

<b>Meeting Title</b>	<b>Board of Directors</b>		
<b>Date</b>	<b>27.05.20</b>	<b>Agenda item</b>	<b>Bo.5.20.37</b>

## INFECTION PREVENTION AND CONTROL REPORT (QUARTER 3): NOVEMBER – JANUARY 2020

<b>Presented by</b>	Karen Dawber, Chief Nurse/Director Infection Prevention and Control		
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<b>Lead Director</b>	Karen Dawber, Chief Nurse/Director Infection Prevention and Control		
<b>Purpose of the paper</b>	<p>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 November and January 2019/20. This is the Quarter 3 (Q3) report for 2019/20 and provides the third of 4 reports which comprises the annual report.</p> <p>To provide assurance on compliance with:</p> <ul style="list-style-type: none"> <li>NHS Outcomes Framework– domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm.</li> <li>Health &amp; 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).</li> </ul>		
<b>Key control</b>	This paper is a key control for the Board Assurance Framework		
<b>Action required</b>	To note		
<b>Previously discussed at/ informed by</b>	Infection Prevention and Control Committee		
<b>Previously approved at:</b>	<b>Committee/Group</b>	<b>Date</b>	
	Infection Prevention and Control Committee		
	Executive and Non-Executive Regulation Committee	29.04.20	

### 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) 3 report for 2019/20 and provides the third 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 Board of Directors by monitoring the activity of infection prevention and control annual work programme and is requested to confirm the

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actions arising from the recommendations identified are appropriate.

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 outbreak of *Enterobacter Cloacae* in the Neonate Unit and subsequent actions taken to prevent further cases.

The Committee is also requested to consider the gaps in compliance with the internal audit report and the actions to improve compliance going forward.

The Committee is requested to approve the COVID-19 preparedness programme 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)						

<b>Benchmarking implications (see section 4 for details)</b>	<b>Yes</b>	<b>No</b>	<b>N/A</b>
Is there Model Hospital data relevant to the content of this paper?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is there any other national benchmarking data relevant to the content of this paper?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is the Trust an outlier (positive or negative) for any benchmarking data relevant to the content of this paper?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<b>Risk Implications (see section 5 for details)</b>	<b>Yes</b>	<b>No</b>
Corporate Risk register and/or Board Assurance Framework Amendments	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Quality implications	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Resource implications	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Legal/regulatory implications	<input type="checkbox"/>	<input checked="" type="checkbox"/>

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Diversity and Inclusion implications	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Performance Implications	<input checked="" type="checkbox"/>	<input type="checkbox"/>

<b>Regulation, Legislation and Compliance relevance</b>
<b>NHS Improvement: (please tick those that are relevant)</b> <div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> Risk Assessment Framework  <input type="checkbox"/> Code of Governance                 </div> <div> <input checked="" type="checkbox"/> Quality Governance Framework  <input checked="" type="checkbox"/> Annual Reporting Manual                 </div> </div>
<b>Care Quality Commission Domain: Safe</b>
<b>Care Quality Commission Fundamental Standard: Safety</b> (Regulation 12(2)(h) and 21(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014)
<b>NHS Improvement Effective Use of Resources: Clinical Services</b>
<b>Other (please state):</b> 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)
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

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## INFECTION PREVENTION AND CONTROL REPORT: NOVEMBER- JANUARY 2019/20

### 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 Q3 report for 2019/20 and provides the third 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 December 2019. The data highlights that BTHFT Is above peers' median infection rate for MRSA, however is equal to or below peers' median for CDI, MSSA and E.coli healthcare acquired infections. Model Hospital data was not included as the data is not up to date.

