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INFECTION PREVENTION AND CONTROL REPORT: JULY – OCTOBER 2019

Presented by	Karen Dawber, Chief Nurse/Director Infection Prevention & Control	
Author	Claire Chadwick, Nurse Consultant/Assistant Director Infection Prevention and Control	
Lead Director	Karen Dawber, Chief Nurse/Director Infection Prevention & Control	
Purpose of the paper	This report summarises progress against the infection prevention and control work plan for 2019/20 and sets out the Trust's infection control activities and performance between July and October 2019. This is the Q2 report for 2019/20 and provides the second of 4 reports which comprises the annual report. To provide assurance on compliance with: • NHS Outcomes Framework– domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm. • Health & Social Care Act 2008: Code of Practice for the NHS on the prevention and control of healthcare associated infections and related guidance (commonly known as The Hygiene Code).	
Key control	This paper is a key control for the Board Assurance Framework	
Action required	For approval	
Previously discussed at/ informed by	Infection Prevention and Control Committee	
Previously approved at:	**Committee/Group**	**Date**
	Infection Prevention and Control Committee	14.11.19
	Quality Committee	18.12.19

Key Options, Issues and Risks

This is the quarterly infection prevention and control report which is required by the Quality Committee to demonstrate progress against the annual infection prevention programme and in achieving compliance with:

- The Health and Social Care Act (H&SCA) 2008: Code of Practice for the NHS on the prevention and control of healthcare associated infections and related guidance.
- Regulation 12(2) (h) and 21(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This is the Quarter (Q) 2 report for 2019/20 and provides the second of four reports which comprises the annual report.

Analysis

The report presents assurances for progress against the annual infection prevention work programme. The report also highlights and provides an escalation summary of key risks in systems and processes which impact on the prevention of healthcare associated infections.

Recommendation

The report provides assurance to the Quality Committee by monitoring the activity of infection prevention and control annual work programme and is requested to confirm the actions arising from the recommendations identified are appropriate.

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The Committee is asked to note the changes to the objectives for Clostridium difficile for 2019/20, the increase in reported cases and confirm that assurance is provided in relation to the controls in place.

The Committee is requested to consider the risks described in relation to the incidents of flies identified in Modular theatres and subsequent mitigation work programme to remove the pigeon infestation from the roof of the building. The committee is also requested to consider the gaps in compliance with waste regulations and the actions to improve compliance going forward. The Committee is requested to approve the further actions and mitigations as detailed in the main report.

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

Benchmarking implications (see section 4 for details)	**Yes**	**No**	**N/A**
Is there Model Hospital data relevant to the content of this paper?	☒	☐	☐
Is there any other national benchmarking data relevant to the content of this paper?	☒	☐	☐
Is the Trust an outlier (positive or negative) for any benchmarking data relevant to the content of this paper?	☒	☐	☐

Risk Implications (see section 5 for details)	**Yes**	**No**
Corporate Risk register and/or Board Assurance Framework Amendments	☒	☐
Quality implications	☒	☐
Resource implications	☒	☐
Legal/regulatory implications	☐	☒
Diversity and Inclusion implications	☐	☒
Performance Implications	☒	☐

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Regulation, Legislation and Compliance relevance
NHS Improvement: (please tick those that are relevant) ☐Risk Assessment Framework ☒Quality Governance Framework ☐Code of Governance ☒Annual Reporting Manual
Care Quality Commission Domain: Safe
Care Quality Commission Fundamental Standard: Safety (Regulation12(2)(h) and 21(b) of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014
NHS Improvement Effective Use of Resources: Clinical Services
Other (please state): NICE [QS61] Infection prevention and control

Relevance to other Board of Director's Committee: (please select all that apply)					
Workforce	Quality	Finance & Performance	Partnerships	Major Projects	Other (please state)
☐	☒	☒	☐	☒	☐

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INFECTION PREVENTION AND CONTROL REPORT: JULY- OCTOBER 2019

1 PURPOSE/ AIM

1.1 The purpose of this report is to demonstrate progress against the annual infection prevention programme and in achieving compliance with national standards and performance indicators. The report provides assurance by monitoring the activity of infection prevention and control and identified key issues are noted. The Committee is asked to note the report in relation to:

- Corporate objectives: strategic objective 1 - To provide outstanding care for our patients.
- NHS Outcomes Framework – domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm.
- Health & Social Care Act 2008: Code of Practice for the NHS on the prevention and control of healthcare associated infections and related guidance.
- NICE [QS61] Infection prevention and control.

2 BACKGROUND/CONTEXT

2.1 Section 21 of the Health and Social Care Act (H&SCA) 2008 contains statutory guidance about compliance with the registration requirement relating to infection prevention (regulation 12(2) (h) and 21(b) (Regulated Activities) Regulations 2014. It should also be noted that Regulation 15 is also relevant.

2.2 CQCs guidance about compliance with the above regulations includes a reference to the 'premises and equipment' regulation (regulation 15) as CQC considers this code to be relevant for the purposes of meeting that regulation.

2.3 The 'Code of Practice' on the prevention of infections under The Health and Social Care Act 2008 sets out the 10 criteria. Criterion 1 requires that systems to manage and monitor the prevention and control of infection and require the Director of Infection Prevention and Control (DIPC) to provide oversight and assurance on infection prevention (including cleanliness) directly to the Trust Board and produce an annual report. This report therefore provides assurance to meet the requirements set out above.

