseries
		• 55 first and primary schools
		• 16 secondary schools
		• 6 special schools
		• 1 further education college and part of a university campus

NHS General Practice	• 36 general practices	• 26 general practices
Children's residential homes	• 5 residential homes	-

6.2 Northumbria Healthcare NHS Foundation Trust IPC team

The NHCT IPC team is currently made up of 10.1 whole time equivalent (WTE) nursing staff broken down into 5.3 WTE staff working in hospital settings and 4.8 WTE staff working in the community (covering Northumberland and North Tyneside).

The activities of the team in the community currently include:

- Training:
    - Care home staff, including face-to-face, webinar, and e-learning training that is regularly updated, and IPC champion training and care home forums.
    - Community services (provided by NHCT).
    - Hand hygiene training in primary schools.
    - Home (domiciliary) care staff: charge may apply and there is no current training programme except for staff employed by NHCT.
    - General practice staff: a charge applies for training.
- Direct support:
    - Outbreak management at Intermediate Care Units. (Note that outbreak management of most community settings is undertaken by the UKHSA Health Protection team.)
    - Care home visits and telephone calls during outbreaks (planning to reduce or cease because of insufficient capacity).
    - Outbreak support for other settings, for example nurseries, at the request of the UKHSA Health Protection Team.
    - Fit testing for FFP 3 masks in care homes and other settings where needed.
- Collaborative working:
    - Care Quality Commission (CQC) monthly information sharing meetings about care homes / home care services, including support where there are safeguarding concerns due to inadequate IPC.
    - Care home provider forum meetings.
    - Link nurse champions meetings.
    - Multi-agency meetings and collaborative working with Adult Social Care Commissioning, ICB, Public Health, and UKHSA.
    - Care home newsletter.
    - Community events e.g. Wooler children's day; IPC week.
- Audit:
    - Community patient hand hygiene satisfaction survey.
    - Hand hygiene audits (validation) of community staff.
    - Care home report on the extent to which IPC measures are being met.
    - General practices: a charge applies to undertake an IPC audit in general practice.
    - Root cause analysis e.g. patients with community-acquired infections (such as *Clostridium difficile*) admitted to hospital.

Since March 2020, the IPC team has supported care homes experiencing around 700 COVID outbreaks. Although there were fewer outbreaks of other infectious diseases during the first year of the pandemic, there were 30 outbreaks of gastroenteritis in care homes in Northumberland and 6 in North Tyneside between April 2021 and March 2022, increasing to 58 in Northumberland and 23 in North Tyneside between March 2022 and January 2023. There have also been cases and outbreaks of seasonal influenza, group A streptococcal disease, pneumococcal disease, scabies, and other infectious diseases. The IPC team has provided telephone or face-to-face support for most if not all these incidents.

Where issues were identified, the themes frequently noted on support visits to care homes were:

- Poor adherence to use of PPE and to guidance.
- Cleanliness.
- Lack of education of staff.
- Leadership.
- Estates issues.

6.3 Guidance and best practice

There are a number of key international and national documents underpinning the IPC responsibilities of organisations and staff including:

- World Health Organization Global report on infection prevention and control.[1]
- Health and Social Care Act 2008: Code of practice on the prevention and control of infections outlines ten criteria which care organisations must demonstrate compliance against.[5]
- National Infection Prevention and Control manual for England.[6]
- Infection Prevention Society Competencies Framework.[7]
- National Occupational Standards.[8]
- Infection Prevention Society Competencies Framework.[9]
- NHS England and Public Health England: Supporting excellence in infection prevention and control behaviours IPC implementation toolkit.[10]
- COVID-19 national guidance for health and care professionals.[11]
- Health protection in children and young people settings, including education.[12]
- E-Bug: a health education programme that aims to promote positive behaviour change among children and young people to support IPC efforts.[13]
- IPC guidance for adult social care.[14]
- IPC guidance for adult social care COVID-19 supplement.[15]
- CQC advice on IPC for general practice.[16]

Summaries of each are provided in Appendix 1. All of these seek to ensure that organisations and staff have the knowledge, skills, training, behaviours, values, support, monitoring, culture, and leadership to prevent infections. And yet, as the pandemic revealed, these frameworks had not fully embedded in organisations: there were numerous barriers to implementation which the strategy group sought to understand.