Standard Indicator Set: Clinical Quality	Trust Performance			Benchmarking 		Position 
Indicator	Current	Previous	Change	Peer	National	
Infection rate - C. diff (12 mth rolling) PHE C. Diff Infection Rates, HES Inpatients (Dec 2019) 	8.69 (Nov 2018 - Oct 2019)	9.82 (Oct 2018 - Sep 2019)	-1.14 ↓ 	15.49	13.45	
Infection rate - MRSA (12 mth rolling) PHE MRSA Infection Rates, HES Inpatients (Dec 2019) 	1.18 (Nov 2018 - Oct 2019)	0.79 (Oct 2018 - Sep 2019)	0.40 ↑ 	0.63	0.67	
Infection rate - MSSA (12 mth rolling) PHE MSSA Infection Rates, HES Inpatients (Dec 2019) 	5.13 (Nov 2018 - Oct 2019)	4.72 (Oct 2018 - Sep 2019)	0.42 ↑ 	8.71	9.20	
Infection rate - E. coli (12 mth rolling) PHE E. coli Infection Rates, HES Inpatients (Dec 2019) 	110.97 (Nov 2018 - Oct 2019)	109.64 (Oct 2018 - Sep 2019)	1.33 ↑ 	117.37	119.53	

## 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 November - January 2019/20 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 outbreak of *Enterobacter Cloacae* in the Neonate Unit are described and subsequent actions taken to preclude further cases is summarised.

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- 5.5 Gaps in compliance following an Internal Audit report have been noted actions to improve compliance going forward will be monitored as part of the IPCC agenda.
- 5.6 Risks associated with COVID-19 preparedness are summarised within the main report and any new guidance or protocols such as community testing are detailed.

<b>6</b>	<b>RECOMMENDATIONS</b>
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- 6.1 The report provides assurance to the Board of Directors 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 outbreak of *Enterobacter Cloacae* in the Neonate Unit and subsequent actions taken to prevent further cases.
- 6.4 The Committee is also requested to consider the gaps in compliance with the internal audit report and the actions to improve compliance going forward.
- 6.5 The Committee is requested to approve the COVID-19 preparedness programme as detailed in the main report.

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<b>7</b>	<b>Appendices</b>
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## 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 Q3 report for 2019/20 and provides the third 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 HCAs.

- 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.

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### 3.2 MRSA bacteraemia:

- The Trust has investigated 8 cases and following post infection review (PIR) investigation, reported a second attributed MRSA bacteraemia case on 15.10.19.

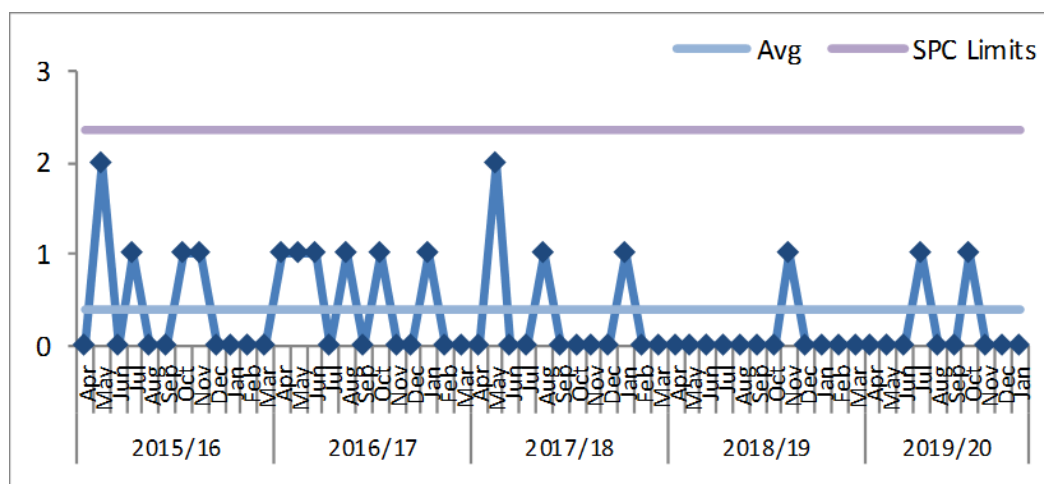


Figure 1

### 3.3 MSSA Bacteraemia

The Trust has reported 14 hospital attributed (>48hr) MSSA blood stream infections for April – January 2019/20. Figure 2 statistical process (SPC) chart showing Trust allocated cases from April 2015 to present.