3 PROPOSAL

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

3.2 This is the Q2 report for 2019/20 and provides the second of 4 reports which comprises the annual report.

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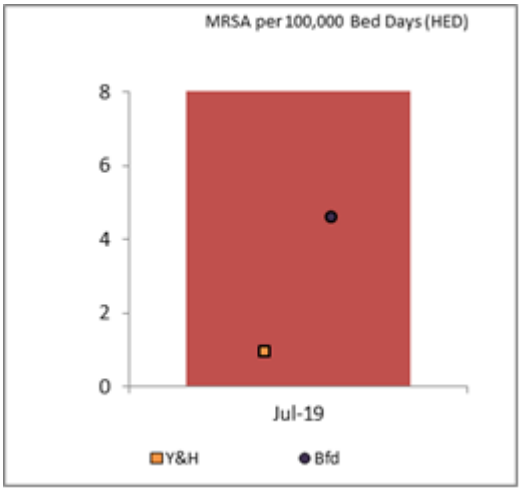
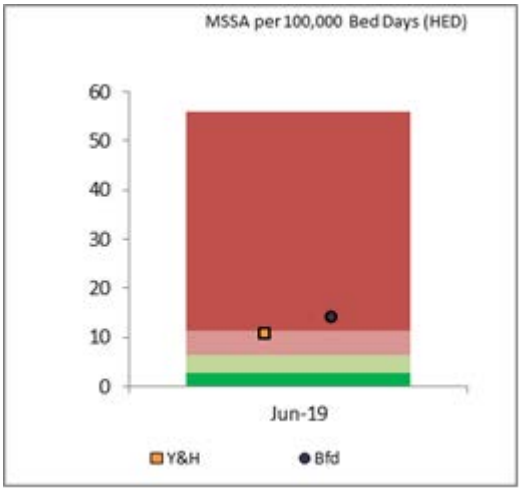
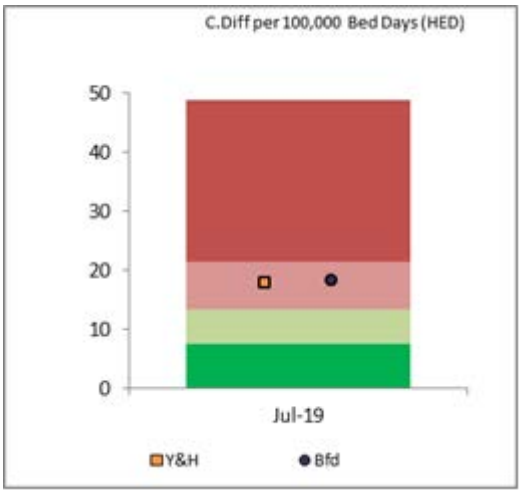
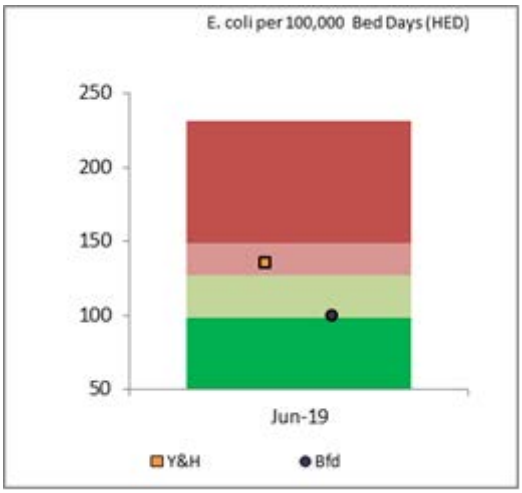
4 BENCHMARKING IMPLICATIONS

The latest information available on the Healthcare Evaluation DATA (HED) in relation to infection rates is included in the section below. It shows the Trusts position in relation to MRSA and MSSA bacteraemia, Clostridium difficile and E. coli, in relation to the national distribution for each of these infections as at July 2019. The data highlights that BTHFT Is above peers' median infection rate for MRSA and MSSA, however is equal to or below peers' median for CDI and E.coli healthcare acquired infections. Model Hospital data was not included as the data is not up to date.









5 RISK ASSESSMENT

5.1 The paper provides assurance for compliance with:

- Corporate objectives: strategic objective 1 - To provide outstanding care for our patients.
- NHS Outcomes Framework – domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm.
- Health & Social Care Act 2008: Code of Practice for the prevention and control of healthcare associated infections and related guidance.
- NICE [QS61] Infection prevention and control.

5.2 Gaps in compliance during July- October 2019 that have been identified are highlighted below and within the main report (Appendix 1).

5.3 There is a reported increase in Trust apportioned CDI cases since April 2019; this reflects the changes to the definitions for Trust apportioned case as detailed in the main report. Key themes from post infection reviews are outlined and controls are described to mitigate the increase in cases.

5.4 Risks associated with the ingress of pigeons into the roof space of the modular theatre building were identified and mitigating actions taken to remove the infestation. Further work is required to survey other buildings for areas where pigeons can enter roof spaces across the Trust.

5.5 Gaps in compliance with waste regulations have been noted as part of the pre-acceptance annual audit process. A programme of work has been implemented with the recruitment of a Waste Manager, to develop a system for implementation of an offensive waste stream.

