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Date	23 September 2021	Agenda item	Bo.9.21.13

INFECTION PREVENTION AND CONTROL REPORT: JANUARY–MARCH 2021 (QUARTER (Q) 4)

Presented by	Karen Dawber, Chief Nurse		
Author	Claire Chadwick, Director Infection Prevention and Control		
Lead Director	Karen Dawber, Chief Nurse/ Executive Lead Infection Prevention and Control		
Purpose of the paper	This report summarises progress against the infection prevention and control work plan for 2020/21 and sets out the Trust’s infection control activities and performance between January and March 2021. This is the Q4 report for 2020/21 and provides the fourth of 4 reports which comprises the annual report. To provide assurance on compliance with: <ul style="list-style-type: none">NHS Outcomes Framework– domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm.Health and 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		
	Regulation Committee	11 May 2021	
Key Options, Issues and Risks			
<p>This is the quarterly infection prevention and control report which is required by the Board of Directors to demonstrate progress against the annual infection prevention programme and in achieving compliance with:</p> <ul style="list-style-type: none">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. <p>This is the Quarter (Q) 4 report for 2020/21 and provides the fourth of four reports which comprises the annual report.</p>			
Analysis			
<p>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.</p>			

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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 actions arising from the recommendations identified are appropriate and approve the annual work programme for 2021/22.

The Committee is requested to note the risks identified and 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?	<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"/>

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Risk Implications (see section 5 for details)	Yes	No
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"/>
Diversity and Inclusion implications	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Performance Implications	<input checked="" type="checkbox"/>	<input type="checkbox"/>

Regulation, Legislation and Compliance relevance			
NHS Improvement: (please tick those that are relevant)			
<input type="checkbox"/> Risk Assessment Framework	<input checked="" type="checkbox"/> Quality Governance Framework		
<input type="checkbox"/> Code of Governance	<input checked="" type="checkbox"/> Annual Reporting Manual		
Care Quality Commission Domain: Safe			
Care Quality Commission Fundamental Standard: Safety (Regulation 12(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 academies: (please select all that apply)			
People	Quality	Finance & Performance	Other (please state)
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

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INFECTION PREVENTION AND CONTROL REPORT: JANUARY – MARCH 2021 (QUARTER (Q) 4)

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 Q4 report for 2020/21 and provides the fourth of 4 reports which comprises the annual report.

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4 BENCHMARKING IMPLICATIONS

- 4.1 The latest information available on 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 January 2021. The data highlights that BTHFT is equal to or below peers' median for CDI and E.Coli, but above the median for MRSA, MSSA healthcare acquired infections. Model Hospital data was not included as the data is not up to date.
- 4.2 The charts below are also taken from Healthcare Evaluation DATA (HED) and highlight the Trusts peer group benchmarking for MSSA and MRSA as a 12 month rolling rate. It indicates that the rate has increased for MSSA and MRSA during 2020; however CDI and E.Coli remains low relative to peer Trusts in Yorkshire.

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 (Mar 2021)	12.26 (Feb 2020 - Jan 2021)	11.99 (Jan 2020 - Dec 2020)	0.27	18.69	16.07		
Infection rate - MRSA (12 mth rolling) PHE MRSA Infection Rates, HES Inpatients (Mar 2021)	1.47 (Feb 2020 - Jan 2021)	1.44 (Jan 2020 - Dec 2020)	0.03	0.67	0.86		
Infection rate - MSSA (12 mth rolling) PHE MSSA Infection Rates, HES Inpatients (Mar 2021)	11.77 (Feb 2020 - Jan 2021)	11.51 (Jan 2020 - Dec 2020)	0.26	10.95	10.50		
Infection rate - E. coli (12 mth rolling) PHE E. coli Infection Rates, HES Inpatients (Mar 2021)	117.74 (Feb 2020 - Jan 2021)	119.85 (Jan 2020 - Dec 2020)	-2.11	133.26	122.19		

Infection rate - MSSA (12 mth rolling)

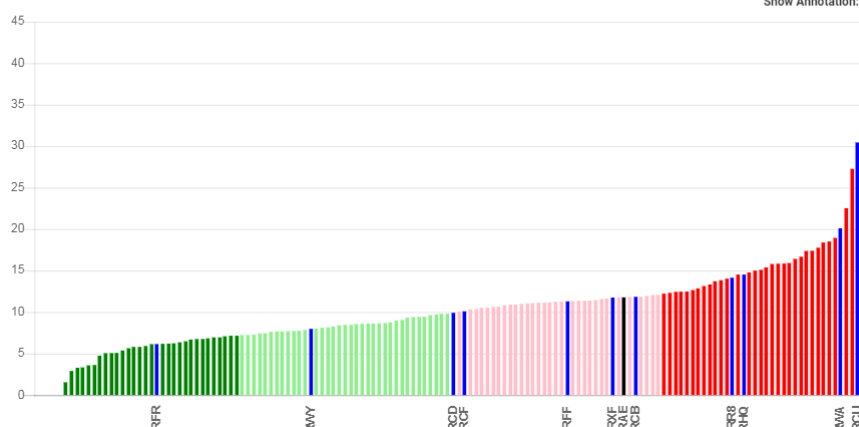


Peer Group:

Yorkshire Region

Latest Trust's Value: 11.77

Show Annotation: ☒



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Infection rate - MRSA (12 mth rolling)

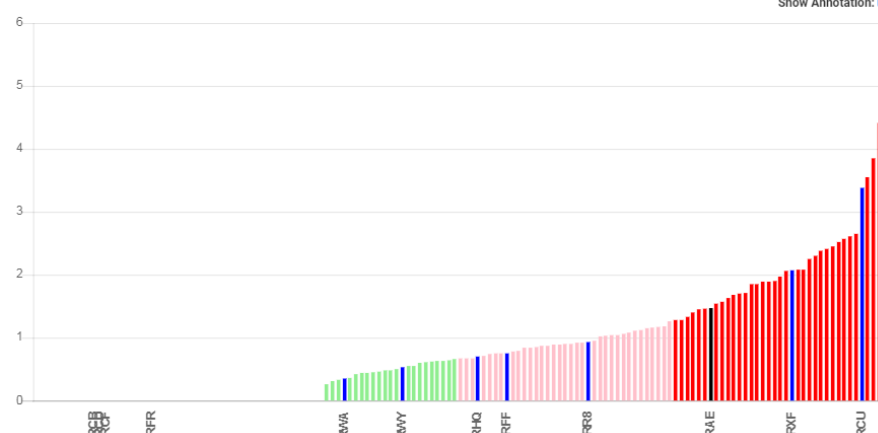


Peer Group:

Yorkshire Region

Latest Trust's Value: 1.47

Show Annotation: ☒



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 January – March 2021 that have been identified are highlighted below and within the main report (Appendix 1).

6 RECOMMENDATIONS

6.1 The report provides assurance to the Board of Directors by monitoring the activity of infection prevention and control annual work programme, is requested to confirm the actions arising from the recommendations identified are appropriate and approve the annual work programme for 2021/22.