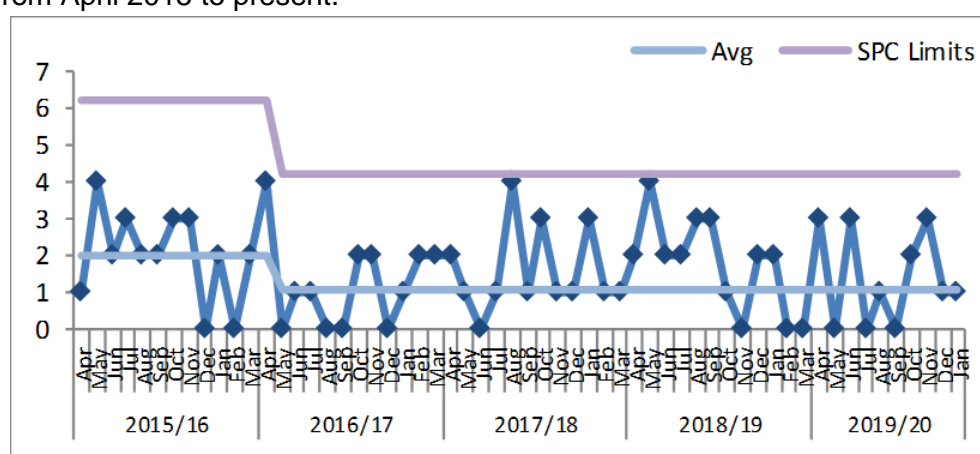


Figure 2

#### 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



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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 36 cases of CDI attributed to the Trust for Apr – Jan 2019/20 against an annual trajectory of 30. These cases have been assigned under the categories as listed below:
  - 26 cases of Hospital onset healthcare associated (HOHA).
  - 10 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.

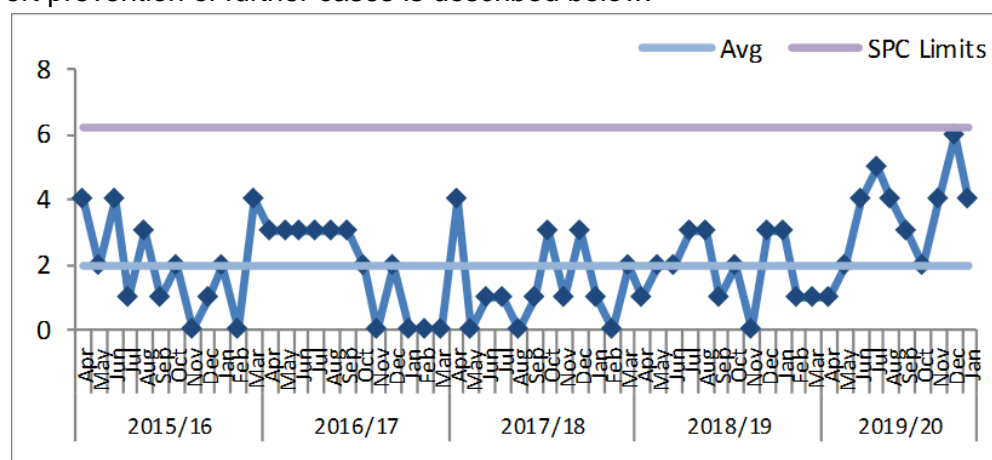


Figure 3

### 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.
- The reported increase in CDI cases during November and December has received a detailed investigation and an exception report with comprehensive analysis presented in January. No episodes of cross infection were identified.
- A summary of the investigation and potential risks are summarised below:
  - No episodes of cross contamination have been identified and are most likely antibiotic related.