6 RECOMMENDATIONS

6.1 The report provides assurance to the Quality Committee by monitoring the activity of infection prevention and control annual work programme and is requested to confirm the actions arising from the recommendations identified are appropriate.

6.2 The Committee is asked to note the changes to the objectives for Clostridium difficile for 2019/20, the increase in reported cases and confirm that assurance is provided in relation to the controls in place.

6.3 The Committee is requested to consider the risks described in relation to the incidents of flies identified in Modular theatres and subsequent mitigation work programme to remove the pigeon infestation from the roof of the building.

6.4 The committee is also requested to consider the gaps in compliance with waste regulations and the actions to improve compliance going forward. The Committee is requested to approve the further actions and mitigations as detailed in the main report.

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7	Appendices

Appendix 1: Infection Prevention and Control: Main Report

1. Introduction

1.1 The following report demonstrates progress against the annual infection prevention programme and in achieving compliance with national standards and performance indicators. The report provides assurance by monitoring the activity of infection prevention and control and identified key issues are noted. The Committee is asked to note the report in relation to compliance with corporate objectives; the Health & Social Care Act 2008: Code of Practice for the NHS on the prevention and control of healthcare associated infections and related guidance (commonly known as The Hygiene Code).

2. Strategic Context

2.1 To provide assurance on compliance with:

- NHS Outcomes Framework – domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm.
- Health & Social Care Act 2008: Code of Practice for the NHS on the prevention and control of healthcare associated infections and related guidance (commonly known as The Hygiene Code).
- NICE guidance.

2.2 This report summarises progress against the work plan for 2019/20 and sets out the Trust's infection control activities and performance. This is the Q2 report for 2019/20 and provides the second of 4 reports which comprises the annual report.

2.3 The infection prevention programme of work continues to be delivered. The progress is monitored through the Infection Prevention and Control Committee (IPCC), which meets 6 times a year and has been chaired by the Assistant Director Infection Prevention & Control. Reports are submitted at each committee on progress against the annual plan and key performance objectives.

3. Objectives for reduction of HCAIs.

3.1 The objectives for reduction for *Clostridium difficile* infections (CDI) cases for 2019/20 have been reclassified and have been reduced from 2018/19 objective as 50 cases to 30 cases. The objective for MRSA bacteraemia remains as zero tolerance.

3.2 **MRSA bacteraemia:**

- The Trust has investigated 7 cases and following post infection review (PIR) investigation, reported a second attributed MRSA bacteraemia case on 15.10.19.

- Following the post infection review (PIR), a summary of the root cause and lesson learnt reported a 43 year old Lady admitted on 9.10.19 with painful, swollen right foot and abdominal pain and some diarrhoea. The Lady had a past medical history of arthritis Rt. foot (DNA appointment with orthopaedics), necrotising fasciitis, IVDU (bilateral groin sinus), septic arthritis and know blood borne virus.

- This lady had several investigations during inpatient stay on ward 9 which identified both renal and splenic infarcts. IV antibiotics were prescribed and administered intermittently due to severe difficulty in cannulation. The sepsis alert did not identify sepsis on admission, however inflammatory markers (WCC and CRP) were raised and continued to increase over next 4 days.

- The Lady was transferred to ward 9 from ward 1 and a PICC line was inserted due to poor IV access. However, the patient was absent from ward on a number of evening episodes and subsequently returned to ward drowsy, slurred speech and incontinent.

- On the 15.10.19, the Lady was reported with pyrexia of 40 degrees C; blood cultures were taken and IV antibiotics reviewed by a Microbiologist. The Lady's condition deteriorated and repeat CT abdomen reported further splenic infarct, new liver infarct, pleural effusion and pericardial effusion; CT Head reported Rt ischaemic infarct (stroke confirmed clinically) and cardiac echo confirmed aortic endocarditis. The Lady was transferred to cardiothoracic team at LTHT.

- In conclusion the MRSA bacteraemia was associated with endocarditis, splenic, renal and cerebral infarcts. Poor IV access and possible misuse of the PICC line by the patient may have been contributory factors. No lapses in care were identified, however a multidisciplinary review of the case highlighted the importance of careful discussion with patients receiving a PICC or central access IV line, who may be non-compliant and at risk of personal misuse.

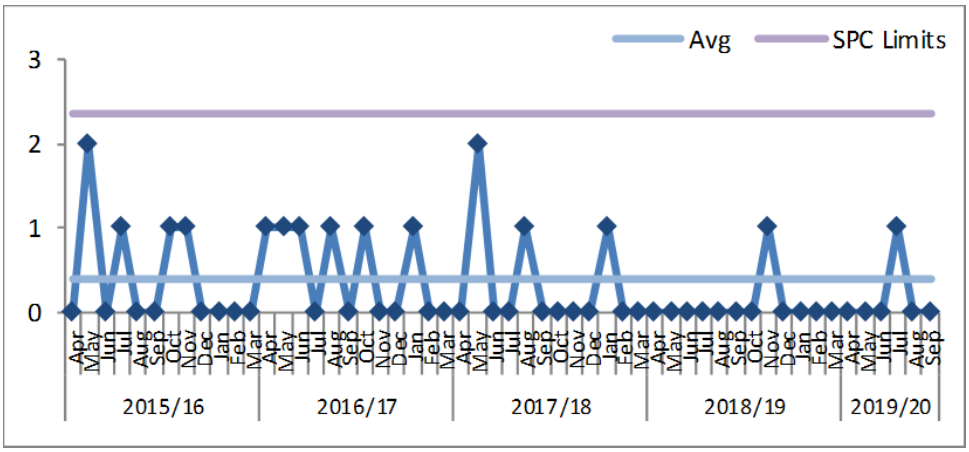

Figure 1

3.3 MSSA Bacteraemia

The Trust has reported 7 hospital attributed (>48hr) MSSA blood stream infections for July-October. This compares to 17 cases reported for the same period in 2019/19. Figure 2 statistical process (SPC) chart showing Trust allocated cases from April 2015 to present.