6.2 The Committee is requested to note the risks identified and 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.

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 2020/21 and sets out the Trust's infection control activities and performance. This is the Q4 report for 2020/21 and provides the fourth 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 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

The objectives for reduction for *Clostridium difficile* (now renamed *Clostridioides difficile*) infections (CDI) cases for 2020/21 have not been published and therefore the Trust is continuing with the objectives set in 2019/20 as 30 cases. The objective for MRSA bacteraemia remains as zero tolerance.

- During August the Public Health England (PHE) Data Capture System (DCS) started to report cases of MSSA, E.Coli, Pseudomonas sp. and Klebsiella sp. bacteraemias in a similar way to CDI. The classification of cases is split into the defined groups:
 - Hospital-onset, healthcare associated (HOHA) - Date of onset is ≥ 3 days after admission (where day of admission is day 1).

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- Community-onset healthcare-associated (COHA) - Date of onset is ≤ 2 days after admission and the patient was admitted to the trust in the 28 days prior to the current episode days (where day 1 is date of discharge).
- Community-onset, community associated (COCA) - Date of onset is ≤ 2 days after admission and the patient had not been admitted to the trust in the previous 28 days prior to the current episode.
- Therefore the surveillance reporting of HCAs for all reportable organisms has aligned with the same categories as CDI.
- Consequently there has been transference in numbers of cases that are trust assigned, particularly as healthcare associated cases will include those with recent (last four weeks) hospitalisation.
- The current SPC charts presented in this report reflect this change to indicate the re-assignment.

3.1 MRSA bacteraemia

The Trust has investigated 12 cases during 2020/21 and following post infection review (PIR) investigation, reported 6 attributed MRSA bacteraemias. Figure 1 statistical process (SPC) chart highlights the Trust allocated cases from April 2015 to March 2021.

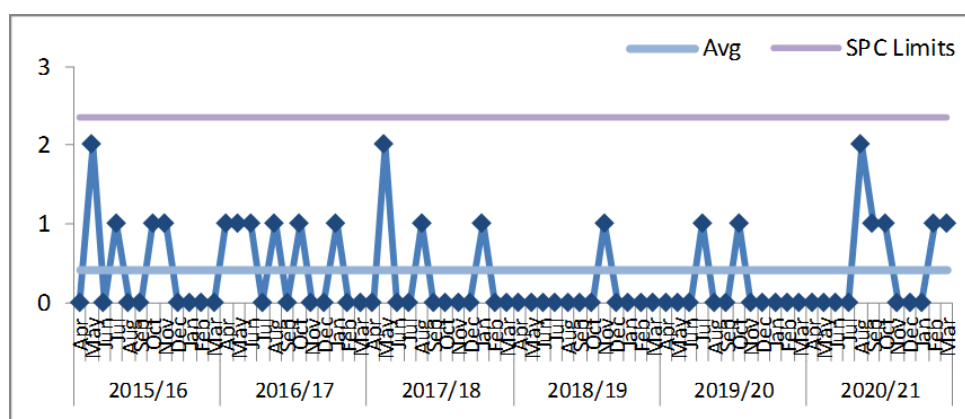


Figure 1

3.1.1 Post Infection Review (PIR) for Hospital attributed MRSA Bacteraemia

- The MRSA bacteraemia cases are summarised below and represent complex cases with multiple co-morbidities.
- 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.

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Case No 1:

- Admitted 30.7.20 ward 3 - Ulcers to left foot noted with no sign of infection and were usually reviewed and dressed in the community by the District nurses.
- It was decided that due to his frailty the patient was not suitable for surgery.
- On the 9th August 2020 the patient's condition started to deteriorate with ischaemic right foot and hospital acquired pneumonia. Restarted on tazocin and teicoplanin.
- The ulcer/ischaemic foot is likely source of MRSA bacteraemia, although the contribution of pneumonia cannot be excluded. No lapses in care were identified.

Case No.2:

- Gentleman admitted on 4th September via AED with shortness of breath and consolidation on chest x-ray with exacerbation of COPD. The patient had previous leg amputation in June 2020 and pressure sores noted to buttocks.
- 8th September the patient discharged himself due to Mother's death.
- 12th September the patient was readmitted with shortness of breath - ?pneumonia ?TB.
- 13th September the patient deteriorated and diagnosed with pneumonia and sepsis; blood cultures reported MRSA.
- The pneumonia secondary to TB is likely source of MRSA bacteraemia, although the contribution of pressure sores cannot be excluded. No lapses in care were identified.

Case No. 3

- Gentleman admitted 20th August with confusion and slurred speech. Patient was initially referred to Stroke Team but further diagnosed with UTI related to self-catheterisation and multiple previous UTIs following bladder cancer in 2019.
- MRSA bacteraemia reported on 24th August and CT reported septic vasculitis, possible perforated ureter and inflammatory collection seen.

Case No.4

- Gentleman admitted with deterioration in cardio-renal failure. Patient had multiple admissions, was known MRSA from 2019 and diabetic foot ischaemic ulcer.
- The patient deteriorated and blood cultures reported MRSA with likely source following MRI of deep seated bone infection associated with ischaemic foot.

Case No. 5

- Gentleman admitted following a fall in his care home.
- On admission chronic changes to lower legs bilaterally noted with dressings in situ for leg ulcers present with Cat 3 pressure sore to Rt. heel. The chest x-ray reported bilateral small pleural effusions with pulmonary oedema. The Rt ankle x-ray reported possible displaced avulsion fracture. The Gentleman was morbidly obese and diabetic.
- The patient was reviewed by the Diabetic team, Physio and Tissue viability. History of longstanding leg ulcers and small sores over body noted. The patient's MRSA screen was reported as positive including pressure sore swab.
- The patient also had a history of Covid 19 on 19/12/2020.
- The patient had developed extremely oedematous pitting oedema of the sacrum, abdomen and chest wall with clinical impression of acute kidney injury secondary to fluid overload and subsequent pyrexia; blood cultures were obtained and reported

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MRSA with likely source difficult to ascertain due to complex co-morbidities but risk factors included leg ulcers, pressure sores, chest, and urine.

Case No. 6

- 68 year old lady with diabetes, recurrent breast cancer with chest wall lymph node involvement and spread to spine under treatment was admitted with established COVID-19 which required transfer to ICU.
- However the Lady's condition worsened with increased oxygen requirement, hypertension, fever therefore sepsis screening completed and blood cultures and sputum reported MRSA with likely source confirmed as ventilator associated pneumonia.

3.1.2 Recovery Plan for MRSA and MSSA bacteraemia Cases

- Please refer to appendix 1 for the MRSA/MSSA completed improvement plan.
- Following the PIR and lessons learnt from the MRSA and MSSA bacteraemia cases, a recovery plan has been developed and is in progress. This will form part of the 2021/22 annual work programme and be monitored through the IPCC.
- Key actions as part of the recovery programme are:
 - Audit and feedback by the IPC Team of peripheral cannulas routine visual inspection for phlebitis (VIPs) to the ward teams.
 - Ensuring daily review of all new inpatients with previous history of MRSA to ensure all MRSA protocols in place.
 - Audit of topical decolonisation compliance with support from Antibiotic Pharmacist.
 - Recommencement of ANTT training and assessment programme.