6.4 Barriers, facilitators, and interventions

A rapid review was undertaken of the literature on views, attitudes, experiences, or knowledge of IPC in our target settings, barriers, and facilitators to implementing IPC measures, and interventions to improve adherence. Barriers and facilitators are summarised in Table 2, although studies were only available for healthcare and care home settings.

Several interventions have been identified as being effective in improving adherence to IPC measures among healthcare workers including: educational materials combined with educational meetings; local opinion leaders; audit and feedback; reminders; tailored intervention; monitoring the performance of the delivery of health care; educational games; and patient-mediated interventions.[17]

Table 2. Barriers and facilitators to implementing IPC measure in healthcare and care home settings[18 19 20 21]

	Barriers to or associations with lower implementation of IPC measures	**Facilitators or association with higher implementation of IPC measures**
Healthcare settings and staff	• High workload or/ time constraints • More beds or higher patient-to-nurse ratio • Glove overuse • Non-availability of equipment (in particular sinks or hand towels) • Gaps in knowledge of occupational vaccinations, the modes of transmission of infectious diseases, and the risk of infection from needle stick and sharps injuries	• Knowledge, education and training, and experience • Being a nurse as opposed to a doctor • Good hand hygiene is an important predictor of overall IPC level
Care home settings and staff	• IPC seen as outside control of care home • Negative feedback loop of outbreaks on staffing • Staffing skills & education • Low wages, staff shortages, and high staff turnover • High workload (burnout) • IPC not viewed as appropriate to making a 'homely environment' • Isolation of residents creating moral distress among staff	• Staff training • Monitoring • Organisational support (in particular, effective leadership) • Attention to organisational issues (barriers)

During the height of the COVID pandemic, NHS England undertook a research project to understand the drivers of behaviours that influenced compliance with COVID-19 IPC measures. Insight was gathered from frontline staff, patients, professional bodies, and clinical, communication and IPC experts to understand

these drivers, and a suite of co-designed products were developed to address the key themes.[22] The key insights are summarised in Table 3.

Table 3. Key insights and advice from the NHS England and Public Health England Supporting excellence in infection prevention and control behaviours IPC implementation toolkit (March 2021)

- Strong, compassionate leadership and role modelling.
- Enhance the mindset of the workforce about both protecting SELF and OTHERS, creating a culture of kindness where compliance is associated with being kind and caring to all.
- Staff need support to challenge colleagues and patients/visitors on IPC compliance, particularly when speaking to senior staff and medics.
- "Hotspots" are areas where infrastructure issues (mainly space) aren't easily overcome but can be improved with some quick fixes, improved monitoring, and situational comms.
- Training to further enhance awareness and understanding of IPC measures and their purpose.
- Clear messaging for patients and visitors, outlining not just what we want them to do, but how to do it e.g. wearing a mask over nose and mouth. Direct messaging was felt to be more effective than softer messaging for this group.
- Zero-risk approach to sickness will relieve pressure on staff to come in with minor symptoms.

6.5 Surveys of staff in community settings

Surveys were undertaken of staff working in each setting to understand the met and unmet needs of staff to enable effective IPC measures to be in place to prevent harmful infections or outbreaks, and the barriers and facilitators to implementation of effective IPC measures in each setting. The questionnaire was informed by the literature review on barriers, facilitators, and interventions to promote adherence to IPC measures together with the Theoretical Domains Framework (TDF). [23] [24]

The number of responses was quite low in all settings apart from children's residential homes, and no responses were received from staff working in early years settings – see Table 4.

Key findings from the surveys were:

- Respondents were generally confident in their IPC knowledge, skills and behaviours, but the survey findings suggest opportunities for additional training, increased awareness of guidance, and monitoring of IPC behaviours through audit and other approaches.
- Many care homes use in-house IPC training but we have no information about its quality. Some staff are unaware of training that is available.
- Cost and time are barriers in education and general practice.
- Many respondents across all sectors said they feel compelled to come into work even if they are unwell with an infection.