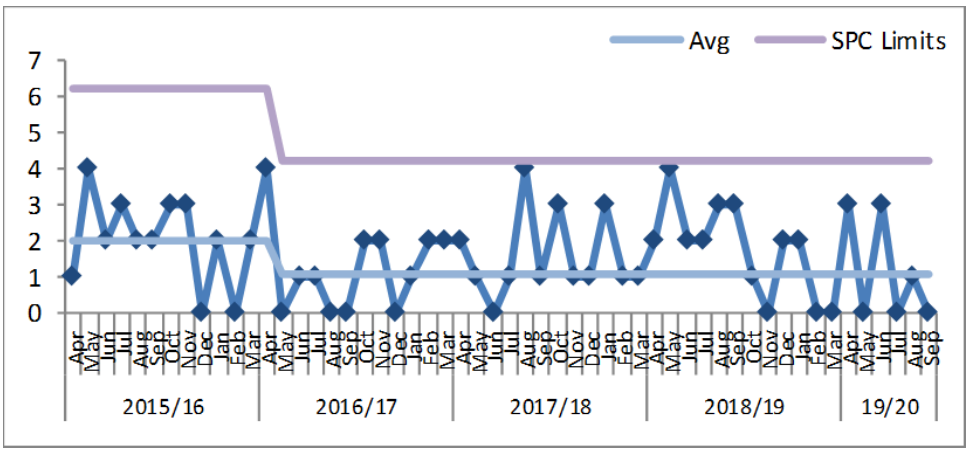

Figure 2

3.3.1 Enhanced Surveillance of MSSA bacteraemia cases

Enhanced surveillance is completed for MSSA >48hr cases and potential lapses of care are reported through the clinical incident reporting system. A review of the enhanced surveillance has highlighted a significant proportion are associated with skin and soft tissue infection from leg ulcers and IV drug users' related abscess.

3.3.2 Actions to support reduction of MRSA and MSSA Bacteraemia:

As part of the 2019/20 infection prevention work plan, Aseptic Non-Touch Technique competency assessment programme for the care of invasive devices is in progress.

3.4 *Clostridium difficile* infection

- There have been 22 cases of C difficile infection attributed to the Trust for Apr – October 2019/20 compared to 13 cases reported for the same period in 2018/19 and against an annual trajectory of 30. These cases have been assigned under the categories as listed below:
    - **15 cases of Hospital onset healthcare associated (HOHA)**
    - **7 cases of Community onset health care associated (COHCA)**

- The SPC chart (figure 3) below identifies the number of Trust attributed CDI cases. An increase in Trust attributed cases has been reported since April 2019; the rationale for this increase, key themes following a review of the cases and controls in place to support prevention of further cases is described below.

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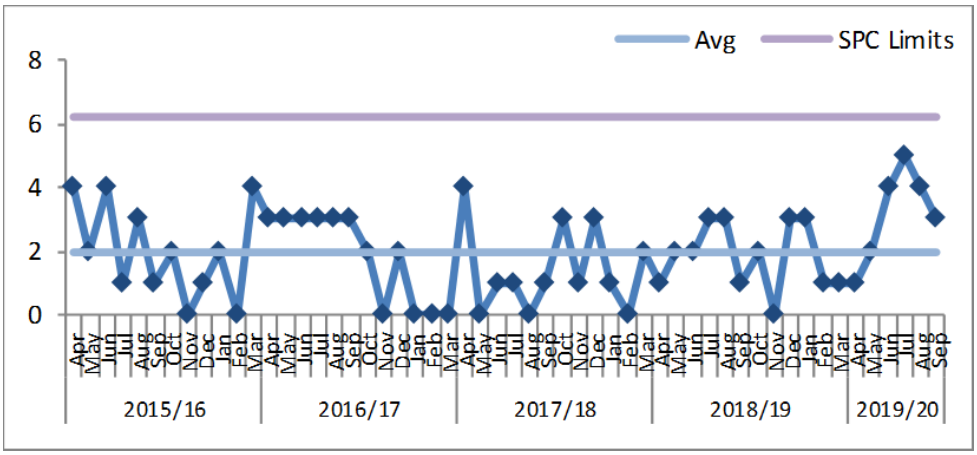

Figure 3

3.4.1 Post-infection Review (PIR) of C difficile cases

The PIRs are presented at monthly Planned Care and Unplanned care IPC sub-group meetings and action plans to correct any lapses of care are approved and monitored for completion through these meetings, with final assurance provided by the Assistant Directors of Nursing reports to the Trust IPCC. A review of the Trust attributed cases for 2019/20 following PIR investigation has highlighted the following key themes:

- Failure to isolate in a timely manner.
- 3 cases identified a delay in stool sample being sent – would have most likely been a community associated case if sampling was timely.
- 3 cases identified issues relating to antibiotic prescribing – (1) prolonged course of antibiotic (2) The absence of review of penicillin allergy to ensure this is a true allergic status is directing prescribing to alternative antibiotics which cause a greater risk of CDI. These cases have been discussed with Microbiology colleagues and the clinician responsible for prescribing.
- The increase in cases seen in July, August and September may possibly be associated with the industrial action and the reduction in cleaning frequencies. C.difficile spores can survive in the environment for months and are removed by robust cleaning and decontamination processes. Although this association cannot be directly linked, it is important to include as a contributory factor.

3.4.2 *Clostridium difficile* infection objectives for NHS organisations in 2019/20

- The Trust objective for 2019/20 is 30 cases (reduced from 50) and the CDI reporting algorithm has had significant changes for Trust apportioned cases:
  - Reducing the number of days to apportion hospital associated cases from three (post 72hr) to two (post 48hrs) days following admission.
- In addition, there are new criteria for how hospital associated CDI cases are assigned using two categories:
  - **Hospital onset healthcare associated (HOHA)**: cases that are detected in the hospital three or more days after admission.

- **Community onset healthcare associated (COHA)**: cases that occur in the community (or within two days of admission) when the patient has been an inpatient in the previous four weeks.

- Figure 4 highlights the increase in total Trust apportioned cases, with a breakdown of cases as per the new algorithm and compared with 2018/19.

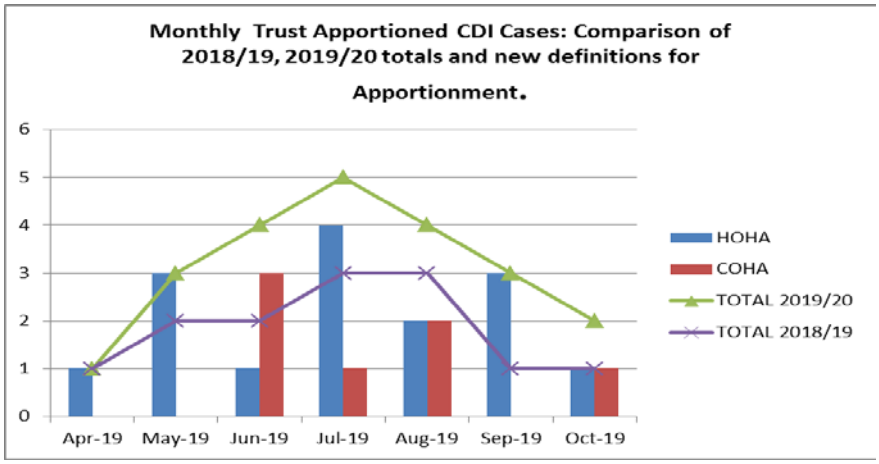

Figure 4

3.4.3 Actions to Support CDI Improvement

- IPC Nurse Specialists assurance visits will focus on patients with *C difficile* and compliance with completion of the Bristol Stool Chart on EPR and isolation precautions.
- Focus of environmental cleaning and decontamination to ensure that CDI cases (either colonised or infected) to ensure enhanced cleaning and appropriate decontamination (i.e. HPV fogging) is in place.
- The Consultant Microbiologist and Antibiotic Pharmacist are undertaking ward antibiotic stewardship visits and supporting the post infection review of CDI cases with the Medical team.
- The IP Team are collaborating with the Joint Venture Microbiology laboratory to introduce C difficile toxin gene testing. This will aid faster recognition for patients who may develop C difficile infection and therefore support timely treatment and isolation precautions.

3.5 Gram-negative Blood Stream Infections (BSI)

- The Department of Health launched objectives to halve E.Coli blood stream infections by 2024.
- The Trust has reported 23 >48hr E.Coli blood stream infections (BSI) attributed to the Trust to 31.10.19.
- Figure 5 SPC chart highlights the Trust attributed E Coli BSI cases per month. There was an increase in cases reported during Q1 which replicates a similar increase seen in 2018/19. This reflects the national picture of seasonal variation associated with warmer weather.

- The 23 cases to date relate to neutropenic sepsis and urinary tract infection with associated contributory factors of urinary catheter, central lines/PICC lines and significant multiple complex co-morbidities.