3.2 MSSA Bacteraemia

- The Trust has reported 28 hospital attributed MSSA blood stream infections to 31.3.21.
- Figure 2 statistical process (SPC) chart shows Trust allocated cases from April 2015 to February 2021. However from July onwards are included in the new criteria.

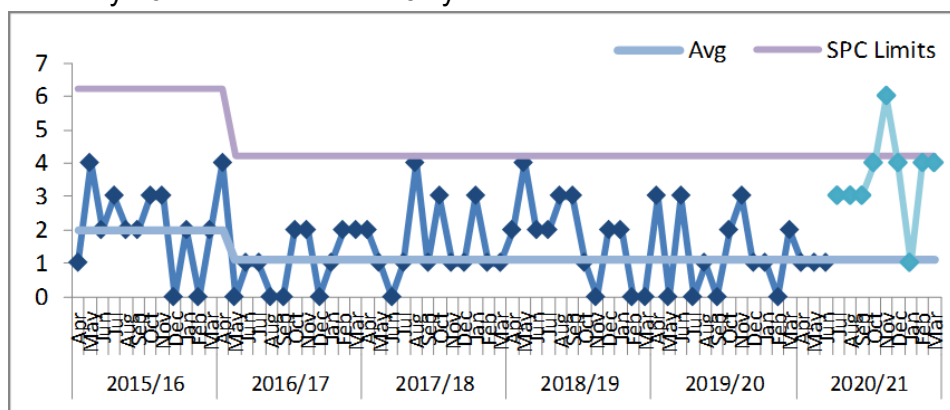


Figure 2

- The cases have been re-assigned under the new categories as listed below:
 - 25 cases of Hospital onset healthcare associated (HOHA).

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- 7 cases of Community onset health care associated (COHCA).

3.2.1 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.
- An increase in cases has been reported since September 2020.
- A review of the enhanced surveillance highlighted a significant proportion associated with skin and soft tissue infection from leg ulcers and IV drug users' related abscess.
- Further scrutiny of the cases has highlighted the following route causes:
 - IV drug users' related abscess.
 - Covid related multi-organ failure.
 - Infected ascites.
 - Covid related haemodialysis and organ failure.
 - Infected portacath for regular transfusions for Beta Thalassemia – multiple antibiotics and repeated MSSA infections but Medical Consultant noted portacath required as patient has poor venous access.
 - Skin infections – e.g. infected eczema and cellulitis.
 - Perineal abscess.
- No key theme or ward area has been highlighted; however this will continue to be monitored.
- An audit of MSSA bacteraemias has been agreed to commence with support from Infectious Diseases Consultant and a junior medical colleague.

3.3 *Clostridium difficile* infection

- Figure 3 statistical process (SPC) chart shows Trust allocated cases.
- There have been 25 cases of CDI attributed to the Trust to 31.3.21 against an annual provisional trajectory of 30.
- An increase in Trust attributed cases has been reported since April 2019; this relates to the changes in provenance reporting of cases, however all cases are sent for typing with no evidence of cross transmission reported. These cases have been assigned under the categories as listed below:
 - 21 cases of Hospital onset healthcare associated (HOHA).
 - 9 cases of Community onset health care associated (COHCA).

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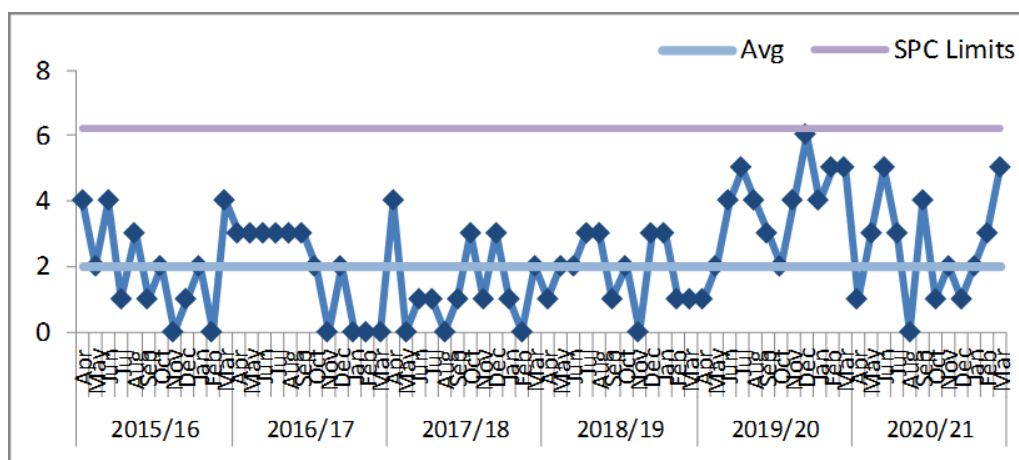


Figure 3

- 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 observed improvement in the number of cases during 2020/21 theoretically relates to the change in patient admissions and pressure with antibiotics. However it is also likely that the intensity of ward deep cleans and the increased use of HPV fogging has also removed the spores from the environment.

3.4 Gram-negative Blood Stream Infections (BSI)

- Figure 4 SPC chart highlights the Trust attributed E Coli BSI cases per month from April 2016 to February 2021. However from July 2021 onwards are included in the new criteria.
- 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, neutropenic sepsis and significant multiple complex co-morbidities.

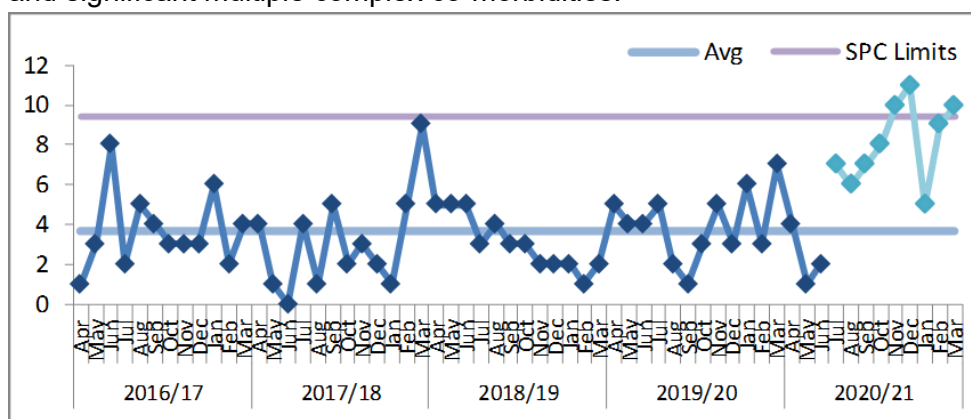


Figure 4

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- The introduction of the new definitions in July has resulted in a 41% increase in Trust assigned E.Coli cases from July 2020 onwards.
- These cases have been assigned under the categories as listed below:
 - 43 cases of Hospital onset healthcare associated (HOHA).
 - 30 cases of Community onset health care associated (COHCA).
- An investigation into the increase in E.Coli blood stream infections has not identified a theme related to ward or Clinical area. Following post infection review the most common route causes have been identified and detailed below:
 - Pyelonephritis.
 - Aspiration pneumonia following stroke.
 - Biliary sepsis.
 - Cholangitis.
 - Decompensated Alcoholic Liver Disease with variceal bleed.
 - Post C Section (transferred to BTHFT from external Trust for neonate support).
 - Pancreatitis.
 - CAUTI – related to change of catheter in a renal patient.
- The majority of patients appeared to be admitted unwell and developed E.Coli sepsis as part of their ongoing clinical condition. Whether these patients are attending hospital much later than pre-Covid and therefore more advanced in their disease severity is being explored with Medical Specialist support.