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- The patients may have either been previously colonised and antibiotics and/or PPI medication may have triggered toxin release, or acquired the CDI spores from the environment.
- During November the Trust modified its type of disinfectant wipe to an alternative wipe to reduce the use of Chlorox (bleach wipes). However the Chlorox wipes were reintroduced as the main disinfectant wipe during December. Following re-establishing Chlorox wipes, no further cases were reported after 11<sup>th</sup> December.
- It was unusual that the cases reported in December were clustered within 1 week. This prompted a review with the microbiology laboratory and the samples were retested to ensure correct diagnosis. All cases were reconfirmed as CDI.
- The affected wards were reviewed to ensure that levels of nurse staffing were not a contributory factor. None of the wards were identified through clinical incident reporting for nurse staff shortages.
- No decline in standards of cleaning have been reported or identified following spot-check inspections.
- In conclusion, contributory risk factors which may be causally related are a change in disinfectant wipe and an increase in antibiotic consumption, especially co-amoxiclav. This theoretically may have caused a distribution of CDI spores in the environment and triggered by antibiotic consumption, was acquired by the most vulnerable.
- Other risk factors identified were the use of PPI medication and NG feeding – both of which have an impact on gut microbiome which causes susceptibility to CDI proliferation in the bowel.

### 3.4.2 Actions to Support CDI Improvement

- An action plan has been developed and approved at the Infection Prevention and Control Committee (IPCC) in January; this will be monitored through the Care Group IPCC and the Trust IPCC.
- A task and finish group has been set up to support and drive the action plan, review standards of environmental cleaning and arrange with Estates and Facilities teams to de-clutter and provide an enhanced clean of affected wards. There will also be significant focus on hand hygiene and use of personal protective equipment (PPE).
- IPC Nurse Specialist's assurance visits will focus on patients with CDI 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 look at the feasibility of introducing C.difficile toxigenic gene testing. This will aid faster recognition for patients who may develop CDI and therefore support timely treatment and isolation precautions.

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- A CDI checklist has been developed to augment the information collated within the PIR (post infection review) and to provide assurance that the ward have the correct procedures and practices in place.
- The PIRs are presented at monthly Care Group IPCC 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 Care Group Associate Directors of Nursing reports to the Trust IPCC.
- Standards of environmental cleaning inspections have been introduced with the Head of Facilities and Nurse Consultant Infection Control to provide assurance that the cleaning audits completed by the Facilities team reflect safe standards.

### 3.5 Gram-negative Blood Stream Infections (BSI)

- The Department of Health launched objectives to halve E.Coli blood stream infections by 2024.
- Figure 4 SPC chart highlights the Trust attributed E Coli BSI cases per month. The cases are investigated and a Datix entered. The cases investigated to date relate to neutropenic sepsis, biliary sepsis and urinary tract infection with associated contributory factors of urinary catheter, central lines/PICC lines and significant multiple complex co-morbidities.

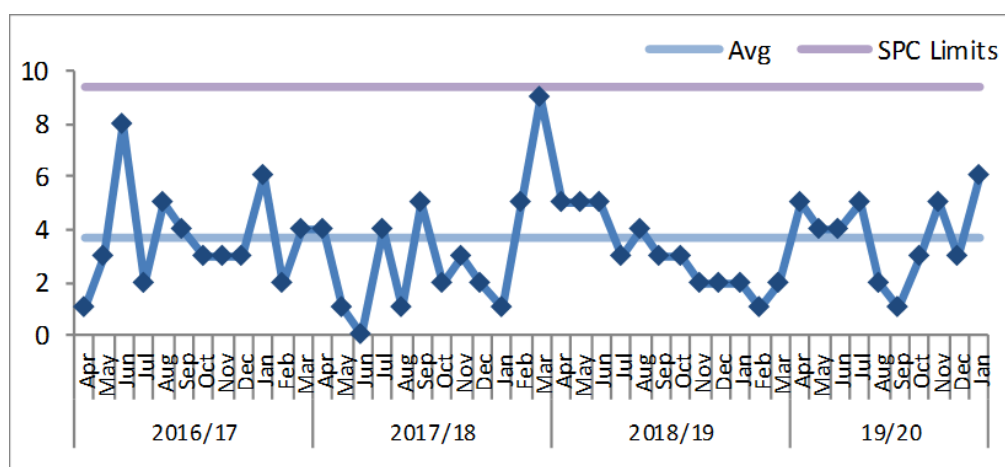


Figure 4

#### 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:

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- 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 stalled due to the extensive preparedness plans for Coronavirus, however it is planned to evaluate the QI work with the test ward nursing teams and a QI pack and training will be developed 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 5 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.