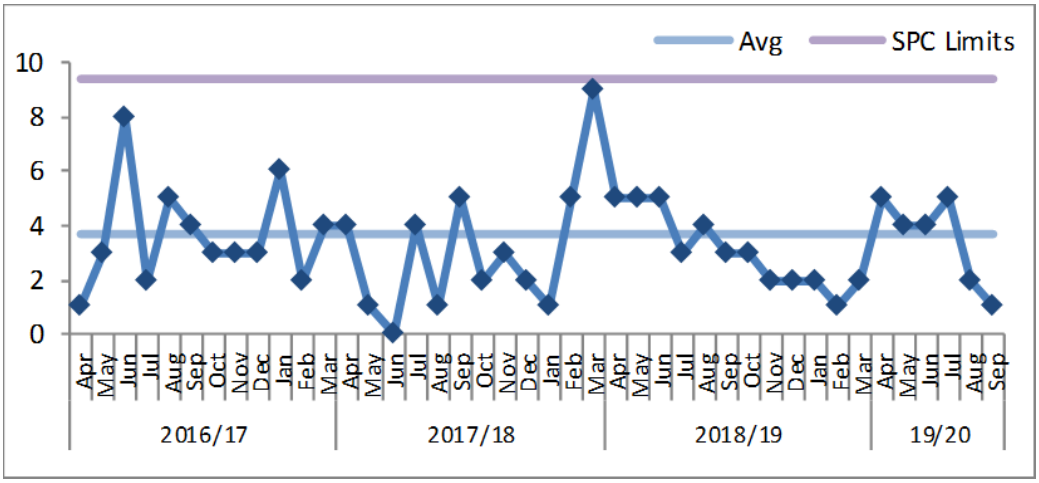

Figure 5

3.5.1 Gram Negative Quality Improvement Programme

- The E Coli improvement strategy supports the collaborative work programme for the Infection Prevention Teams at Bradford Council and Bradford Teaching Hospitals NHS Foundation Trust, who will support the CCGs to develop action, plans to reduce E. coli BSI.
- The IPC quality improvement programme, as part of the annual work plan, included promoting hydration to prevent urinary tract infections. The aims and objectives through a small test of change are:
  - To deliver a hydration education and training programme to nominated *'Hydration Champions'* on designated wards, (Ward 29, Elderly Medicine, West Bourne Green, Ward F5&6 at SLH) including structured drinks rounds.
  - To recognise patients who are at risk of poor oral fluid intake and to monitor and encourage oral fluid intake and identify patient's individual choices and preferences for drinks.
  - This programme is currently in its evaluation stage with the test ward nursing teams and a QI pack and training will be developed during 2019/20 to roll out to all elderly medicine wards.
- As part of the deteriorating patient collaborative, a new quality improvement project is in development to improve the diagnosis of urinary tract infections (UTI) without the reliance on dipstick urinalysis, which is nationally not recommended for patients over the age of 65 years.

3.6 Carbapenemase-producing Enterobacteriaceae (CPE)

3.6.1 Figure 6 highlights the number of newly reported CPE cases identified on or during admission to BTHFT since April 2014. An increase in sporadic cases was identified in

September related primarily to foreign travel and 2 members of a family. This is becoming an increasing risk.

3.6.2 Active screening for CPE on admission to ICU and admission for emergency acute gastrointestinal surgery has been agreed as part of the outbreak lessons learnt as these specialities were identified as at risk of CPE.

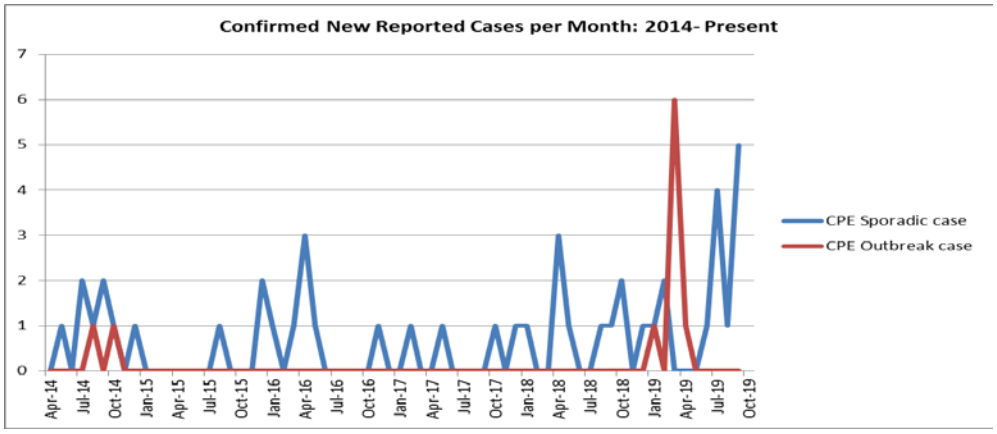

Figure 6

4. Outbreaks, Incidents and Bay/Ward closures

4.1 **Ward F5 SLH – ward Restriction due to Diarrhoea and Vomiting.**

- Ward F5 has reported cases of sudden onset vomiting and diarrhoea on 5.11.19 and this has affected 19 patients a 3 staff to date (10.11.19). Figure 7 below highlights the epidemiology curve for the outbreak. Norovirus has been confirmed as the causative organism.
- The IPN team regularly liaise with the Clinical Site Team to prioritise side rooms and any ward bay or full ward restrictions are communicated twice a day.

