Northumberland & North Tyneside Community Infection Prevention and Control Strategy (July 2023): Appendices 1-4

Appendix 1 – IPC guidance and best practice

WHO Global report on infection prevention and control (IPC)

The World Health Organization (WHO) has identified that there are significant gaps in IPC that were amplified by the COVID pandemic and other major outbreaks:[1]

> *"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 demonstrated how epidemic-prone pathogens can spread rapidly through health care settings. These events have exposed the gaps in infection prevention and control (IPC) programmes that exist irrespective of the resources available or the national level of income.*
>
> *Furthermore, other less-visible health emergencies are also a compelling reason to address gaps in IPC, such as the silent endemic burden of health care-associated infections (HAIs) and antimicrobial resistance (AMR), which harm patients every day across all health care systems."*

The WHO has reinforced the need for well-funded IPC provision both to address existing infections and to be better prepared for new threats or pandemics. It has identified three priorities to accelerate progress:

1. Political commitment and policies to scale up and enforce the core components of IPC programmes and the related minimum requirements, including through sustained financing, legal frameworks and accreditation systems.
2. IPC capacity-building and creation of IPC expertise.
3. Development of systems to monitor, report, and act on key indicator data.

Health and Social Care Act 2008: Code of practice on the prevention and control of infections

All registered care providers must demonstrate compliance with the Health and Social Care Act 2008: Code of practice on the prevention and control of infections[2] which outlines ten criteria which care organisations must demonstrate compliance against (see Table 1).

[1] World Health Organization. (2022). Global report on infection prevention and control. World Health Organization. https://apps.who.int/iris/handle/10665/354489.

[2] https://www.gov.uk/government/publications/the-health-and-social-care-act-2008-code-of-practice-on-the-prevention-and-control-of-infections-and-related-guidance/health-and-social-care-act-2008-code-of-practice-on-the-prevention-and-control-of-infections-and-related-guidance

Table 1. Criteria that all care organisations must demonstrate compliance against in the Health and Social Care Act 2008: Code of practice on the prevention and control of infections

Criterion 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 that their environment and other users may pose to them.
Criterion 2: The provision and maintenance of a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.
Criterion 3: Appropriate antimicrobial use and stewardship to optimise outcomes and to reduce the risk of adverse events and antimicrobial resistance.
Criterion 4: The provision of suitable accurate information on infections to service users, their visitors and any person concerned with providing further social care support or nursing/medical care in a timely fashion.
Criterion 5: That there is a policy for ensuring that people who have or are at risk of developing an infection are identified promptly and receive the appropriate treatment and care to reduce the risk of transmission of infection to other people.
Criterion 6: Systems are in place 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.
Criterion 7: The provision or ability to secure adequate isolation facilities.
Criterion 8: The ability to secure adequate access to laboratory support as appropriate.
Criterion 9: That they have and adhere to policies designed for the individual's care, and provider organisations that will help to prevent and control infections.
Criterion 10: That they have a system or process in place to manage staff health and wellbeing, and organisational obligation to manage infection prevention and control.

National Infection Prevention and Control manual

This provides an evidence-based practice manual for use by all those involved in care provision in England and should be adopted as guidance in NHS settings or settings where NHS services are delivered, including general practice.[3]

In all non-NHS care settings, to support with health and social care integration, the content of this manual is considered best practice.

The manual states that managers/employers of all services must ensure that staff:

- Are aware of and have access to IPC guidance, including the measures required to protect themselves and their employees from infection risk.
- Have had instruction/education on infection prevention and control by attending events and/or completing training.

[3] https://www.england.nhs.uk/publication/national-infection-prevention-and-control/

- Have adequate support and resources to implement, monitor and take corrective action to comply with IPC guidance; and a risk assessment is undertaken and approved through local governance procedures.
- Who may be at high risk of complications from infection (including pregnancy) have an individual risk assessment.
- Who have had an occupational exposure are referred promptly to the relevant agency (e.g. GP, occupational health or accident and emergency), and understand immediate actions (e.g. first aid) following an occupational exposure including process for reporting.
- Have had the required health checks, immunisations and clearance undertaken by a competent advisor (including those undertaking exposure prone procedures (EPPs).
- Include infection prevention and control as an objective in their personal development plans (or equivalent).
- Refer to infection prevention and control in all job descriptions.

Infection Prevention Society Competencies Framework

Although the Infection Prevention Society Competencies Framework[4] is aimed at IPC practitioners, several competencies are relevant to all those working in community settings.

In particular, staff in community settings should be able to

- Apply the relevant IPC principles design and implement strategies to prevent and control infection.
- Recognise gaps in knowledge, skills and competence of self and others in relation to IPC and develops improvement strategies.
- Communicate IPC information effectively in a verbal and/or written form at an appropriate level for their target audience.
- Ensure key services supporting the IPC agenda e.g., cleaning and waste management are meeting the needs, requirements and specification of the service, assessing and identifying any risks or gaps in provision.

Standard infection control precautions (SICPs)

Standard infection control precautions (SICPs) should be used by all staff, in all health, care and education settings, at all times, for all patients whether infection is known to be present or not, to ensure the safety of those being cared for, staff and visitors in the care environment.[5]

There are ten elements of SICPs and five may be applicable to all settings.

1. Assessment of infection risk.
2. Hand hygiene.
3. Respiratory and cough hygiene.

[4] https://www.ips.uk.net/resources/file/IPS-R-QMVNQ2HHNX3P9L6

[5] https://www.england.nhs.uk/national-infection-prevention-and-control-manual-nipcm-for-england/chapter-1-standard-infection-control-precautions-sicps/

4. Personal protective equipment (where required).
5. Safe management of the environment and managing prevention of exposure (including sharps).

Setting-specific national guidance and resources

The following setting-specific national guidance are currently available and should be followed:

- COVID-19 national guidance for health and care professionals.[6]
- Health protection in children and young people settings, including education,[7] which includes sections on:
    - What infections are, how they are transmitted and those of higher risk of infection.
    - Preventing and controlling infections.
    - Supporting immunisations programmes.
    - Managing outbreaks and incidents.
    - Managing specific infectious diseases.
    - Specific settings and populations: additional health protection considerations.
    - Children and young people settings: tools and resources.
- E-Bug is a health education programme that aims to promote positive behaviour change among children and young people to support IPC efforts, and to respond to the global threat of antimicrobial resistance.[8]
- IPC guidance for adult social care.[9]
- IPC guidance for adult social care COVID-19 supplement.[10]
- CQC advice on IPC for general practice.[11]

IPC Education framework

NHS England published the IPC Education Framework in March 2023.[12] It sets out a vision for the design and delivery of IPC education for staff working in NHS and adult social care. Whilst it is not directed at other settings, many of the principles will be relevant to education and children's social care.

The framework encourages organisations to commit to demonstrating:

- a culture of ongoing IPC learning and development
- strong IPC leadership at board/executive level, supported by visible IPC role models

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[6] https://www.gov.uk/guidance/covid-19-information-and-advice-for-health-and-care-professionals
[7] Health protection in children and young people settings, including education - GOV.UK (www.gov.uk)
[8] Home (e-bug.eu)
[9] https://www.gov.uk/government/publications/infection-prevention-and-control-in-adult-social-care-settings/infection-prevention-and-control-resource-for-adult-social-care
[10] https://www.gov.uk/government/publications/infection-prevention-and-control-in-adult-social-care-covid-19-supplement/covid-19-supplement-to-the-infection-prevention-and-control-resource-for-adult-social-care
[11] https://www.cqc.org.uk/guidance-providers/gps/gp-mythbusters/gp-mythbuster-99-infection-prevention-control-general-practice
[12] https://www.england.nhs.uk/long-read/infection-prevention-and-control-education-framework/

- that IPC education and training is developed by and with IPC experts, using the expertise of the multidisciplinary team to promote delivery, which is tailored to all staff needs, focusing on behaviour as well as developing knowledge and skills.