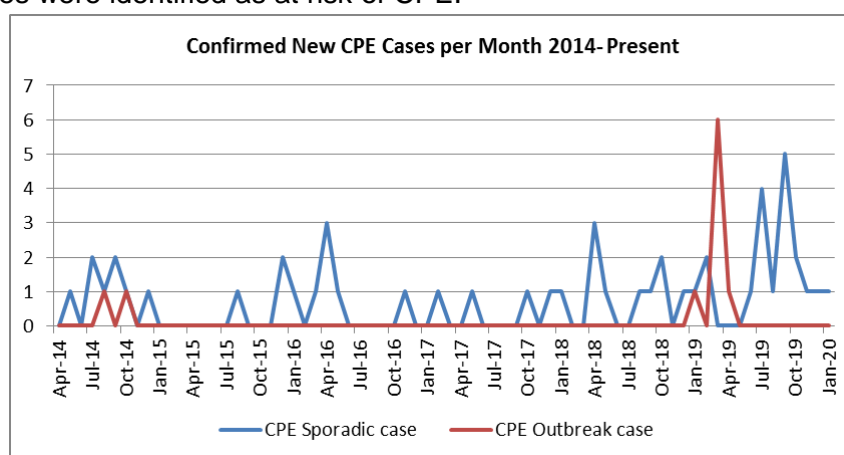


Figure 5

## 4. Outbreaks, Incidents and Bay/Ward closures

- 4.1 Table 1 below reports the ward/bay restrictions due to diarrhoea and vomiting for November – January.
- 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.

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- Ward 4 restrictions required escalation due to the loss of beds on an admission ward. Whilst no organism was isolated, a significant number of patients exhibited signs of diarrhoea.
- All ward or bay restrictions receive a full enhanced clean and disinfection prior to reopening.

Month	Ward	No. Patients affected	No. Staff Affected	Date of first Symptoms	Date of last Symptoms	No. Days affected	Confirmed organism
Nov.19	F5, SLH	19	1	05/11/2019	14/11/2019	9 days	Norovirus identified
	CCU – Ward 17	2	0	28/11/2019	04/12/2019	7 days	Norovirus identified
Dec. 19	AMU4	10	0	19/12/2019	24/12/2019	5 days	Organism not identified
	Ward 15	6	1	23/12/2019	27/12/2019	4days	Organism not identified
Jan. 2020	Ward 9	9	0	11/01/2020	15/01/2020	5 days	Organism not identified
	F6	10	3	20/01/2020	6/02/2020	18 days	Norovirus identified

#### 4.2 Report Outbreak of AmpC Resistant *Enterobacter* sp. In the Neonate Unit

- During November 2019 – a sputum specimen from Baby No.1 and a blood culture specimen were reported with *Enterobacter cloacae* (with an Amp C resistance mechanism). This implies resistance to certain antibiotics routinely used to treat these infections. *Enterobacter* is a gram negative organism which normally colonises the gut; however can cause infections such as wound, urinary and respiratory.
- On 26<sup>th</sup> December 2019 – Baby No. 2 sputum sample was reported as Resistant (AmpC) *Enterobacter cloacae*
- The results were not notified to the Infection Control team (ICT) but notified to relevant clinicians on the Neonate Unit; however the Clinical Team were not aware/appreciative of the resistance “Amp C” implications.
- On the 8<sup>th</sup> January 2020, the Neonate Consultants contacted ICT to notify and requested infection control advice.
- The ICT advised cohort the affected babies and implement isolation precautions. The ICT also advised the following:
  - Requested screening via stool sample / rectal swab from other babies on unit.
  - Isolation/hand hygiene/PPE/Cleaning advice.
  - visit to Unit to observe practices.
- Further sputum was reported with *Enterobacter Cloacae* with AmpC resistance mechanism on baby No.3 on the 18<sup>th</sup> January.