3.4.1 Recovery Plan for E.Coli Bacteraemias

- Review of gastroenterology/hepatology related cases to understand if there are any changes to presenting disease severity.
- Collaborate with community IPC colleagues to understand the overall increase in cases both in the community and hospital.
- Full post infection review (PIR) of hospital attributed cases and notification via Datix so that any identified risks can be tracked.
- Lessons learnt from the PIRs will be shared through the Care Group IPCC and Governance meetings and action plans developed to support any identified lapses in care.

3.4.2 Recovery Programme for Gram Negative Bacteraemias in Intensive Care Unit (ICU)

- The IPC Team in collaboration with senior nurses and ICU Clinicians jointly reviewed PIRs from patients with gram negative bacteraemias and were also aware of a national increase in these infections associated with the potential overuse of gloves during enhanced Covid PPE and a consequent decline in hand hygiene.
- Though the PIRs did not conclude that the glove use was a causal link, due to the national picture, it was agreed to review ICU staff PPE use and revisit asepsis practices of staff on the department.
- A programme of training and assessment has commenced for Aseptic Non Touch Technique (ANTT) and support the staff to push up gown sleeves, improve bare below the elbows and hand hygiene compliance and only apply gloves for direct patient care as single use items.

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4. Reported Incidents and Outbreaks

4.1 Tuberculosis Episode of Cross Transmission

- Patient AK was admitted on 16th November 2019 initially to AMU4 and then rapidly transferred to ward 7 (side room 2) following review of the chest x-ray on 19 November 2019. He was very unwell with disseminated TB and sadly died on 29 November 2019.
- Patient MK was admitted on 18th November 2019 to ward 7 (side room 1) and was discharged on 20th November 2019. His Pulmonary TB diagnosis was made in May 2020. MF had a past medical history of renal transplant as was therefore immunocompromised.
- The 2 patients were notified to PHE and typing was undertaken where both cases were reported as part of the ongoing Bradford cluster. Following review of their social and community history were not considered related.
- A health care worker (HCW) worked at BTHFT (BRI site) between August 2019 and August 2020 who has since developed non-pulmonary TB.
- Following review with PHE of other relevant Bradford TB cases, the whole genome sequence for the HCW is identical to the two patient cases described above.
- The described incident is now part of a serious incident investigation and regular meetings are taking place to ensure all relevant patient and staff contacts are being followed up by the TB Team and Occupational health Team respectively.

4.2 Reported Cluster of CPE (KPC) Cases:

- A cluster of 4 patients who were reported with CPE over several months have been confirmed as CPE (KPC specific type) with PHE typing results confirming that there is an epidemiological link between the cases.
- An extensive and detailed look back exercise has identified that:
 - 3/4 of the patients have been inpatients in Bay 2 on ward 21 but not at the same time.
 - 2/4 have been inpatients on ICU at the same time but not in the same side room.
- Actions completed to date include sampling all drains of sinks and showers on ward 21, ward 20 and ICU.
- A CPE (KPC enzyme) was identified in the hand wash basin in bay 3, bay 2 and 2 side rooms on ward 21. All other samples have been confirmed negative.
- As a result the bays were restricted to admissions and the affected HWB were taken out of service. The waste trap and piping has been replaced by the Estates team and the bays have received an infection clean followed by HPV prior to reopening to admissions.
- Following the look back, any patient contacts have been cross-checked to ensure no gaps and EPR/ICE alert flag are in place.
- 16 outlets on ICU have also been sampled and reported 2 outlets contaminated which were waste water hoppers. These rooms were restricted and the plumbing replaced. The rooms were then cleaned and decontaminated.
- Ward 20 sampling of all drains of sinks and showers has been completed and reported negative.

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- The areas where positive drains were identified will be resampled in early May to ensure no regrowth.
- Hand wash basin stickers are being designed with Medical Illustration to remind staff to only use these sinks for hand washing.
- No further cases have been reported to date, although these patient contacts will continue to be followed up.

5. Theatre Improvement Programme

- 5.1 During March, senior theatre nursing staff and Infection Control completed a walk round of theatres to look at the estate and improve ways of working from lessons learnt during Covid. The following actions were implemented in relation to suggested changes in practices:
- Equipment storage reviewed and placed back into theatres if stored in cupboards or within scrub areas.
 - Review of patient flow through theatres following review of ventilation.
 - To continue to minimise entry into theatre for essential reasons only.
 - The laminar flow area needs marking out on the floor so that staff are not impacting on the air flow and to aid best practice for theatre working.
 - Changes to improve storage following improvements in ventilation.
 - Review of protocols for staff accessing theatres.
 - Excessive wearing of gloves was note; communication plan agreed to remind staff re appropriate use of gloves.
 - PPE can go into theatres and PPE required for visitors such as parents can be kept in the recovery areas.
- 5.2 Further ongoing work to support quality and safety in theatres includes:
- New Team brief document to ensure safety brief is completed, recorded and actioned.
 - Working with Recovery staff re flow, patient experience and engagement with team brief.
 - New boards coming outside each theatre in NUC's to identify staff in theatre and who is the safety officer identified for each list.
 - Implementation of theatre accreditation.
 - A new induction programme and competences for scrub and recovery.

6. PPE and Covid Secure Review of Outpatients at St Luke's Hospital (SLH)

- 6.1 Following a cluster of staff reported with Covid in October 2020 within the outpatients department at SLH, an inspection of the department highlighted concerns relating to PPE correctly worn, clutter and social distancing.
- 6.2 An action plan was implemented and completed with repeat visits from the IPC Team to ensure compliance was embedded.

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6.3 A further visit was arranged in March as a joint spot-check with the Matron and IPC Nurse following concerns regarding PPE compliance observed on a television documentary. During the visit, the nursing staff were aware of the concerns from the documentary and had implemented rapid remedial actions and good practice observed including:

- New visors ready in each clinic room for staff.
- PPE posters available.
- All staff were aware of correct PPE requirements when challenged.
- Evidence of good practice for clinic desk cleaning signs, which have now been adopted Trust-wide.
- Evidence of regular touch-point cleaning in place.
- Declutter of staff rest room.
- Evidence of good practice with seating signage to encourage attendees to maintain 2 meters social distancing.