The framework outlines both standards for organisations who develop and deliver IPC educational programmes for health and social care, and standards to ensure health and social care systems and providers maintain a learning environment for IPC. It identifies three tiers based on staff role, and or each tier lists the knowledge and understanding needed, as well as behaviours to demonstrate knowledge and understanding. Tier 1 is “everyone working in health and social care settings”.

Behaviours expected by people at Tier 1:

- Staff ensure good IPC practice is appropriately embedded into their work.
- Staff ensure their actions minimise risks to health and safety and contribute to positive and safe practice.

Individuals demonstrate these behaviours (Learning outcomes for people at Tier 1) by being able to:

1. Perform appropriate, effective hand hygiene and glove use to prevent the spread of infection.
2. Use a range of PPE which is relevant to their role and know how and when to use it.
3. Contribute to the cleanliness of the work environment as relevant to their role
4. Dispose of waste immediately in the correct waste stream as close to the point of generation as possible.
5. Use antibiotics appropriately, personally and professionally as relevant to their role.
6. Engage in vaccination programmes, personally and professionally as relevant to their role.
7. Cover their nose and mouth with a disposable tissue when sneezing, coughing, wiping, and blowing their nose, where this is not possible to at least sneeze into their elbow/sleeve.

The behaviours and learning outcomes for Tier 1 are relevant to staff in all of the target settings for this strategy.

National Occupational Standards

National Occupational Standards (NOS) are statements of the standards of performance for individuals when carrying out functions in the workplace, together with specifications of the underpinning knowledge and understanding.

NOS are developed for employers by employers through the relevant sector skills council or standards setting organisation.

NOS for IPC were developed in 2012 and revised in 2021[13]:

[13] https://www.skillsforhealth.org.uk/info-hub/national-occupational-standards-overview/?from=20

- IPC1.2012 – Minimise the risk of spreading infection by cleaning, disinfecting and maintaining environments
- IPC2.2012 – Perform hand hygiene to prevent the spread of infection
- IPC3.2012 – Clean, disinfect and remove spillages of blood and other body fluids to minimise the risk of infection
- IPC5.2012 – Minimise the risk of exposure to blood and body fluids while providing care
- IPC6.2012 – Use personal protective equipment to prevent the spread of infection
- IPC7.2012 – Safely dispose of healthcare waste, including sharps, to prevent the spread of infection
- IPC8.2012 – Minimise the risk of spreading infection when transporting and storing health and social care related waste
- IPC10.2012 – Minimise the risk of spreading infection when transporting clean and used linen
- IPC11.2012 – Minimise the risk of spreading infection when laundering used linen
- IPC12.2012 – Minimise the risk of spreading infection when storing and using clean linen
- IPC13.2012 – Provide guidance, resources and support to enable staff to minimise the risk of spreading infection

Appendix 2 – Stakeholder surveys

Methods

Surveys of staff were undertaken using Microsoft Forms across five settings in Northumberland North Tyneside, including:

- Care homes.
- Domiciliary care.
- Residential children's homes.
- Educational settings.
- General practices.

The questionnaire was informed by the literature review on barriers, facilitators, and interventions to promote adherence to IPC measures (see Section **Error! Reference s ource not found.**) together with the Theoretical Domains Framework (TDF). The TDF is "an integrative framework developed from a synthesis of psychological theories as a vehicle to help apply theoretical approaches to interventions aimed at behavio[u]r change".[14] It identifies 14 domains that cover the determinants of behaviours. These include: knowledge; skills; social/professional role and identity; beliefs about capabilities; optimism; beliefs about consequences; reinforcement; intentions; goals; memory, attention, and decision processes; environmental context and resources; social influences; emotion; and behavioural regulation.[15] Of note, TDF underpins the COM-B model that is used to understand what needs to be altered to facilitate behaviour change, identifying three factors that need to be present for any behaviour to occur:

- Capability: having the psychological capacity and physical ability to enact the desired behaviour.
- Opportunity: the environment that enables the behaviour.
- Motivation: the desire to carry out the behaviour over other behaviours.

The COM-B model is advocated in the recently published Infection prevention and control education framework.[16]

The objectives of the surveys were:

- To understand the met and unmet needs of staff to enable effective IPC measures to be in place to prevent harmful infections or outbreak either between or during pandemics.
- To understand the barriers and facilitators to implementation of effective IPC measures in each setting.

[14] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4370908/#:~:text=The%20TDF%20domains%20and%20their,%2C%20and%20decision%20processes%2C%2011

[15] https://implementationscience.biomedcentral.com/articles/10.1186/s13012-017-0605-9

[16] https://www.england.nhs.uk/long-read/infection-prevention-and-control-education-framework/

Results

The number of responses by location and setting are shown in Table 1.

Table 1. 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%)

Results – Care homes

Out of a total of 64 responses, 17 (27%) were from people working in North Tyneside, 46 (72%) from Northumberland, and one (1.6%) respondent who stated they worked in Newcastle. Most areas of Northumberland were represented, and there were most from the Alnwick area (18; 28% of all responses). Most respondents (56; 87.5%) were either care home managers or care workers or assistants.

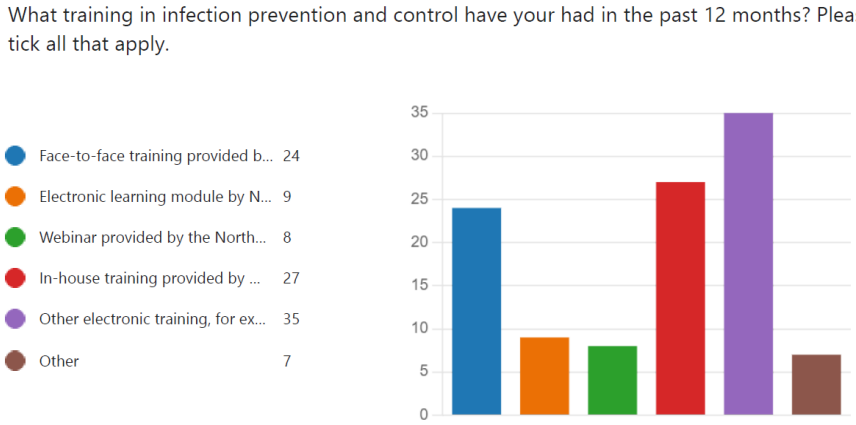
Many of the responses implied confidence or good practice:

- 91% said they have an IPC champion or lead in their care home.
- 86% said they have had IPC training in past 12 months.
- 86% said their organisation has a policy of being bare below the elbow when delivering direct care.
- Few respondents identified any barriers to training.
- Respondents completely or somewhat agreed that:
    - IPC is everyone's responsibility.
    - They had sufficient knowledge of guidance, skills, training (including in managing residents with challenging behaviours), time, access to handwashing facilities and alcohol handrub, personal protection equipment (PPE), organisational support, monitoring, space, and reminders to implement IPC measures.
    - They were confident to intervene if they witnessed a breach in guidance.
    - Visitors are happy to follow guidance.
- In questions about hand hygiene, they were more likely to report being over-cautious.

Findings suggesting opportunities for development included:

- The most common training in the past 12 months was e-learning or in-house training (not provided by the Northumbria Healthcare IPC team) – see Figure 1. There may be an opportunity to quality assure the training delivered.
- Less than half of staff will contact IPC team or UKHSA about IPC issues, but most will contact line manager; they are unlikely to contact local authority about IPC issues.
- 16% of respondents stated they are expected to come into work if unwell with an infection.