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- An outbreak investigation was initiated and an outbreak control team (OCT) meeting scheduled as per the Trust outbreak protocol and a Datix report (WR93291) was completed.
- All babies in the affected room were screen for the organism and this reported 7 further babies positive from stool samples. None of the 10 babies had infections associated with the organism at the time of the OCT.
- The OCT scheduled weekly meetings and an action plan initiated with support from Public Health England.
- Weekly screening of the babies on the unit did not identify further cases and after 3 weeks of screening, the outbreak was closed. The action plan continues to be monitored through the IPCC.
- Figure 6 below highlights the movement of the 10 affected babies through the Neonate Unit during their admission and aims to identify points of potential cross transmission. The chart shows that Baby 1, 2, 3, 5, 6 and 7 were in room 1 during November/early December where possible transmission occurred and subsequent transfer to the babies to other rooms within the unit may have allowed further transmission to other babies.
- It is probable that the likely route of transmission is hands; extensive environmental screening did not identify any contamination form *Enterobacter* species.

Timeline of BRI admissions in outbreak-associated cases, n=10

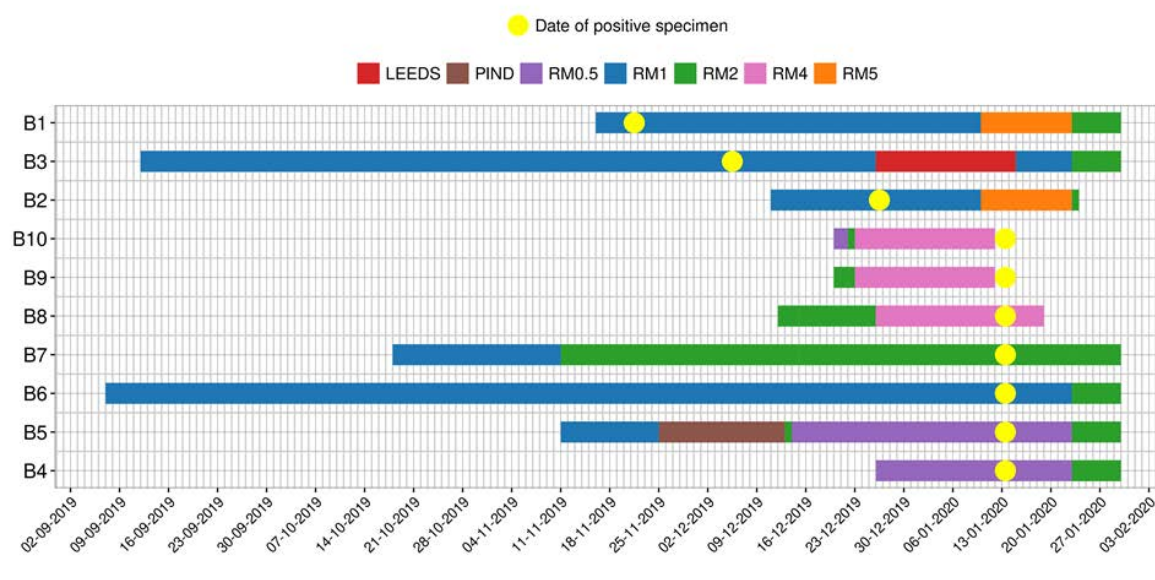


Figure 6

## 5. Internal Audit Hand hygiene report

- 5.1 The Internal Audit Team completed an audit during November 2019. The audit objectives were to provide assurance that effective systems and processes are in place to ensure that staff practice hand hygiene and use personal protective equipment to the expected standard and ensure the safety of patients, staff and visitors.



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5.2 An overall opinion of significant assurance was provided. The Internal Audit Team visited four adult wards and the Neonatal Unit and reported that there was embedded knowledge in using personal protective equipment and practising hand hygiene to prevent cross-infection; wards were well-stocked in aprons and gloves and gel dispensers were maintained with gel. The final report noted that the Audit Team observed 40 moments for hand hygiene of which 36 were positive (90% compliance).

5.3 The report noted that through other observation however, areas that required improvement were:

- Hand hygiene on entering and leaving the wards by staff and visitors,
- Use of personal protection equipment when delivering meals to isolation rooms
- Cleaning portable equipment between patients in isolation rooms.
- Ensuring Agency staff were aware and understood infection control protocols.