- Whilst many staff are aware of an IPC champion or lead in their organisation, in others including domiciliary care and general practice, awareness or existence of such a role is less common. (This question was not asked of education because an IPC lead or champion is not currently common practice, although there is a health and safety lead.)

Table 4. Number of responses to IPC surveys by location and setting

Setting	Number of responses	Northumberland	North Tyneside	Other
Care homes	64	46 (72%)	17 (27%)	1 (1.6%)
Domiciliary care	57	22 (39%)	27 (47%)	8 (14%)
Education	24	10 (42%)	14 (58%)	0 (0%)
Children's residential homes	44	44 (100%)	0 (0%)	0 (0%)
General practices	36	13 (39%)	22 (61%)	0 (0%)

In a survey in September 2022 of Northumberland and North Tyneside care homes, high levels of satisfaction were reported about the involvement of IPC team in past 2 years, their face-to-face visits, and the monthly webinars the team provided.

Full details on the methods, results, and interpretation of the surveys in each setting can be found in Appendix 2.

6.6 Stakeholder focus groups and interviews

Key findings from stakeholder interviews and focus groups were:

- There is a high value placed on the role of the IPC team, the support they gave during the pandemic, and the relationships that have developed during the pandemic.
- Relationships between system partners, and with providers, improved during the pandemic because of the good communication, collaboration, and support given.
- There is a need for IPC support and training for staff in early years settings.
- There is a need for sustainable, capacity-building solutions in view of the small size of the IPC team. Examples proposed included upskilling of professionals who visit care homes, and the IPC team working with Council Health and Safety teams to support educational settings to implement IPC measures.
- Whilst IPC champion approaches were broadly supported, some caution was expressed about the difficulties for IPC champions in care homes to challenge their colleagues.

Further information can be found in Appendix 3.

6.7 General Practice audit

Currently, not all general practices in Northumberland and North Tyneside have face-to-face IPC training or audit undertaken by the NHCT IPC team because this incurs a financial charge. However, of practices that asked the team to undertake an IPC audit, a number of themes were identified – see Table 5.

Table 5. Common themes and issues identified from IPC audits conducted by IPC Team of General Practices in Northumberland and North Tyneside 2019-2022

Theme	Issue
PPE	• Not stored appropriately, stored in drawers, cupboards and not freely accessible to staff
Furnishings	• Fabric chairs: ripped, stained • Fabric chairs in reception areas unable to be effectively cleaned • Ripped pillow covers
Staffing	• IPC not on agenda for staff meetings • No IPC leads identified • Staff not receiving regular IPC training/updates
Environment	• Heavily cluttered treatment/consultation rooms • Sinks cluttered with extraneous equipment, urinalysis sticks, phlebotomy equipment, gloves, loose paper towels etc… • Sinks not overflow free • Carpeted areas in patient areas
Audit	• No audits formally completed around environmental cleanliness • Hand hygiene audits not routinely completed
Storage	• Lack of storage e.g. couch rolls stored on floor

7 Where do we want to get to, how will we get there, and how will we know we have arrived?

7.1 Vision

Our vision is for all health and care professionals working in the community to have the capability, opportunity, and motivation to implement infection prevention and control measures in their setting to protect those who use their services or live, work, or study in their settings.

7.2 Mission statement

We will work in partnership to build capacity in community settings to minimise preventable incidents and outbreaks of harmful infection and be resilient to new threats of infectious disease.

7.3 Prioritisation

Recognising that the specialist community IPC nurse team is a finite resource of 4.8 whole time equivalent nursing staff, the steering group undertook a prioritisation exercise to explore the balance of resource committed between prevention and control and between each type of setting based on agreed criteria.

After a discussion, the group agreed the focus between types of setting for the specialist IPC team as in Table 6.