Figure 1. Responses from care home staff (n=64) about type of training received



Results – Domiciliary care (home care)

Of a total of 57 responses, 22 (39%) reported that they worked in Northumberland, and 27 (47%) that they worked in North Tyneside. Of the remainder, one worked in both Northumberland and North Tyneside, one indicated the North East, and five stated other areas in the North East including Newcastle, Gateshead, and Hartlepool. Because this may indicate the site of the office, these results were included but a sensitivity analysis undertaken to exclude these with results reported if it changes the conclusions. Most respondents (49; 86%) were homecare or supported living managers, deputy managers, directors, or care coordinators. Seven (12%) were homecare workers and one was an infection control admin.

As with care home staff, many of the responses implied confidence or good practice:

- 95% said they have had IPC training in past 12 months.
- 86% said their organisation has a policy of being bare below the elbow when delivering direct care.
- Respondents completely or somewhat agreed that:
    - IPC is everyone's responsibility.
    - They had sufficient knowledge of guidance, skills, training, time, access to handwashing facilities and alcohol handrub, personal protection

equipment (PPE), organisational support, and monitoring to implement IPC measures.
    - They were confident to intervene if they witnessed a breach in guidance.
- In questions about hand hygiene, they were more likely to report being over-cautious.

Findings suggesting opportunities for development included:

- 65% of respondents reported having an IPC champion or lead in their workplace – see Figure 2.
- 18% identified barriers to training, including cost, not knowing what is available, and time – see Figure 3. One respondent said:

    "Access to IPC training for staff is no longer available, new staff do not have access to the training previously available to staff during the pandemic".
- The most common training in the past 12 months was e-learning or in-house training (not provided by the Northumbria Healthcare IPC team) – see
- Figure4. There may also be an opportunity to quality assure the training delivered.
- 9% state they are expected to come into work if unwell with an infection.

Figure 2. Responses from domiciliary care staff about IPC champion or lead

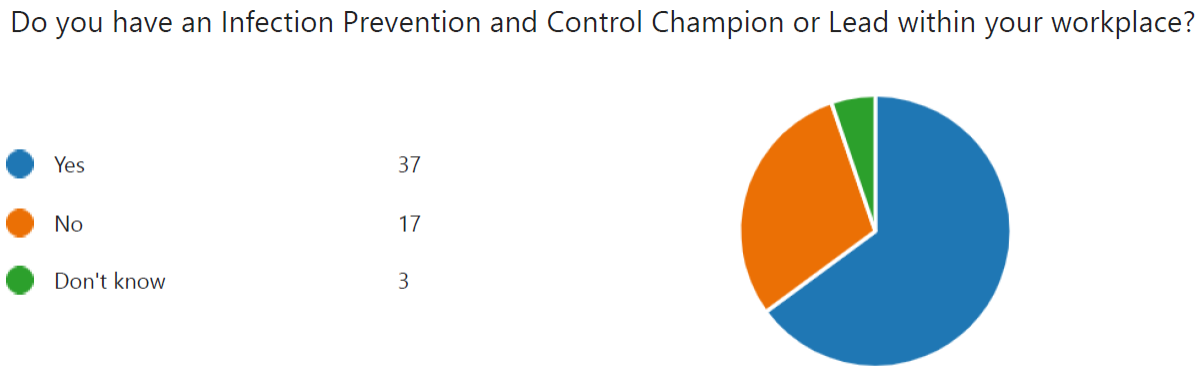


Figure 3. Responses from domiciliary care staff (n=57) about barriers to accessing training

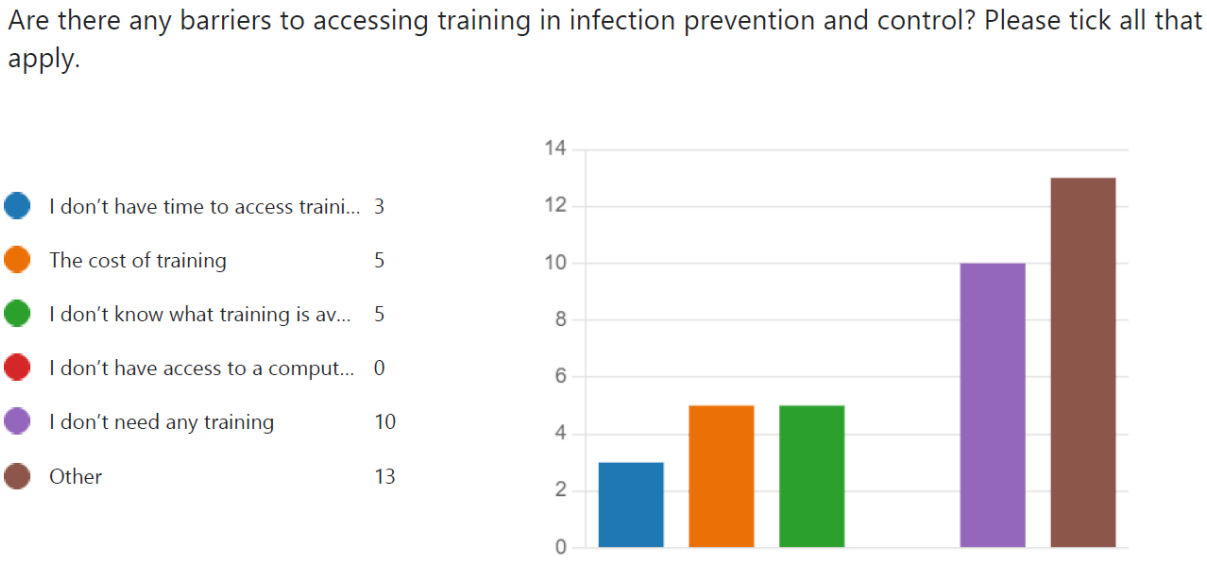
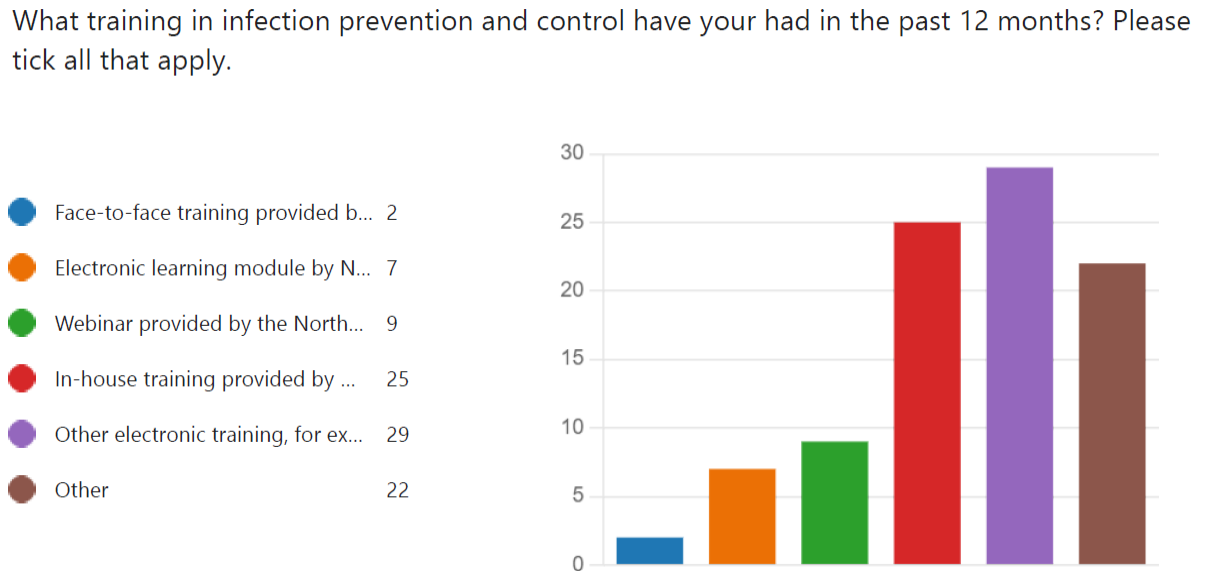


Figure 4. Responses from domiciliary care staff (n=74) about type of training received



Results – Educational settings

There were 24 responses, of which 14 (58%) were from North Tyneside and 10 (42%) from Northumberland. There were no responses from early years settings, and 18 out of 22 responses were from primary or middle schools. A total of 19 responses were from head teachers (including one executive head teacher). The remaining responses were from business managers or an administrator.