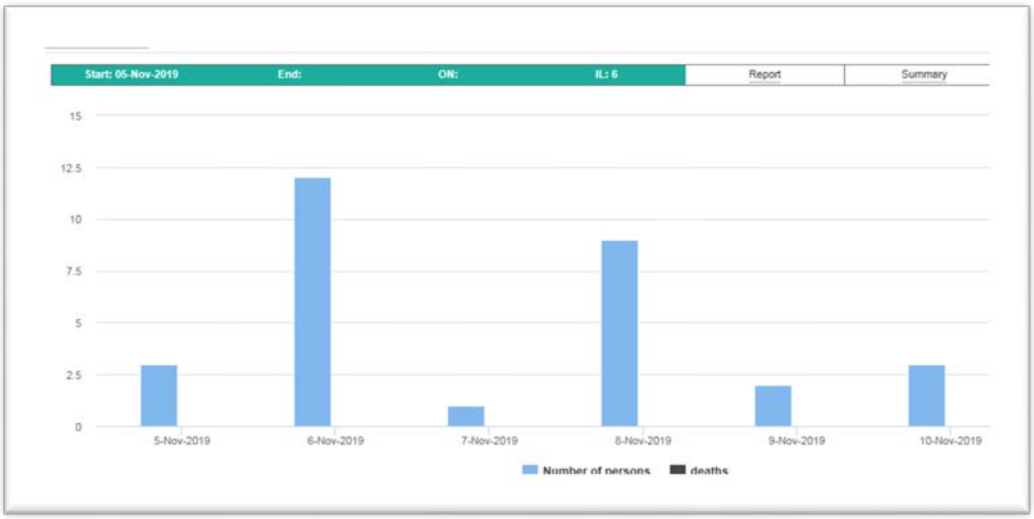

Figure 7

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4.2 **Bordetella Pertussis Confirmed on the Paediatric Ward**

- The Paediatric team reported a case of Pertussis (whooping cough) which is a reportable infection to Public Health England.
- The case was an eight week baby with history of dry cough for the previous 3 weeks prior to admission, corresponding shortness of breath, cyanosis and chest recession. The baby was admitted to a side room and on 26/10/2019 swabs were sent for virology and chest x-ray performed revealing consolidation inferior to the left helium behind the heart.
- The patient was prescribed Azithromycin for three days as prophylaxis for suspicion of Pertussis. On 28/10/2019, Bordetella pertussis was confirmed on virology swab and the case was notified to PHE as it's a notifiable disease.

4.2.1 **Staff contacts:**

- 18 staff contacts were identified by the ward manager as having significant exposure.
- 15/18 staff reported that they did not have significant exposure as per PHE guidelines so they were discharged by the Occupational Health Department.
- 3/18 reported significant exposure as per PHE guidelines and commenced chemoprophylaxis and Boostrix vaccine.
- All staff involved have been informed of the signs and symptoms and actions required if they became unwell with possible Bordetella pertussis.

4.2.2 **Learning points:**

- Staff had not routinely worn appropriate PPE when in close contact with patients suspected/confirmed with droplet infection. Therefore education sessions will be provided for Paediatric staff which will focus on droplet infections and required PPE to manage such patients.

4.3 **Potential Contamination of Modular Theatres**

- A concern was raised by the theatre staff to the IPC Team in relation to large flies seen in modular theatres during October.
- The potential causes of this were discussed with the Estates team and the ventilation system was checked for any ingress of vermin etc. and was found to be clean and intact.
- Pigeons were observed as congregating and nesting in the soffits/gutters between the cladding and panelling on the roof(s) of Modular block and Estates have identified multiple carcasses and an abundance of faeces/guano.
- This has been identified as the potential cause of flies being identified in theatres in the modular block. Although this is not conclusive, this is the most likely cause.
- As yet – a point of entry for flies from the gutter down into the building has not been identified despite extensive checks; they are not thought to be coming through ventilation system and are not thought to be throughout the fabric of the building – this would be consistent with the small number of flies that have been seen in theatres.
- Modular theatres 1-6 were been suspended whilst urgent estates and pest control mitigation took place.

- A working group from operations, theatres, IPC and nursing met daily to manage situation and action plan.
- Pest control treatment is taking into account the proximity of wards 26, 27, 28 and 33. IPC team ensured widows were kept closed during the outside cleaning programme.

4.3.1 **Mitigating Actions**

- Estates department undertook 6 stage plan to deal with the congregating pigeons in the Modular block. The works required by the Estates team to resolve the issue was as follows:
  - Expose and clean all areas accessible without scaffolding.
  - Erect scaffold to inaccessible areas of the roof in 3 stages. Removal of facia cladding to expose voids for cleaning.
  - Pest Control Contractors clear and disinfect exposed voids.
  - Spray of pesticide to eliminate any remaining fly eggs/larvae.
  - External estate maintenance of guttering and insertion of void barriers, refix panels and covers.
- Facilities and Infection Control carried out a 3 stage cleaning and assurance process as follows:
  - Facilities team completed a thorough deep clean of all Modular theatres, anaesthetic rooms and PACU areas.
  - External contractor completed UV light disinfection of all areas listed above.
  - Micro-Biological air testing completed in all theatre blocks and reported within National recommended standards.
- Modular theatres were reopened and further survey work for other buildings is in progress by the Estates Team to ensure pigeon infestation can be removed.

5. Waste Pre-Acceptance Audit Summary

- The Environmental Permitting (England and Wales) Regulations require that all clinical wastes generated by the Trust must be subject to a pre-acceptance audit prior to collection via an approved contractor. Failing to comply can result in the approved contractor being unable to collect the Trusts clinical waste.

- Every August the Trust conducts the Pre Acceptance Audit of the following buildings:
  - Bradford Royal Infirmary
  - St Luke's Hospital
  - Westbourne Green
  - Westwood Park DTC & Ward
  - Skipton Hospital

- The 2019 audit was conducted and the audit results are presented to the Trust Waste Producers Group for approval and action. Each ward or department receive a specific action plan within the pre acceptance audit which is shared with the relevant Matron responsible for that area to complete and sign off.