Table 6. Prioritisation of specialist IPC resource by setting or sector

Setting or sector (number)	*Percentage of specialist IPC*
Care homes (140+)	60%
Education and early years (700+)	25%
Domiciliary care (100+)	10%
Primary Care (62)	5%
Total	100%

After further discussion, the balance of time spent between prevention and supporting settings with 1-2 cases, a cluster, an outbreak, or frequent incidents was agreed for each type of setting. This was then translated into days per month for each setting based on 4.8 WTE IPC nurses as shown in Table 7.

Table 7. Days per month of focus for specialist IPC resource by setting and phase

Phase	Name	Days per month of specialist IPC resource (4.8 WTE)			
		Care homes	Education	Domiciliary care	Primary care
1	Prevention	18.9	11.3	7.2	3.6
2	1-2 cases	2.7	2.3	0	0.2
3	Cluster	13.5	3.4	0.5	0.2
4	Outbreak	10.8	4.5	0.5	0.2
5	Frequent incidents	8.1	1.1	0.1	0.2
	Total	54	22.5	9	4.5

This prioritisation demonstrates that the specialist IPC resource is stretched between multiple settings and between prevention and control such that, for some settings or sectors such as domiciliary care and primary care (general practice), there is so little time available within existing resource that little can be achieved within that time. This reinforces the need not only for additional resource, but also for approaches that build resilience and capacity within the setting as opposed to direct delivery.

Further details of the prioritisation exercise can be found in Appendix 4.

7.4 Principles

This strategy is guided by the following principles:

- We will work as a whole system to implement IPC measures in community settings.
- Recognising that the specialist community IPC nurse team is a finite resource, we will seek to work as partners to maximise impact by prioritising the deployment of the team.
- With the support of partners, the specialist community IPC team will seek to build resilience and capacity within the community by training and supporting key professionals already working in or with settings.

7.5 Reporting

The Northumberland and North Tyneside community IPC strategy steering group will meet twice yearly to update on progress against the goals and monitoring framework below, and report to the Health Protection Assurance Board in each of Northumberland and North Tyneside on an annual basis, or more frequently if needed or requested to do so.

7.6 Goals, how we will achieve them, and monitoring

Goal	*How will we achieve it?*	*Indicator*
Funding and prioritisation		
Goal 1: The NHCT IPC team has additional, long-term, sustainable funding to maintain and increase the scope and magnitude of activities of the IPC team to support more settings/providers in the community, including care homes, general practices, domiciliary care, educational establishments, and children's residential care.	• We will work with partners across the system to continue to make the case for equitable, sustainable investment in IPC expertise to support community settings in Northumberland and North Tyneside.	• Increased number of whole-time equivalent specialist IPC nurses working to support community settings
Goal 2: Where resources are limited, priorities for work within community settings will be agreed with system partners.	• We will work as system partners to ensure that we are able to maximise impact of limited resources through agreed priorities and principles.	• Annual review of priorities
Building IPC capacity in community settings		
• *All community settings*		
Goal 3: Managers and staff will be aware of training that is available.	• Together with and via system partners, the NHCT IPC team will share a list of quality assured training opportunities to care home providers, domiciliary care providers, educational settings, general practices, and children's residential homes.	• Annual survey of community settings / providers
Goal 4: All training, whether external or in-house, is of high quality and updated to reflect current guidance.	• Where training is provided in-house, system partners will work with providers to quality assure training. • Where training is provided by the NHCT team or system partners, the content will be regularly reviewed to ensure its accuracy.	• Record of annual review of webinar and module training provided by NHCT • Surveys of staff attending training • Number of care home providers sharing their