There was strong agreement that IPC is everyone's responsibility, and 87% stated that arrangements to manage outbreaks are recorded in their organisation's

Emergency Plan. Most respondents thought they had sufficient knowledge and skills, access to handwashing facilities and PPE, and organisational support.

There are several findings suggesting opportunities for development (see Figures 5 and 6):

- Only 29% of respondents completely agreed that they have had sufficient training in IPC, with 29% somewhat agreeing, and 25% completely or somewhat disagreeing. All identified barriers to training including not knowing what is available, cost, and time (in that order).
- There was considerable variation in terms of whether respondents reported having sufficient time to implement IPC measures: 12.5% completely agreed; 50% somewhat agreed; 8% neither agreed nor disagreed; 25% somewhat disagreed; and 4% completely disagreed.
- 13% stated they are expected to come into work if they were unwell with an infection.

Figure 5. Responses from education staff (n=24) asking 'Please state how much you agree or disagree with the following statements about preventing infections'.

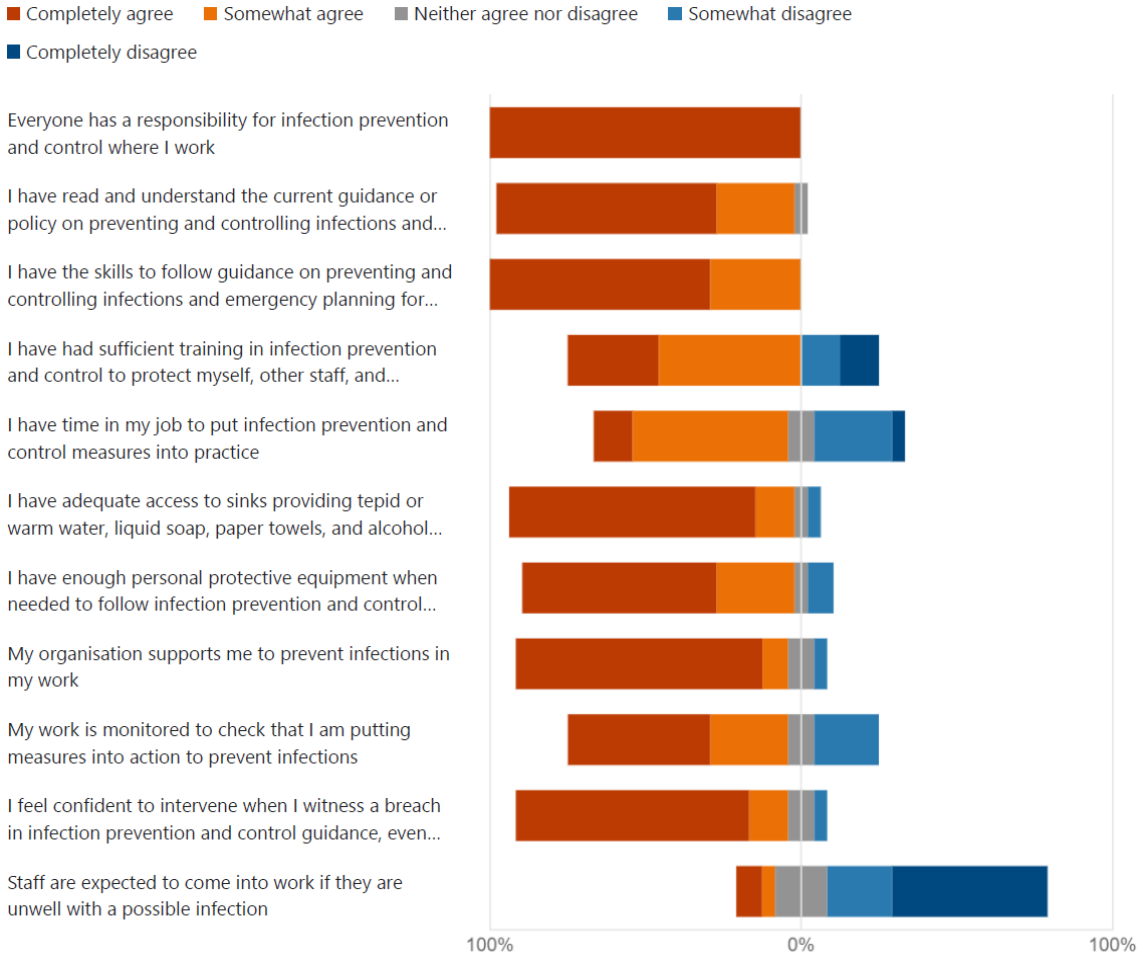
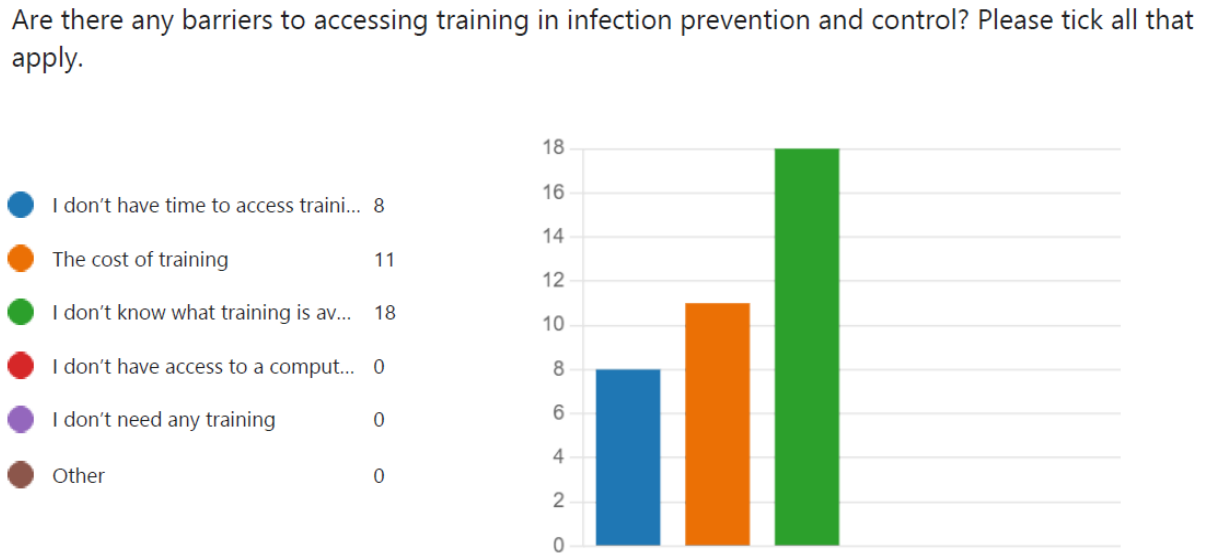


Figure 6. Responses from education staff (n=24) about barriers to accessing training



One headteacher for North Tyneside said:

> *"An understanding of what training is available for my staff would be much appreciated. Also sometimes consistency in information given across Health Care professionals can vary."*

Another headteacher from Northumberland expressed a sense of helplessness at the series of infections affecting students and staff:

> *"One can try ones best and expect everyone else to try [their] best. But pre Christmas and post Christmas it does not seem to make a difference re the illnesses in my school… We have gone from one to the next and then reinfection airborne or not. Tonsillit[i]s, influenza, hand foot and mouth, slapped cheek, chicken pox, scarlet fever, vomiting… [T]he two week break at Christmas seems to have made no difference. Our attendance will be shocking as the children are just not recovering quickly and they are moving from one to the next as I say. Along with staff ."*

One business manager from North Tyneside identified issues accessing PPE or implementing a deep clean during an outbreak:

> *"Whilst we have plenty of PPE now, during the Covid pandemic it was not as easy to get hold of and the DfE were too slow to respond on centralised distribution. It would help to know where any centralised stocks are readily available if another infection outbreak should occur. Additional cleaning in some schools is difficult to get when staff have set hours and responsibilities and can't do or the school can't afford the additional hours for deeper cleans during outbreaks."*

Results – Residential children's homes

All 44 responses were from staff working in Northumberland children's homes. All staff groups responded, with the highest numbers being shift coordinators or support workers.