- The Trust has increased compliance levels in line with the HTM segregation system however significant challenges to its implementation still remain. In order to address some

of the issues; the Trust has recently appointed a Waste Manager. This appointment will support plans to develop the waste management policy.

5.1 Key Findings

The key findings from the audit are as follows:

- The Trust has extended the implementation of Tiger waste across its sites however progress is still needed.
- The Trust has been in emergency measures for clinical waste since October last year and has been focussed on maintaining a control on this in the last year
- St Luke's Hospital (SLH) has improved since last year's audit although challenges remain in managing the compounds and transfer of waste between sites.
- Internal and external segregation and compound management in particular need to be reviewed at Bradford Royal Infirmary (BRI) to raise standards.
- Yellow bag waste has reduced significantly since last year's audit.
- Orange bag use has improved however non-infectious waste and domestic waste are still observed.
- Medicine waste segregation has improved significantly and anatomical waste procedures have improved with waste now been stored in chilled storage. Challenges remain in transfer of waste from Maternity at BRI to the chilled storage areas.
- Cytostatic waste is still not well understood in some areas of the Trust.
- The Maternity wing has improved internal storage and orange bags are now segregated into rigid bins. No solution has been reached however to decanting these into larger bins for transfer to the compound.

Key findings will be monitored by the Waste Producers Group and an improvement action plan will be monitors through the IPCC. These include:

- The Waste Compliance Manager will undertake audits to each department with a plan to work with ward/ department managers to review the recommendations, and agree action plans for the improvement of waste segregation across all areas.
- 70% of pre-acceptance ward audits have been emailed directly to Matrons, with a plan to send the remaining by the end of November 2019.
- Meetings have taken place with 9 Matrons to date and Actions and have been agreed with 16 wards.
- Ward Audits have been completed for Wards 2, 17, 18, 20 & 21, which were not audited within the pre-acceptance audit.

Key generic actions from the audit review meetings agreed to date are:

- Communicate the new waste poster to teams.
- Ensure sharps and bio bins are signed once opened and signed and locked when closed.
- Reduce packaging waste in blue Medicine Bio bins.
- Make changes to bin locations to reduce contamination across Orange, Tiger and General bags.

- Members of the team to attend Clinical Waste Awareness sessions or arrange with Waste Compliance Mgr. a more bespoke training session on the ward.
- Improve bin labelling (staff and patients).

5.2 Offensive Waste (Tiger bags)

- One of the key actions noted previously for the majority of areas, with the exception of SLH and maternity, was the introduction of offensive waste; therefore plans have been developed during the review of each area.

- Offensive waste, also known as tiger waste is non-infectious waste, which is contaminated with no known or suspected infection, such as swabs, dressings nappies or incontinence waste. Offensive waste can be safely disposed of in deep landfill, or through energy for waste plant.

- In addition to assessing each area, there also needs to be an assessment of the waste rooms to ensure that the Facilities are in place to remove the waste from the ward/ department.

- The plan that has been produced will ensure that BTHFT has this waste stream fully implemented by June 2020, prior to the next pre-acceptance audit.

6. Environmental Cleaning Report

The Cleaning and Patient Environment Group meetings report to the IPCC and a summary of the meeting reports is highlighted below.

- Cleaning audits are undertaken by the Facilities Team as per recommended frequencies in the National Cleaning Standards.

- Spot check audits were undertaken with the Infection Control Lead Nurse and Cleaning Services Manager for Wards 30, 32 and ACU. Ward 30, 32 reported issues including high/low dust; shower curtains- all to be changed, stains on bathroom floor and dusty ceiling vents. ACU visit identified an issue with high and low dusty throughout. All issues were rectified.

- Efficacy checks were completed on NICU, ICU Ward 28 in September, and NICU, ICU and Ward 7 in October. Only minor issues were identified and have been corrected.

- Facilities Team regular hand hygiene audits have been undertaken at BRI, with 95% compliance noted. A dress code audit undertaken at BRI reported 99.4% compliance on the 13th September. A plan is in place to ensure all audits are undertaken at SLH.

6.1 **Cleaning Innovation and Improvement Programme**

- UV light decontamination had been utilised in Modular Theatres following works. This is evaluating well during previous trials and recent usage as the time for decontamination is significantly reduced compared to HPV fogging.

- Steam Cleaning has been introduced to allow enhanced deep cleaning in Corridors and Public Toilets/areas.

- Toilet brush change programme is now in place.

- National Standards of Cleaning have been recently revised by NHSI and are currently under consultation.

7. Report Recommendations

7.1 The report provides assurance to the Quality Committee by monitoring the activity of infection prevention and control annual work programme and is requested to confirm the actions arising from the recommendations identified are appropriate.

7.2 The Committee is asked to note the changes to the objectives for Clostridium difficile for 2019/20, the increase in reported cases and confirm that assurance is provided in relation to the controls in place.

7.3 The Committee is requested to consider the risks described in relation to the incidents of flies identified in Modular theatres and subsequent mitigation work programme to remove the pigeon infestation from the roof of the building. The committee is also requested to consider the gaps in compliance with waste regulations and the actions to improve compliance going forward. The Committee is requested to approve the further actions and mitigations as detailed in the main report.