5.4 An action plan has been developed to address the recommendations in the audit and is being reviewed and monitored by the IPCC.

## 6. Maternity theatres Progress

6.1 Following the identification of issues with the design and ventilation of maternity theatres, a detailed risk assessment was completed and is reviewed by the Maternity Governance team. The following summary below outlines the current mitigation work:

- Weekly datix's are completed for the number of times theatre 2 is used during that week.
- An excel spread sheet is in place which is monitoring if women are readmitted with a postnatal wound infection or have a positive wound swab culture on ICE for women that birthed in January and February 2020
- A working group was set up in January 2020 to look at improving current standards and monitoring for post –operative surgical site infections
- Benchmarking of the 'OneTogether' tool has taken place and an action plan has been developed for areas of non-compliance
- Surveillance of Surgical Site Infection (SSI) following Caesarean Section Delivery commenced on 1<sup>st</sup> March for all women.
- There are plans to commence a QI project to support the implementation of the best practice standards not already in place.
- A decision to invest paper for new build theatres has been written which is currently being considered by the Operational Delivery Group and Project Board. This was based on the 3 user group meetings we have had to date to ensure the outline design meets the needs of the team.
- The paper has several options which included for future-proofing services. However, the agreed outline design had been revised to include for 4 recovery bays to support the two new theatres and an enhanced care facility for our more complex cases.
- The appointed design team are in progress of working up a final design for approval at the next Project Board in April 2020. Ground investigation works have been completed for the extension.

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- The aim of the Project Board & Delivery Group is to have the new theatres up and running for December 2020.

## 7. Coronavirus (COVID19) Preparedness

### 7.1 Situation Update

- As of 11.3.2020, 456 people in the UK have tested positive for COVID-19, with a total of 27,476 people have been tested. The latest correspondence relating to the management of COVID-19 received today from NHS England refers to the risk to the public as being moderate.
- The government has issued clinical guidance for the detection and diagnosis of COVID-19 and infection prevention and control protocols. These protocols are continually being updated and changing as new evidence of the disease risks and impact to the general public and healthcare services is understood. Figure 7 below highlights cases confirmed by locality in England.

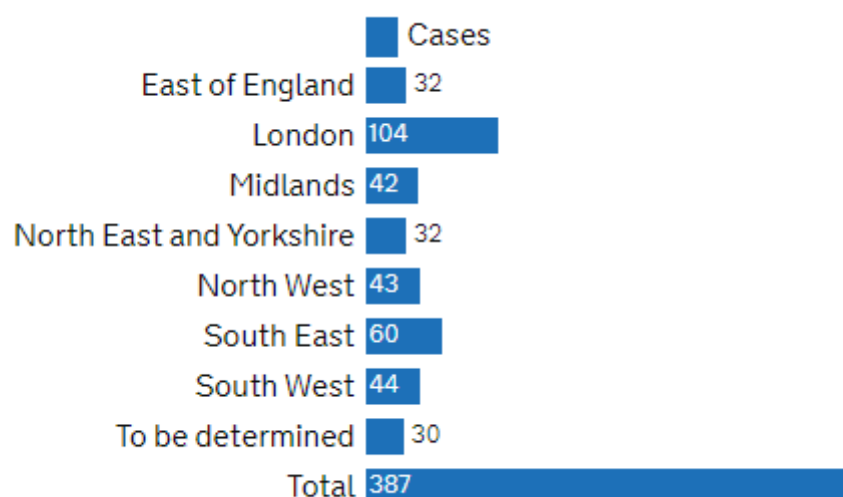


Figure 7

### 7.2 Current Preparedness at BTHFT:

- The assessment of preparation for a patient arriving at BTHFT has been undertaken.
- Action cards have been developed and disseminated widely and have been updated with new versions as new information or guidance is provided nationally. The updated action card is also available on the Infection Control Team intranet site.
- Meetings have taken place with Procurement department and central stock of personal protective equipment (PPE) that meets the national guidance has been ordered and will arrive on site on Monday/Tuesday. The PPE requirements for gown, mask, face visor and gloves has been agreed with Procurement. All high risk areas have sufficient stock.