		training package for quality assurance purposes
• *Care homes*		
Goal 5: All professional staff visiting care homes from all sectors have had training in IPC to identify good practice, recognise when standards of IPC are not being met, provide IPC advice, and link easily to additional specialist support when needed.	• The IPC team will engage with staff who visit care homes to offer additional IPC training, assess competence if appropriate, and maintain a network to enable sharing of best practice and updated guidance, answer questions, and provide specialist support.	• Record of IPC training provided to professional staff visiting care homes • Number of professional staff visiting care homes who have had training in past 1 year
Goal 6: All care homes have an IPC champion who receives additional IPC training, is given time for training and linking with other IPC champions via a network, is empowered to support colleagues, and can link easily to additional IPC support when needed.	• System partners who have existing relationships or contracts with care home providers will promote the need for a named IPC champion in each care home. • NHCT will continue to provide training and support to IPC champions in care homes.	• Record of IPC champions held by IPC team • Annual survey of IPC champions
Goal 7: All agency staff will be trained in IPC.	• Make contact with larger agencies to understand training requirements and explore with regional partners regional approaches to providing and assuring training. • Include a question about training of agency staff in the quality assurance checklist used by the IPC team during care home visits.	• Record of number of agency staff trained in IPC by NHCT • Annual survey of care home managers to determine number of agency staff trained in IPC
• *Educational settings*		
Goal 8: Leaders in educational settings continue to recognise the importance of effective IPC measures to protect the health of their students and staff, minimise student and staff absences, and contribute to	• Strategy group members will offer to join headteacher meetings to promote the benefits of IPC measures and the use a ‘making every contact count’ approach with all educational staff to promote IPC.	• Record of IPC team input to Headteacher meetings

preventing wider spread of infections within the community.		
Goal 9: Staff in educational settings have a basic knowledge of common infections and IPC measures.	• Build links between the NHCT IPC team and the local authority Health and Safety (H&S) teams who already work with schools, including opportunities for additional IPC training for H&S teams and access to specialist advice when needed. • H&S teams in both local authorities will work with the IPC team and system partners to regularly update the IPC policy or guidance within the Health and Safety guidance for use by educational settings. • The IPC team will offer virtual training to H&S leads within educational settings on an annual basis to update knowledge of IPC. • Undertake a specific piece of work to understand issues for early years providers, from whom we had no responses in the survey.	• Record of additional IPC training for H&S teams and access to specialist advice. • Record of IPC team input into Health and Safety guidance for use by educational settings. • Number of H&S leads within educational settings receiving training in IPC. • Report on project with early years settings.
Goal 10: Children and young people aged 3-16 years will have age-appropriate knowledge of hygiene, microbes, vaccinations, and antimicrobial resistance and are supported to play their role in prevention outbreaks and using antimicrobials appropriately.	• We will promote and support educators, community leaders, parents, and caregivers to use E-Bug to educate children and young people and promote positive behaviour change.	• Survey of educational settings on use of E-Bug to educate children and young people and promote positive behaviour change.
• *General practice*		
Goal 11: There is an IPC champion in every general practice who receives additional IPC training, is linked to a wider network of IPC	• System partners who have existing relationships with general practice will	• Number of general practices with an IPC champion.

champions, is empowered to support colleagues, and can link easily to additional IPC support when needed.	promote the need for a named IPC champion in each practice • NHCT will continue to provide training and support to IPC champions in practices.	• Number of IPC champions trained by IPC team.
Goal 12: All practice staff receive regular quality-assured IPC training and audit.	• Work with general practice colleagues to understand demand and willingness to participate in, and promote, regular training. • Work with system partners to secure funding for face-to-face training and audit in general practice.	• Funding secured for face-to-face training and audit in general practice. • Number of general practices who receive face-to-face training.
Preventing infectious presenteeism		
Goal 13: Systems are in place to discourage staff from attending work if they are unwell with an infection ('infectious presenteeism').	• We will use existing communications channels with providers and the general public to discourage infectious presenteeism. • All commissioners will ask providers to include in their business continuity plans how they will manage in the event of staff absence due to sickness. • We will include the discouragement of infectious presenteeism in all training provided. • Commissioners will encourage providers to include mitigations within their risk assessment for when infectious presenteeism is unavoidable, for example use of face masks, enhanced ventilation, and cleaning, or avoiding care of people who are immunosuppressed or otherwise at high risk from the infection.	• Record of communications to providers and the general public to discourage infectious presenteeism. • Record of how providers will manage in the event of staff absence due to sickness in their business continuity plans. • Record of discouragement of infectious presenteeism in all training provided e.g. learning modules.

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