Many of the responses implied confidence or good practice:

- 82% staff have had IPC training in past 12 months and few respondents identified any barriers to training. Most training has been electronic with around half reporting they have accessed the e-learning developed by Northumbria Healthcare IPC team on the Learning Together portal.
- Most respondents completely or somewhat agreed that:
    - IPC is everyone's responsibility
    - They have sufficient knowledge of guidance, skills, training, time, access to handwashing facilities and alcohol handrub, personal protection equipment (PPE), organisational support, monitoring, space, and reminders to implement IPC measures.
    - They were confident to intervene if they observed a breach in IPC guidance.

Findings suggesting opportunities for development were:

- Only 25% respondents said they have an IPC champion or lead in their workplace (see Figure 7).
- Most will contact their line manager if they have an IPC issue, which is appropriate but may suggest lack of awareness of wider support (Figure 8).
- 18% of respondents said that they are expected to come into work if they are unwell with an infection.

Figure 7. Responses from children's residential home staff (n=44) asking if they have an IPC champion or lead

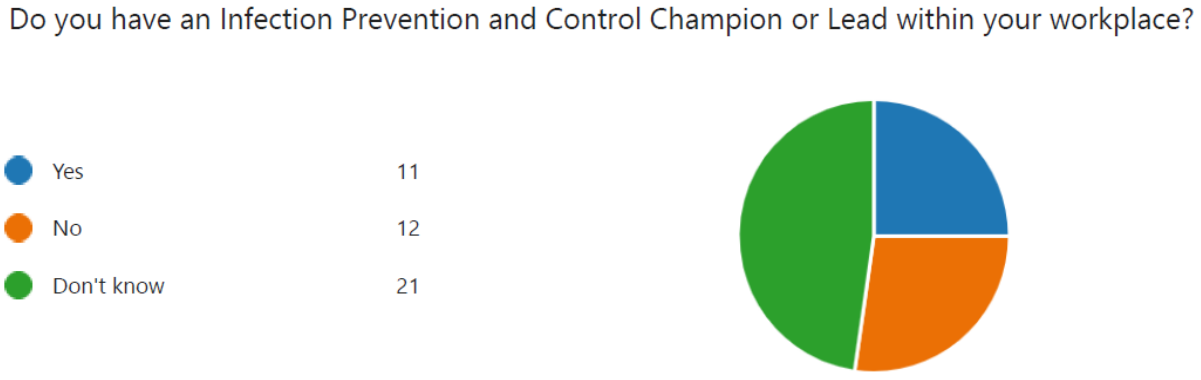
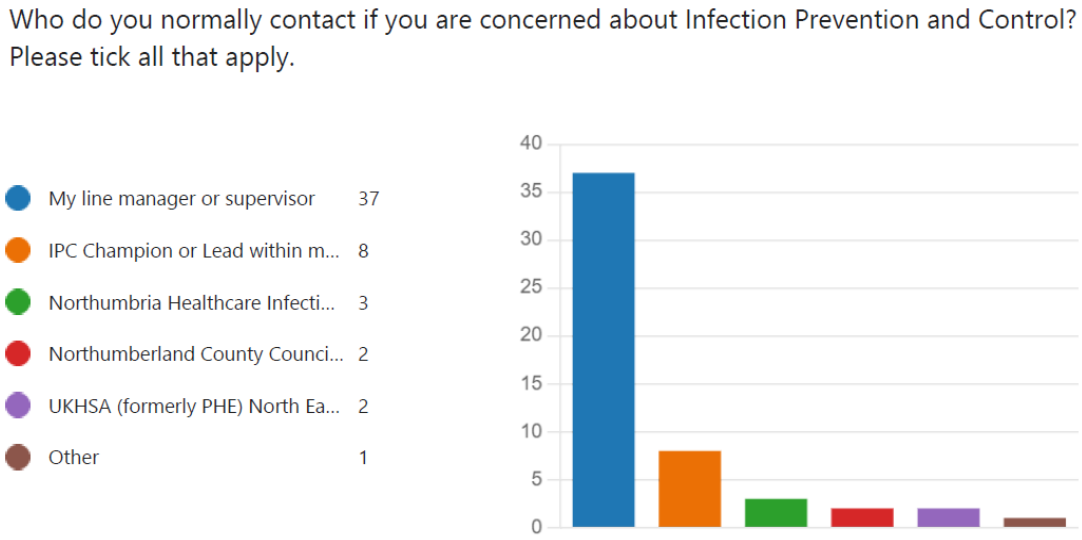


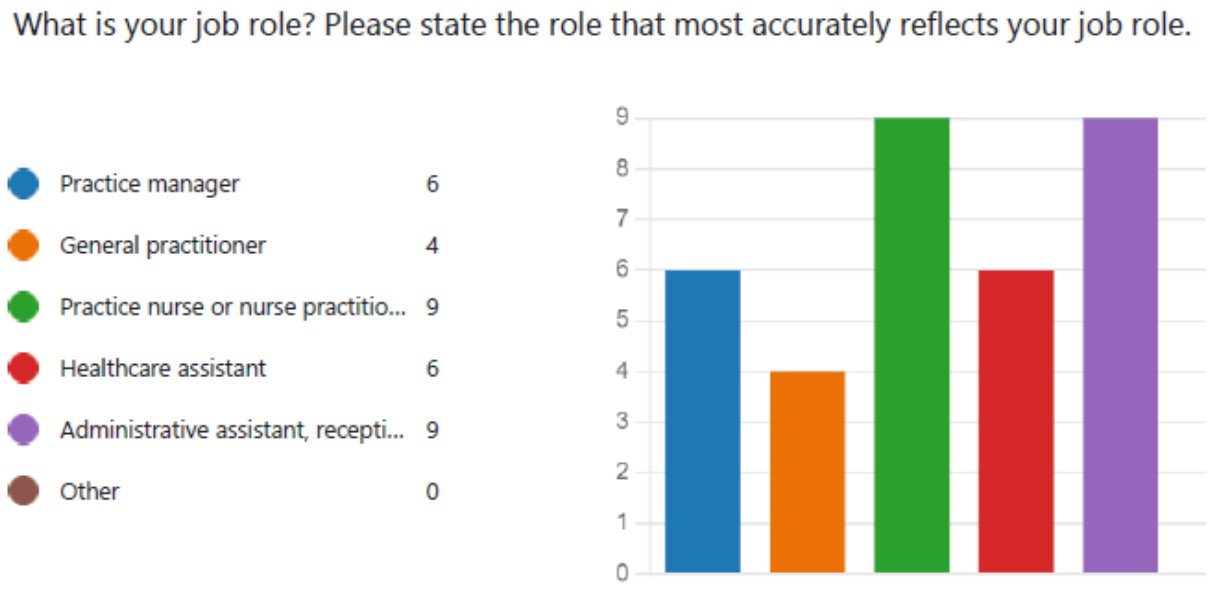
Figure 8. Responses from children's residential home staff (n=44) asking who they contact if concerned about IPC



Results – General practice

Out of a total of 36 responses, 22 (69%) were from North Tyneside general practices, and 14 (31%) from Northumberland. There were no responses from Bedlington, Haltwhistle, Ponteland, or Prudhoe. There was quite an equal spread between different clinical and administrative job roles – see Figure 9.