7. Infection Prevention Programme of Work

7.1 The Infection Prevention Team have supported clinical areas throughout the past year which has primarily focussed on Covid19 safety programme for patients, staff and visitors. This meant the annual work programme focussed on the Covid Board Assurance Framework as its prime objective. This has included:

- PPE donning and doffing training.
- PPE guidance and posters on every clinical area.
- Covid secure assessment for every clinical area.
- Covid outbreak management support.
- Fit testing.
- PPE quality checks and ensuring all staff had the right level of PPE each day.
- Working with Facilities to ensure safe practices for cleaning, waste collection, safe practices for porters and Estates staff.
- Bespoke PPE training for specific departments and cohorts of staff.
- Training videos and information leaflets.
- Working closely with Clinical Site Team to ensure safe placement of patients.
- Developing risk assessments which risks associated with Covid identified.
- Reviewing ward and department building stock and bed configuration to support social distancing.

7.2 As Covid inpatient cases decline, the 2021/22 annual work programme has been drafted to reflect a recommencement of the quality improvement work and a ensuring the fundamentals of infection prevention are refocused.

7.3 The annual work programme includes the MRSA/MSSA improvement work and the IPC-BAF; these 2 work programmes will remain integral and form part of the assurance reports during 2021/22.

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8. Report Recommendations

- 8.1 The report provides assurance to the Executive and Non-Executive Regulation 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 and approve the annual work programme for 2021/22.
- 8.2 The Committee is requested to note the risks identified and approve the further actions and mitigations as detailed in the main report.

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Appendix 1: MRSA & MSSA Bacteraemia Improvement plan

Status:	
O	Open
OC	Open and to be completed
C	Closed
OD	Overdue

Control Objective		Reduction in MRSA / MSSA Bacteraemia					
	1						
No.	Description	Lead	Date Assigned	Scheduled completion	Status	Actual Completion	Comments:
1	All clinical staff have access to ICE & know how to check IPC alert flags in ICE and EPR	IPCT/ADNs	27/07/2021	30/05/2021	OC		IPC team will recirculate guidance for checking alert flags Care groups to provide assurance that all clinical staff have ICE access
2	AED- All clinical staff know how to check for IPC alert on First Net	ADN	27/04/2021	30/05/2021	OC		Band 7s for allocated area to provide education and assurance for their areas of responsibility. Clinical lead for AED to confirm that medical staff are aware
3	All patients admitted to the trust must have an IPC risk assessment correctly completed in EPR for their current admission with non-compliance being reported via the Clinical Datix reporting system	Matron/IPCT	27/03/2021	30/05/2021	O		IPCT to perform point prevalence audit for wards 3, 6, 20, Amu1, Amu4
4	All admission wards must be 100% compliant with MRSA screening Policy	Matron/IPCT	27/03/2021	30/05/2021	O		

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Control Objective		Reduction in MRSA / MSSA Bacteraemia					
	1						
No.	Description	Lead	Date Assigned	Scheduled completion	Status	Actual Completion	Comments:
5	MRSA screen results to be reported by the Microbiology laboratory within 48hrs	Pathology Operational Manager	27/04/2021	1/8/2021	C	27/04/2021	Audit to review Turn around Times agreed with microbiology laboratory team completed
6	Correct decolonisation suppression treatment will be commenced on admission for all patients who have a history of MRSA (without 3 negative screening results) and be correctly administered in accordance with MRSA screening policy	Matron	20/04/2021	01/08/2021	OC		IPC team to report as Datix clinical incident if not administered in accordance with MRSA screening policy
7	All new inpatients with MRSA will receive a IPC review (Monday-Friday)	Lead IPCN	15/03/2021	Review 1 st August 2021	O		Daily reviews commenced to support clinical teams; checking compliance that <ul style="list-style-type: none"> ○ VIPS /Clips ○ Decolonisation suppression treatment commenced and prescribed according to protocol ○ Body was continues for duration of stay ○ Check that Patients receive daily wash with chlorhexidine

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Control Objective		Reduction in MRSA / MSSA Bacteraemia					
1							
No.	Description	Lead	Date Assigned	Scheduled completion	Status	Actual Completion	Comments:
							4% <ul style="list-style-type: none"> ○ Referral to TV team if required ○ Urinary catheter care
8	Antibiotic prescriptions within EPR are in line with prescribing policy or agreed variation with ID or Consultant Microbiologist	Antimicrobial Pharmacist	22/03/2021		O		Audit compliance will be reported to Drug and therapeutic committee and IPCC
9	Consider introduction of universal chlorhexidine 4%/ Octenisan body wash additional high risk specialities such as vascular, cardiac ward, elderly and neurology	DIPC	27/04/2021	1/06/2021	O		
10	Review wound requirements with Tissue viability team for MRSA positive patients with a focus on wound dressings	IPCT/TVN	27/04/2021	30/05/2021	O		Meeting has been requested
11	All clinical areas must be <ul style="list-style-type: none"> ○ supplied ○ Use peripheral cannula packs for insertion of cannula and FREPP available for skin cleansing	Head of Procurement / Director of Pharmacy	27/04/2021	1/07/2021	OC		
12	Blood cultures must be taken using <ul style="list-style-type: none"> ○ closed system SAFETY Blood collection set ○ aseptic technique 	Education Team	22/03/2021	1/07/2021	OC		

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Control Objective		Reduction in MRSA / MSSA Bacteraemia					
1							
No.	Description	Lead	Date Assigned	Scheduled completion	Status	Actual Completion	Comments:
13	Concentrate initial ANTT refresher training in areas with high patients acuity i.e. ward 29, ward 22, ICU, ward 6 & AED	IPCT	22/03/2021	1/09/2021	O		ANTT compliance audit will be performed by IPC team. Training slides, competency assessment reviewed and updated. Retraining to commence on ICU on 28/04/2021
14	Peripheral cannula\CVC to be reviewed by clinical team <ul style="list-style-type: none"> 3 times daily VIPS\CLIPS assessment will be recorded on the patients EPR VIPS/CLIPS care plan within EPR 	Matron	27/04/2021	01/08/2021	OC		
15	Insertion and care of vascular devices will be included in all Trust education programmes relating to vascular access e.g. venepuncture, peripheral cannula insertion, blood culture technique	Education Team	31/03/2021	01/08/21	OC		IPC team to launch 3 times a day VIPS campaign using Screensavers, posters, Let's talk, staff information stalls
16	Explore feasibility of creating MRSA care plan in EPR	IPCT	20/04/2021	01/10/2021	O		Discussion with CHFT IPC team with request to EPR to provide care plan for both trusts
17	All peripheral cannula to be removed within 72 hours of insertion or 96 hours if venous access is limited and VIPS recorded as Zero	IPCT	27/04/2021	01/08/2021	OC		Audit compliance against Vascular access device policy