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- Additional stocks of PPE are held centrally by the Infection Control Team and Clinical Site Team (for out of hours access) to ensure there is no stock depletion risks at ward level.
- Assessment of mask fit-testing, which is a testing procedure that takes approximately 30-40 mins for each individual healthcare professional is in progress, and is being monitored daily.
- Further train the trainer sessions for fit testing have taken place.
- A faster and more accurate testing kit has been purchased and awaiting delivery next week.
- The assessment of PPE wearing and how to put on and take off safely (called donning and doffing) is in progress with daily drop- in sessions provided for all staff to attend.
- The assessment of a suspected and known case pathways have been discussed with all high risk areas (e.g. AED, Maternity, Children's ward, ward 31 and theatres) and is being expanded to assure all clinical areas can develop business continuity plans. This has involved a walk through department, highlighting safe placement without impeding the department's ability to continue to function. This will be repeated regularly to ensure all staff understands the procedure.
- Daily Silver control meetings commenced on 30.01.2020 and continue chaired by either the Director of Nursing or Director Operations for Unplanned Care with representatives for all care groups and support services to discuss and agree the operational priorities associated with emergency preparedness and business continuity for a corona virus single presentation and possible multiple cases and an action log has been developed from the daily meetings. Bronze meetings for each care group have also been implemented.
- AED have been the centre point for referrals from NHS111 for swabbing (nose and throat) and a separate area of the AED department has been utilised to ensure segregation away from other patients, safe donning and doffing of the PPE and also allow careful cleaning of the environment.
- NHS111 Assessment centres (Pods) are now in place as required by NHSE/I and will be available for any person(s) who attend the hospital for advice/support/swabbing for COVID -19. The Pods are fitted with direct dial telephones to NHS111 where they will be assessed for meeting the criteria for swabbing.
- Certain members of the Domestic Cleaning team have completed specific PPE training and mask fit testing, so that the trained team can provide daily cleaning of the assessment pods. This will be after members of the healthcare team from AED have cleaned the pod between cases.

### 7.3 **Emerging Priorities**

- NHSE/I communicated on the 13.02.2020, the next phase of swab testing protocols which will be undertaken in the community setting. This will initially be through the Ambulance paramedic service and subsequently (time to be determined) via community healthcare staff.
- The Trust is participating in both regional and local teleconferences weekly to determine the operational plan to implement home screening.

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- The expansion of laboratory testing is now required as the PHE laboratories reach capacity to test. Therefore the Joint Venture Laboratory team are liaising with BTHFT colleagues to identify and develop an urgent business case for an appropriate testing kit.
- As of 10.03.2020, the clinical criteria for testing now includes any patient requiring admission with clinical signs of community acquired pneumonia. This has created a significant increase in the number of patients within BTHFT who require testing and isolation. Ward 7 is being developed into an isolation ward for suspect cases and ward 31 is being changed to a ward for confirmed cases with respiratory clinical support. Ward 31 is ideal as it has appropriate side room and the bays have en-suite when cohorting will be needed as surge of numbers increase over the next few weeks.

#### 7.4 **Conclusion:**

- The current guidance from the Department of Health, NHSE/I and PHE remains changeable and is likely to change as further understanding of the transmissibility and the associated morbidity and mortality is provided.
- At present the guidance is changing daily and therefore the action card is updated as new guidance is received. Daily Silver control operational planning meetings have commenced and will review any new guidance or reporting requirements.
- The Infection Prevention Team continues to support the Trust's preparedness plans and provide up to date guidance to colleagues.

## 8. **Report Recommendations**

- 8.1 The report provides assurance to the Board of Directors 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.
- 8.2 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.
- 8.3 The Committee is requested to consider the risks described in relation to the outbreak of *Enterobacter Cloacae* in the Neonate Unit and subsequent actions taken to prevent further cases.
- 8.4 The Committee is also requested to consider the gaps in compliance with the internal audit report and the actions to improve compliance going forward.
- 8.5 The Committee is requested to approve the COVID-19 preparedness programme as detailed in the main report.