Figure 9. Responses to IPC survey of general practice by job role



Many of the responses implied confidence or good practice (see Figure 10):

- Most respondents completely or somewhat agreed that:
  - IPC is everyone's responsibility

    - They have sufficient knowledge and understanding of guidance, skills, training, access to handwashing facilities and alcohol handrub, personal protection equipment (PPE), and organisational support to implement IPC measures.
    - They were confident to intervene if they observed a breach in IPC guidance/
- There was a high level of knowledge in relation to hand hygiene.

Findings suggesting opportunities for development were (see Figure 10):

- There was some variation in responses for questions about time, monitoring, and confidence to intervene if witnessing a breach in IPC guidance.
- A total of 64% of respondents have had IPC training in past 12 months. Most training has been electronic, not provided by Northumbria Healthcare. A third of respondents stated they did not need any training. One Northumberland GP said:

  > *"We are too busy for frequent repetitive training, more geared to hospital environments."*

  However, there were several comments suggesting that training is needed, with one respondent saying they needed training tailored to general practice:

  > *"When the changes were made to IPC last April, it was initially stated that it only applied to hospital settings and not GP Practices. This was then changed at the last minute which meant that GP Practices were denied the help, guidance and training that had been given to Trusts. The new guidelines are onerous and there is no information, central training, help or documentation in order to help GP Practices achieve these standards."* (Practice manager, North Tyneside)

  > *"I don't believe enough training and evaluation happens in primary care to maintain adequate infection control and patient safety." (Practice nurse or nurse practitioner, Northumberland)*

  > *"Training specific to primary care rather than hospital would be useful."* (Practice manager, Northumberland)

- Barriers to training (see Figure 11) were not knowing what training was available (12 respondents) and time (10), with cost less of a barrier (5). Time was also a barrier for some in implementing IPC measures. One respondent said:

  > *"Time is a precious resource and training often done in my own time."* (GP, Northumberland)

- Two-thirds of respondents (24 out of 36) report that they do not have an IPC champion or lead, or don't know – see Figure 12.

- 11% of respondents said that they are expected to come into work if they are unwell with an infection.

Figure 10. Responses from general practice staff (n=36) asking ‘Please state how much you agree or disagree with the following statements about preventing infections’.

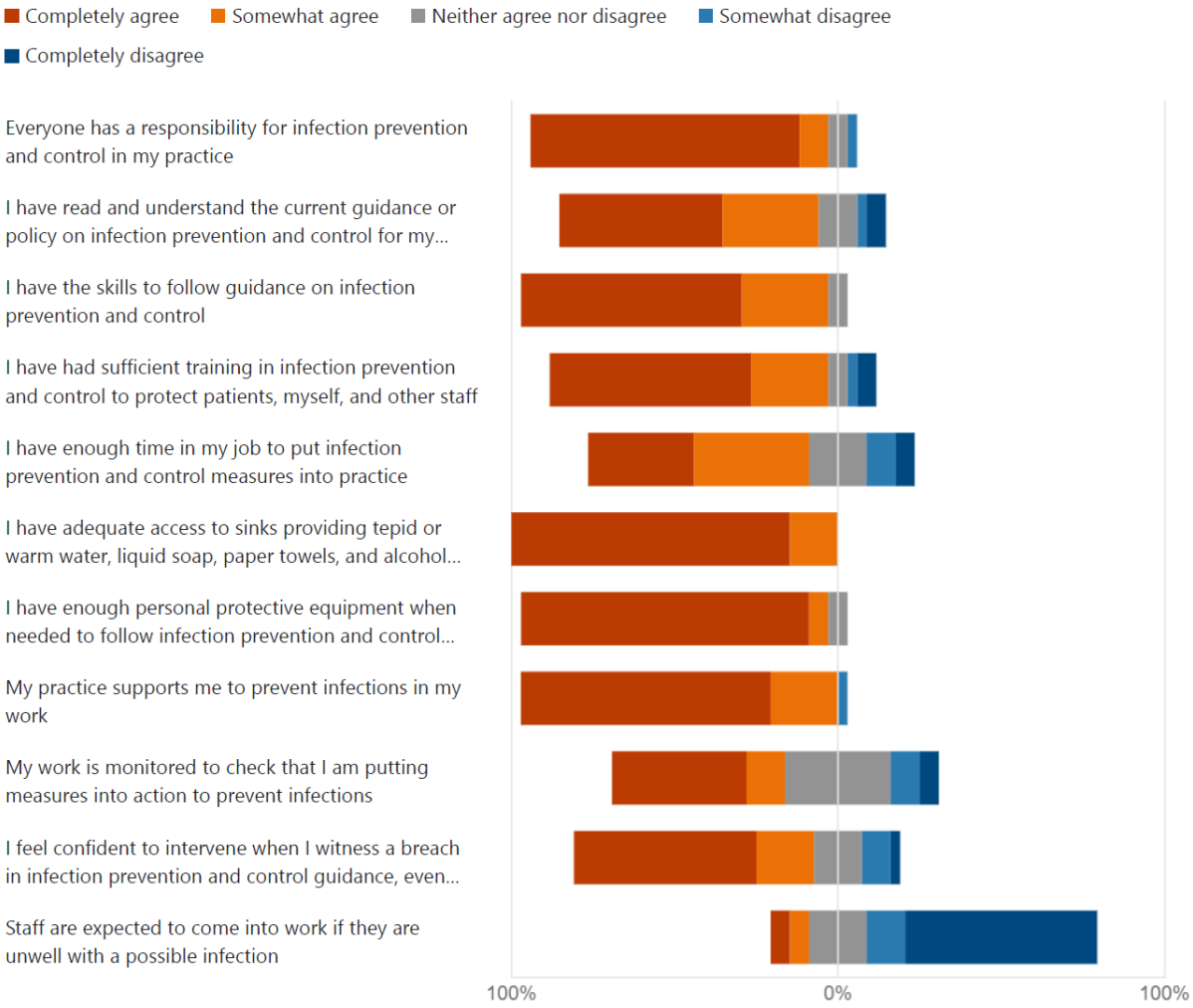


Figure 11. Responses from general practice staff (n=36) about barriers to accessing training