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Control Objective		Reduction in MRSA / MSSA Bacteraemia					
	1						
No.	Description	Lead	Date Assigned	Scheduled completion	Status	Actual Completion	Comments:
18	Remove peripheral cannula within 24 hours of cannula being inserted in emergency situations where aseptic technique cannot be assured	IPCT	22/03/2021	01/08/2021	OC		Audit compliance against Vascular access device policy
19	IV giving sets and TPN changed in accordance with Vascular Access Device Policy	IPCT/ Nutritional team	27/03/2021	01/08/2021	OC		Audit compliance against Vascular access device policy
20	Introduce an annual hand hygiene assessment for all trust staff secure funding for Semmelweis Handscan machine to support hand hygiene assessment	IPCT	01/05/2021	31/03/2022	O		Task and finish group to be set up; include representation IPC link worker group
21	Reintroduce end of bed hand gel dispensers across the Foundation Trust	Matrons/ Departmental Managers	27/03/2021	01/08/2021	OC		
22	Distribute bi lingual 'When to clean your hands' patient information posters across the Foundation Trust	IPCT	12/03/2021	30/05/2021	O		IPC team are currently distributing posters
23	Relaunch the 'Gloves are off Campaign' to support hand hygiene compliance and reduce unnecessary glove use	IPCT	27/04/2021	1/10/2021	OC		

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Control Objective		Reduction in MRSA / MSSA Bacteraemia					
	1						
No.	Description	Lead	Date Assigned	Scheduled completion	Status	Actual Completion	Comments:
24	Summary of incidents form Care groups are reported to IPCC and trends/common themes shared to inform training/guideline development	AND's	05/04/2021	Ongoing	O		
25	Restart matron IPC audit programme; results and actions to monitored by the individual care groups at local IPC meeting and included in report to IPCC	Matron/ ADNs	27/04/2021		OC		
26	All ward managers and matrons will be provided with results of the cleaning service track audit so that they are aware of any cleaning rectifications	Head of Facilities	05/04/2021	01/06/2021	O		
27	Review IPC pages on both the Intranet and Internet to ensure that they provide up to date information of staff and public	IPCT	22/03/2021		O		Reviewed 28/03/2021 with additional information added to Intranet site for staff. Weekly review continues
28	Provide visible support to ward staff and facilitate the progress of promoting patient hydration through structured drinks rounds and themed based drinks	IPCT/Ward Managers	01/05/2021	31/03/2022	OC		Allocate Hydration Champions for each ward concentrating on elderly care areas in the first instance
29	Educate staff to recognise patients who are at risk of poor oral fluid intake and provide an assessment tool to monitor and encourage oral fluid intake and identify patient's individual choices and preferences for drinks	IPCT/Ward managers/Ward sisters/Hydration Champions	01/05/2021	31/03/2022	OC		
30	To ensure that information is provided to patients	IPCT/Ward managers/Ward	01/05/2021	31/03/2022	OC		

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Control Objective		1	Reduction in MRSA / MSSA Bacteraemia				
No.	Description	Lead	Date Assigned	Scheduled completion	Status	Actual Completion	Comments:
	and their families on admission and throughout the hospital stay and promotion good hydration after discharge	sisters/Hydration Champions					

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RAYG Key	
R	red behind schedule with significant risk to implementation
A	ongoing with moderate risk to implementation
Y	ongoing with limited risk to implementation
G	no risk to implementation or complete

Appendix 2: Annual Work Programme: 2021/22

Infection Prevention & Control Annual Work plan: 2021 -22					
Criterion 1 – Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider how susceptible service users are and any risks that their environment and other users may pose to them					
QS No.	Standard required	Where we are now	What we need to do to meet the Standard :Actions for 2021/22	R	Timescale & individual responsibility.
				A	
				Y	
				G	
1.1	Appropriate management and monitoring arrangements should ensure that:				

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1.1.1	<p>A registered provider outlines its collective responsibility for keeping to a minimum the risks of infection and the general means by which it will prevent and control such risks</p> <p>The Covid board assurance framework (February 12th, 2021. V1.5) was developed by NHSE to support all healthcare providers to effectively self-assess their compliance with PHE and other COVID-19 related infection prevention and control guidance and to identify risks.</p>	<p>There is an Infection Prevention and Control Committee with terms of reference, committee work plan; annual programme of work and an annual report. The IPCC is a sub group of the Patient Safety committee which is a sub-committee of the Quality committee. Infection Prevention reports are submitted to the Patient Safety and Quality Committees.</p> <p>The IPC-BAF framework is used to assure The Board by assessing the measures taken in line with current guidance. It can be used to provide evidence and as an improvement tool to optimise actions and interventions.</p> <p>The IPC-BAF has a separate work programme where progress and any escalations are reported to the Quality Academy and Regulation Committee monthly.</p>	<p>CBU IPCC Subgroup Leads to attend Trust IPCC and provide report on :</p> <ul style="list-style-type: none"> • Relevant significant clinical incidents with completed action plans • Assurance for IP&C, ANTT, fit testing mandatory training • Assurance for IP&C audit programme • Escalation of any risks from CBU sub group <p>Quarterly reports from Trust IPCC submitted to Patient Safety sub –committee, Quality Academy and the Regulation Committee.</p> <p>See separate IPC –BAF work Programme document.</p>		<p>DIPC/ IPN Team 30.5.21 And ongoing</p>
1.1.2	<p>The principles and practice of prevention of infection (including cleanliness) are included in induction and training programmes for new staff. There is appropriate ongoing education for existing staff (including support staff, volunteers, agency/locum staff and staff employed by contractors), which should incorporate the principles and</p>	<p>Training programme currently covers mandatory infection control and complies with National Core Skills Framework.</p> <p>Record of Mandatory training held centrally, however compliance not monitored by IPCC routinely.</p>	<p>Mandatory Training Programme:</p> <ol style="list-style-type: none"> 1. Continue “Gloves are off campaign” and embedding of WHO 5 moments for hand hygiene. 2. Link worker profile, training, competencies and information pack to be completed and roll-out programme developed 3. IPCC to receive compliance data on IPC 		<p>IPN Team with support from Learning & Development Team</p> <p>30.9.21 and ongoing</p>

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	practice of prevention and control of infection.		training including ANTT and Fit testing 4. Mandatory Training banner QI project to continue evaluation and expansion of programme		
	Education, training and assessment in aseptic technique (ANTT) should be provided to all persons undertaking such procedures.	<p>Current training and assessment for ANTT not embedded as routine practice.</p> <p>High incidence/rate of MSSA bacteraemia compared to National average. Need focus on lessons learnt from PIRs and improve care of IV lines and urinary/super-pubic catheters. This needs a focus aseptic non touch technique.</p> <p>Refer to MRSA/MSSA Improvement Programme</p>	<p>ANTT Programme: Continue to implement programme of training and assessment for ANTT for relevant healthcare professionals. Training/assessment programme at induction will also be provided.</p> <p>Register of trained trainers to be developed.</p>		IPN Team /Education Team 30.12.21