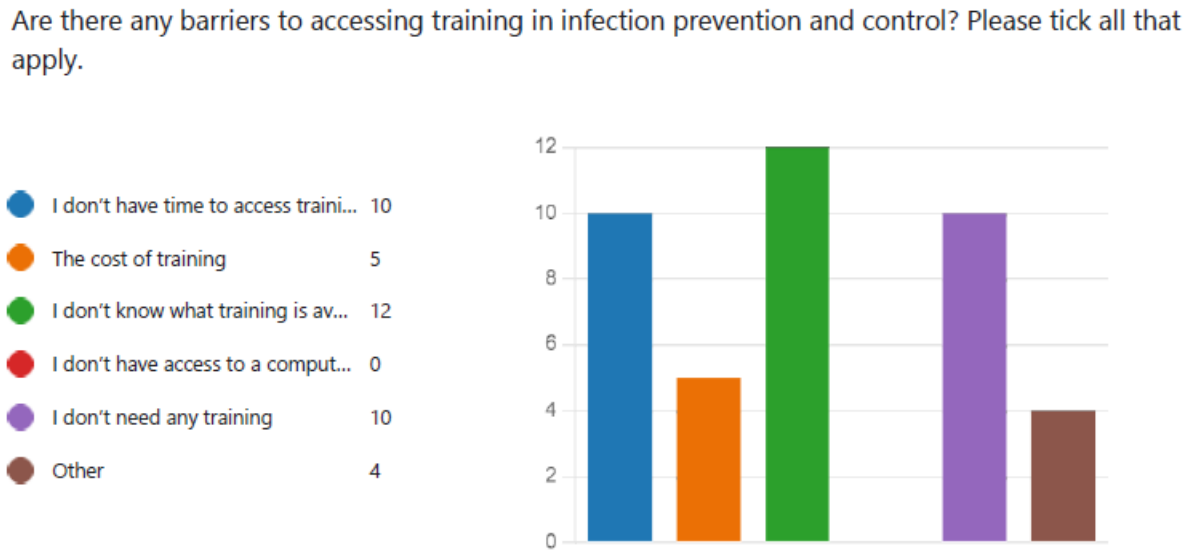
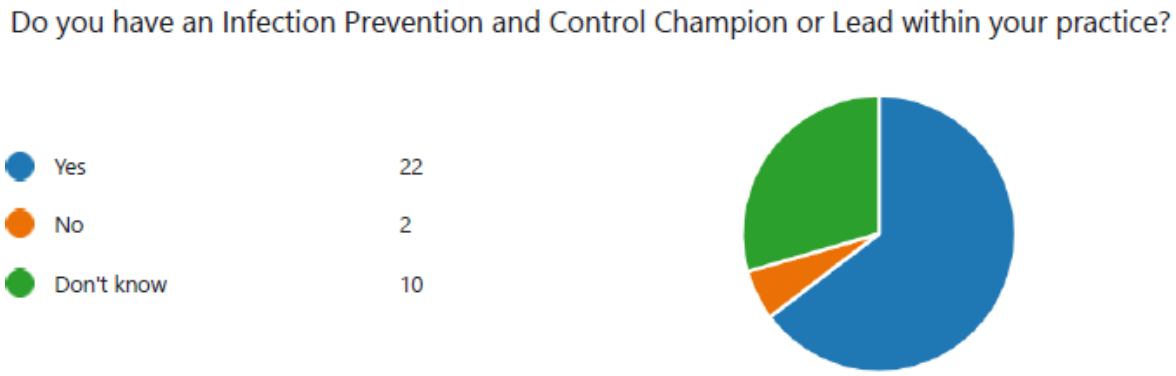


Figure 12. Responses from general practice staff (n=36) about IPC champion or lead



Summary and discussion of survey findings

First, caution is needed in interpreting the findings of some of the surveys owing to the number of responses, and likelihood that people who did not respond are systematically different from those who did respond (non-response bias).[17] With the exception of the survey of staff working in children's residential care, the number of responses was quite low. This was particularly true of general practice and education. Indeed, there were no responses from staff working in early years settings: further work may be needed to gain insights in this sector.

It is also worth recognising that there may also have been factors related to the survey questionnaires themselves that lead respondents to answer falsely or

[17] https://www.sciencedirect.com/topics/nursing-and-health-professions/nonresponse-bias

inaccurately (response biases), for example the tendency to agree with a statement particularly if it is more socially acceptable.

Indeed, many of the responses suggested that respondents were confident in their IPC knowledge, skills and behaviours. Given the common themes that are noted on care home visits or during risk assessments, this may not be the case universally. Despite the high confidence, the survey findings still suggest opportunities for training, increased awareness of guidance, and monitoring of IPC behaviours through audit and other approaches.

Many staff use in-house training for which the quality may or may not be high. Some staff are unaware of training that is available. And for some, cost and time are barriers, particularly in education and general practice.

A worrying number of staff across all sectors feel compelled to come into work even if they are unwell with an infection. The reasons for this may be varied, due to attitudes and values of the organisation, manager, and employee.

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.

Many staff report that they do not contact the local authority if they are concerned about IPC, which is somewhat at odds with perceptions within both local authorities.

Finally, the surveys do not identify the many structural barriers to implementing good IPC measures that were identified during the pandemic, such as inability to recruit and retain staff in social care, use of agency staff, the state of repair of some settings, and the importance of effective leadership.

Previous local survey findings

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 – see Figure 13-15. The number of responses were limited to 50, but this provides an important snapshot of how valued the team was during the pandemic by care home managers and staff.

Free text responses were very positive about the role of the IPC team:

- *“I think that the team have been great with advice and support.”*
- *“The team have always supported us during covid answering questions and advising us on certain things. The training has been delivered to a very high standard and our staff team have learnt and retained information given so as to put it into practice.”*
- *“Keep doing what you are already doing really well!”*

- *"We have had training recently and that has been most effective. It didn't stop us from having an outbreak but these have been small. I have only been at the home for a few months but am very happy with the input that we receive."*
- *"The support has been fantastic."*
- *"I believe that the IPC has been very helpful with all their advice and training especially the Donning and Doffing training. I am mindful that there is always someone to speak to over the telephone if we have any queries or concerns."*
- *"They are a phone call away if needed for advice."*

Figure 13. Satisfaction with IPC team (September 2022)

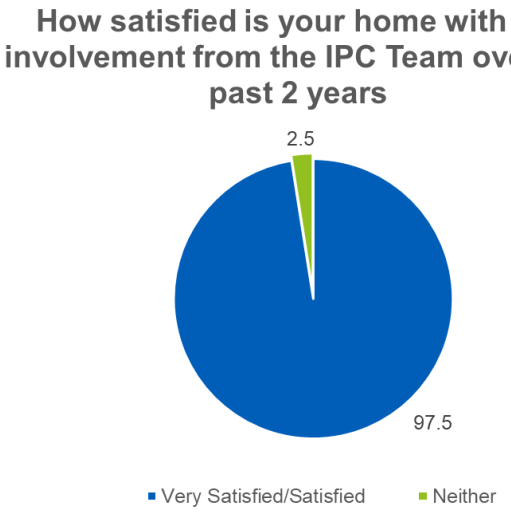


Figure 14. Satisfaction with monthly webinars by the IPC team (n=50; September 2022)

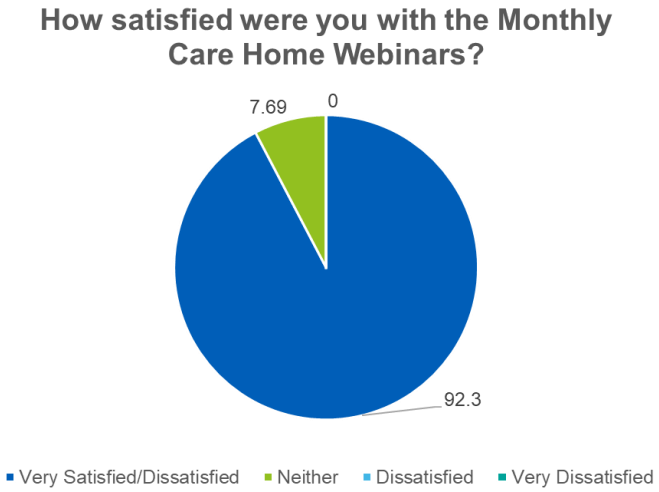
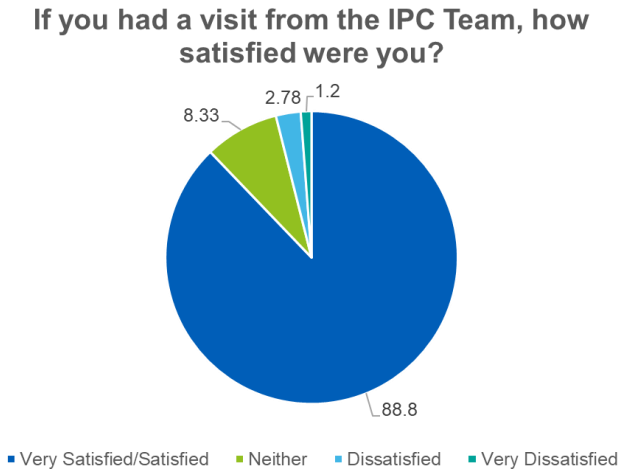


Figure 15. Satisfaction with face-to-face visits by the IPC team



In a separate survey of Northumberland care home managers earlier in the pandemic in November 2020 by the care sector outbreak prevention and control team, they were asked about the training their staff had received. Responses were received from 34 care homes indicating that, for a third of care homes that responded, one third had had in-house training only. Together with other data sources, this survey helped to target offers of support.