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1.1.3	A programme of audit is in place to ensure that key policies and practices are being implemented appropriately	<p>There is an audit programme which covers the DoH High Impact Interventions (HII) for clinical practice; standards of environmental hygiene and fundamentals of infection prevention. These are reported via the Meridian audit system and compliance with these audits is reported to the IPCC.</p> <p>Observations of practice highlighted 'key parts' not protected/ '5 moments hand hygiene' not consistent/ PPE practices for ANTT not understood.</p>	<p>Audit Programme: Continue to deliver joint IPN & Matron Hygiene code spot-check and Peer review High Impact Intervention (HII) audits as per agreed audit programme. Provide training for those nurses undertaking Infection prevention audits and HII's to ensure standardisation of auditing.</p> <p>Implementation of "fundamentals of Infection Control" with emphasis on IPN ward –based focussed support to ensure compliance with hand hygiene, use of PPE and standards of cleaning are optimised. Implementation of IPN spot-checks audits and rapid feedback process.</p>		IPN Team /Education Team 30.12.21
1.1.4	Designation of a decontamination lead.	<p>There is a Decontamination Lead and a Decontamination group which reports quarterly to the IPCC</p> <p>There is an annual audit of decontamination services including Endoscopy which is produced by the Authorised Engineer.</p>	<p>Decontamination Programme: Formal quarterly report from Decontamination group to be implemented as part of the revised terms of reference for the IPCC and the IPCC work plan.</p>		Decontamination Lead 30.5.21
1.2.	Risk assessment - A registered provider should ensure that it has:				
1.2.1	Made a suitable and sufficient assessment of the risks to the	Tackling antimicrobial resistance 2019–2024 The UK's five-year national action plan	HCAI improvement programme: to include Gram Negative Bacteraemia improvement		IPN team ,

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	person receiving care with respect to prevention and control of infection:	1. Sets out measures to ensure progress towards 20-year vision. 2. Implement Bradford Collaborative E Coli reduction strategy	programme - Hydration awareness and promotion – Evaluate 2018/19 programme, develop change package with embedding programme to all wards. (i.e. training package, leaflets, bulletins, etc.)		30.10.21 and ongoing
		Post Infection Reviews (PIR) is undertaken for MRSA, MSSA, E.Coli bacteraemias and hospital associated Clostridium difficile.	1. Datix submitted for any hospital onset MSSA/MRSA/E.Coli/CDI cases so that each care group can track HCAI PIR and log PIRs as evidence with Datix 2. MRSA and CDI PIR summary with completed action plan to be presented by CBU Team to the Care Group IPCC and Trust IPCC for the following month committee date 3. Ensure key themes and lesson learnt are shared through Care Group Governance processes.		CBU ADNS continuing to be undertaken. IPN Team, Performance Team, Informatics Team 30.6.21
1.3.	Activities to demonstrate that infection prevention and cleanliness are an integral part of quality assurance should include:				
1.3.1	A review of mandatory and voluntary surveillance data, including antimicrobial resistance ,outbreaks and serious incidents;	ICNet Surveillance data base implemented during 2018/19. Now require further development of surveillance systems utilising ICNet capabilities	Further training of IPN team to ensure full potential of ICNet surveillance systems implemented.		

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1.4.	The infection prevention including cleanliness annual programme should :				
1.4.1	Set objectives that meet the needs of the organisation and ensure the safety of service users, health care workers and the public; identify priorities for action; provide evidence that relevant policies have been implemented; • report progress against the objectives of the programme in the DIPC's annual report	Annual programme is in place, but needs to reflect the gaps in assurance/compliance as identified through IPCC work plan evaluation.	Annual Work Programme as standing item on IPCC agenda		DIPC/ IPC team 30.4.21
1.5.	An infection prevention infrastructure should encompass:				
1.5.1	Mechanisms are in place to ensure that sufficient resources are available to secure the effective prevention and control of infection. An infection prevention team consisting of an appropriate mix of both nursing and consultant medical expertise (with specialist training in infection prevention	Infection Prevention Nursing Team with recognised qualifications, knowledge and experience is in place. ICD – Not established through ID Consultants. Protected PAs not established in work plan and specialist training for ID Consultants in Infection Control specialist areas uncertain (e.g. decontamination, water safety, ventilation, cleaning, food safety, asepsis national guidance or legislation)	Risks Noted for risks associated with loss of ID Consultant service and limited Consultant Microbiologist support to IP& C service. Recruitment of 2 Band 7 IPN to support mitigations for above risks identified in paper. Risk assessment completed outlining the above risks from paper.		DIPC/Medical Director /Nurse Consultant/Dep uty Dir. Ops Completed and ongoing review

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	and cleanliness), 24-hour access to a nominated qualified infection control doctor (ICD) or consultant in health protection/ communicable disease control.	Loss of Infectious Diseases (ID) Consultant Team and only 1 substantive Consultant Microbiologist – additional locum in place (May – Aug 2019) Risk due to lack of Senior specialist Medical support to Infection Prevention and Control service.			
1.6.	Movement of service users				
1.6.1	Provides suitable and sufficient information on a service user's infection status; · Movement of patients between wards/department and moved from the care of one organisation to another.	Good working relationship with Clinical Site Team. Risk assessment for side room prioritisation completed and revised posters distributed. Alert flagging system in place on EPR.	Liaise with Clinical Site Team to develop systems to ensure appropriate isolation placement for patients with HCAs and communicable infections. Joint MDT Review of BTHFT clinical isolation requirements to ensure best use of side room capacity		DIPC/Lead Nurse IPC 30.7.21
Criterion 2 : Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections					
Standard required		Where we are now	What we need to do to meet the Standard Actions for 2021/2022	R A Y G	Timescale & individual responsibility.
2.1	Designated leads for environmental cleaning	Cleaning reports submitted to IPCC	Cleaning, waste and Patient Environment Committee (sub-group of IPCC) to be further developed to ensure Matrons have engagement with the Cleaning committee and		Assistant General Manager Facilities

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2.2			take an active role. Assurance reports to IPCC.		30.6.21
	the storage, supply and provision of linen and laundry are appropriate for the level and type of care	Storage of linen often left on corridors and not properly covered.	Improve removal of linen from corridors and review covers for linen transport.		Assistant General Manager Facilities 30.7.21
2.3	Heads of nursing, matrons and the IPT included in all aspects of cleaning services, from contract negotiation and service planning to delivery at ward and clinical level.	Cleaning audits are provided to Matrons and HON. Senior review spot-checks of standards of cleanliness required to ensure systems of assurance in place. Hygiene audits completed with IPT and Matrons.	Joint cleaning spot –checks to be re-introduced with IPN, Facilities and Matrons Hygiene audit programme continues with data reported on Meridian and compliance monitored through the IPCC.		Assistant General Manager Facilities 1.7.21 Matrons/ADNS 1.8.21
	All parts of the premises from which it provides care are suitable for the purpose, kept clean and maintained in good physical repair and condition;	Review of Trust-wide facilities which are relevant to HTM 03 01 Specialised ventilation for healthcare premises, to assess ventilation is fit for purpose, maintained and validated as per HTM requirements. . Governance arrangements for assurance processes to support ventilation validation reports and escalation processes are needed to ensure patient safety.	Ventilation 1. Risk assessments for all non- compliant ventilation to be monitored at Ventilation Working Group and any changes submitted to risk register 2. Any areas where ventilation does not meet HTM standards to be escalated promptly through CBU Leads 3. Ventilation Working Group report to IPCC to support assurance processes for HTM 03 01 and provide robust governance		Assistant Director Estates/ DIPC / 1.7.21