Appendix 3 – Stakeholder focus groups and interviews

Stakeholder focus groups or interviews were undertaken with IPC strategy group members, the Northumbria Healthcare IPC team and the Northumberland County Council Adult Social Care Commissioning and Contracts team. At the sessions, the survey findings were shared, and the participants were asked:

- What are your reflections on these findings?
- What aspects of IPC went well during the pandemic?
- What didn't go so well? What gaps were and are there?
- What are or were the barriers and facilitators?
- What difference would an expanded IPC team make, or have made?
- What else should we be doing as a system to increase the effectiveness of IPC measures?

Several key themes emerged from the discussions that are summarised below.

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.

In both surveys and focus groups, many people praised the role of the IPC team particularly during the pandemic, and expressed concern if there were to be any reduction in resource:

> *"I would say that the links with the infection control team were fantastic and I think they've always been strong there, but they really came into their own and I suppose touching on a point about the size of that team, it is a bit worrying if the if they've shrunk a little bit."* [Adult social care commissioning manager, Northumberland]

Relationships between system partners, and with providers, improved during the pandemic because of the good communication, collaboration, and support given:

> *"I think the way we all linked in, you know, IPC team, [Public health] and contracts team, I think that was really beneficial. That was really good…*
>
> *And we have quite a good relationship with the providers, I think that's strengthened throughout the pandemic."* [Adult social care commissioning manager, Northumberland]

There is a need for IPC support and training for staff in early years settings

Several participants identified the challenge but also opportunity in ensuring implementation of effective IPC measures within early years settings, because of the high risk of transmission of infection, the challenges in controlling outbreaks in these settings, and the impact on parents being able to work, and the health of the wider community:

> *"We got very involved with early years settings early in the pandemic... People were attending work sick because they didn't get paid otherwise... We did training for Early Years managers and practitioners that was well received, leading them to change their guidance from work we had done."* [IPC nurse]

The need for sustainable, capacity-building solutions in view of the small size of the IPC team

There was consistent agreement that, whilst face-to-face support by the IPC team was always appreciated and expansion of the IPC team would be preferable, the IPC team would need to prioritise and could not provide training and support to all providers in all sectors. Models that require training and support of IPC champions, professionals who visit the setting or have existing relationships with the setting, were likely to be more sustainable:

> *"I think also [it would be good if] the small number of us that do go out and about [were] to have some additional training as well because we've been the people that have been advising. So I think if CQC are looking at what we do, we need to keep our skills up... So any additional training we can have would be beneficial that we can be passing on the right information basically."* [Adult social care commissioner, Northumberland]

A 'hub and spoke' model was suggested. In particular, upskilling professionals who visit care homes, such as community nurses, frailty nurses, care home nurse practitioners, adult social care commissioning teams, care managers, and safeguarding teams (as well as CQC inspectors), would enable staff to identify good or bad practice, provide immediate advice, and share findings so that additional support can be offered, whether IPC training or wider support for the manager around staffing or environmental issues. This would also reduce duplication, promote greater collaboration, and increase system preparedness for future threats.

Whilst IPC champion approaches were broadly supported, some caution about the challenges for IPC champions in care homes was expressed:

> *"I do wonder how well [having an infection control champion] actually works in in practice. You know, how much challenge there is there from those champions to their colleagues, because I think that's tough. I think that's a really tough thing to do."* [Adult social care commissioning manager, Northumberland]

It was not thought to be feasible to ensure that all educational settings had an IPC champion, and other approaches would be needed. Health and safety teams already have relationships with schools and would be in a good position to support them, particularly if they built links with the IPC teams and received additional support to build on their already considerable knowledge of IPC. Other suggestions were trying to build IPC into the PHSE curriculum.

Appendix 4 – Prioritisation

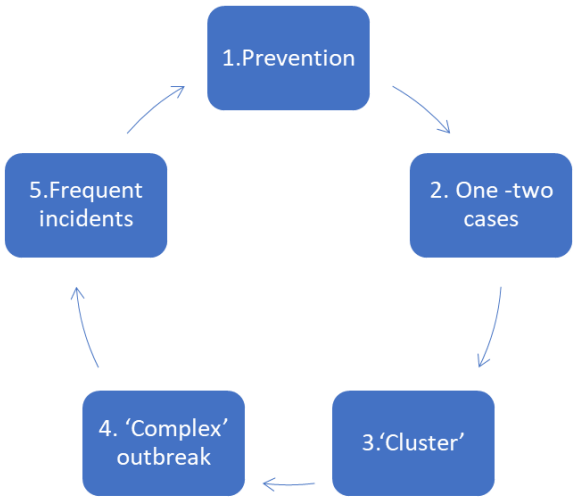
Recognising that the specialist community IPC nurse team is a finite resource of 4.8 whole time equivalent nursing staff, the steering group undertook a prioritisation exercise to explore the balance of resource committed between prevention and control for the specialist resource across and between each type of setting. Settings were split into four:

- Care homes
- Education and early years (including children's residential homes)
- Domiciliary care
- Primary care (general practice)

Phases in the IPC 'cycle' were split as in Figure 1 and steering group members were asked to prioritise each setting and each phase using the following criteria:

- Vulnerability of resident or service user
- Number of settings
- Risk of infection
- Types of infection
- Infection spread
- Wider community impact
- Frequency and complexity of outbreaks

Figure 1. Suggested phases in the IPC cycle to inform prioritisation

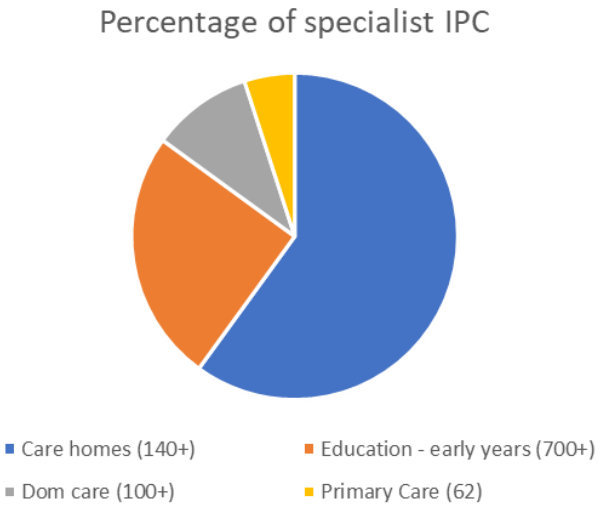


After a discussion the group agreed the focus between types of setting for the specialist IPC team as in Table 1 and Figure 2.

Table 1. Prioritisation of specialist IPC resource by setting

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

Figure 2. Prioritisation of specialist IPC resource by setting



After further discussion, the balance of time spent on each phase was agreed for each type of setting as in Table 2.

Table 2. Distribution of specialist IPC resource by phase for each setting

		Percentage of specialist resource			
Phase	Name	Care homes	Education	Domiciliary care	Primary care
1	Prevention	35	50	80	80
2	1-2 cases	5	10	0	5
3	Cluster	25	15	5	5
4	Outbreak	20	20	5	5
5	Frequent incidents	15	5	10	5
	Total	100	100	100	100

This was then translated into days per month for each setting based on 4.8 WTE IPC nurses as shown in Table 3.

Table 3. Days per month of focus for specialist IPC resource by setting and phase

		Days per month of specialist IPC resource (4.8 WTE)			
Phase	Name	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 like 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.