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2.5		Water Safety Steering group TOR revised to support assurance processes for HTM 04 01: Safe water in healthcare premises, and provide robust governance systems through a formal quarterly report to the IPCC and subsequently the Patient Safety Sub Committee.	systems through the IPCC and Patient Safety Sub Committee. Water Safety: Ensure water sample results, actions and recommendations communicated to relevant CBU Leads		Assistant Director Estates /DIPC 30.6.21 and ongoing
	The cleaning arrangements detail the standards of cleanliness required in each part of its premises and that a schedule of cleaning responsibility and frequency is available on request; Policies on the environment should take account of infection prevention team expert advice.	Cleaning Schedules may require further review on publication of revised National Cleaning Standards.	Cleaning Standards: Cleaning Schedules and may require review on publication of revised National Cleaning Standards. Continue Programme of policy review where review date is due for expiry or where new national guidance, best practice, lessons learnt from RCAs requires a policy development/review. Ensure cleaning audits shared with Matrons monthly and any actions arising.		Facilities Team/ Estates Team/ 30.7.21 publication

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Criterion 3 : Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance					
Standard required		Where we are now	What we need to do to meet the Standard : Actions for 2021/2022	R	Timescale & individual responsibility.
				A	
				Y	
				G	
3.1	An antibiotic stewardship committee responsible for developing, implementing and monitoring the organisation's stewardship programme.	<p>The Trust has an Antimicrobial Prescribing Review Group (APRG) which currently reports to Drug and therapeutics committee.</p> <p>Terms of reference do not currently explicitly use the terms antimicrobial stewardship. These TOR are more specifically about development of protocols and guidelines, although they include reference to monitoring prescribing</p>	Antimicrobial Stewardship Programme: Review antimicrobial prescribing policy and amend TOR where necessary to make stewardship a key responsibility.		Consultant Microbiologist, ID Consultant Antibiotic Pharmacist 30.8.21
3.2	The IPCC committee should report antimicrobial stewardship activities to the Trust board via the organisation's Director of Infection Prevention and Control or equivalent.	Nothing currently reported beyond monthly prescribing compliance audits	Stewardship program to be drafted -		Lead pharmacist antimicrobial therapy – 30.8.21

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3.3	Adherence to prescribing guidance and compliance with in hospital post-prescribing review at 48-72 hours should be monitored and audited on a regular basis, with data fed back to prescribers and incorporated into patient safety reporting systems to Boards	Nothing currently reported beyond monthly prescribing compliance audit	Lead Pharmacist antimicrobial therapy to compile draft stewardship program for approval To be presented to IPCC meeting OR for approval at APRG meeting		Lead pharmacist antimicrobial therapy – 30.8.21
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Criterion 4 : Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support for nursing/medical care in a timely fashion					
Standard required		Where we are now	What we need to do to meet the Standard : Actions for 2021/2022	R	Timescale & individual responsibility.
				A	
				Y	
				G	
4.1	Areas relevant to the provision of information include: <ul style="list-style-type: none"> • principles on prevention of infection • importance of appropriate use of antimicrobials; • compliance by visitors with hand hygiene; • reporting concerns relating to hygiene and cleanliness including hand hygiene • explanations of incident/ outbreak management 	Patient information leaflets are available on the Trust external webpage including: Reducing risk of Infection, MRSA and Clostridium difficile.	Review of patient leaflets to identify and gaps in compliance for CQC compliance and IPC-BAF compliance. If any gaps identified – develop patient information leaflets as required		IPN Team/DIPC 30.10.21

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Criterion 5 : Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people

Standard required		Where we are now Ensure that advice is received from IP practitioners and should inform their local health protection team of any outbreaks or serious incidents relating to infection in a timely manner.	What we need to do to meet the Standard: Actions for 2021/2022 .	R	Timescale & individual responsibility.
				A	
				Y	
				G	
5.1	Ensure that advice is received from IP practitioners and should inform their local health protection team of any outbreaks or serious incidents relating to infection in a timely manner.	<p>Outbreak policy in place.</p> <p>PHE represented on IPCC.</p> <p>Infection Control Policy provides roles and responsibilities outlined for all healthcare staff. Outbreak and SI reports submitted to IPCC.</p>	<p>1. Outbreak policy in place – to be reviewed to ensure EPRR resilience in place and corresponds to West Yorkshire outbreak plans. To work with EPRR office.</p> <p>2. Review Outbreak policy to ensure new management structures are incorporated and in compliance with Covid guidance and IPC -BAF</p>		Nurse Consultant 30.9.21

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Criterion 6: Systems 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.

(Refer to 1.1.2 above)

Criterion 7: Provide or secure adequate isolation facilities

Standard required		Where we are now	What we need to do to meet the Standard : Actions for 2021/2022	R	Timescale & individual responsibility.
				A	
				Y	
				G	
7.1	<p>Provide, or secure the provision of, adequate isolation facilities, as appropriate, sufficient to prevent or minimise the spread of infection.</p> <p>There is adequate provision of suitable hand washing facilities, isolation side rooms, bathrooms and toilets, bed spacing optimised and antimicrobial hand rubs where appropriate; to Comply With HBN Infection Control in the Built Environment</p>	<p>Limited isolation facilities – need to improve prioritisation for side room allocation</p> <p>Policy for Isolation in place and Priority protocol for isolation side rooms is in place using RAG rating.</p> <p>Hand wash facilities are available in all patients and clinical areas - Alcohol gel is available at patient bed area;</p> <p>Bed spacing for all inpatient areas reviewed at non-compliant (<2meters) are risk assessed and mitigations in progress.</p>	<p>The Built Environment:</p> <p>Sink to bed ratio/side room capacity and bed spacing review completed.</p> <p>Above review shared with Care Groups and Execs.</p> <p>Risk assessments completed for wards where bed spacing less than 2meters.</p> <p>Further risk assessments required to understand side room capacity and sink to bed ratio requirements and develop plans for increasing capacity.</p>		<p>Assistant Dir Estates/DIPC./ Director Ops for Care Groups/Dir. Transformation</p> <p>30.9.21</p>

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Criterion 8: Secure adequate access to laboratory support as appropriate					
Standard required		Where we are now	What we need to do to meet the Standard : Actions for 2021/2022	R	Timescale & individual responsibility.
				A	
				Y	
				G	
8.1	Ensure that laboratories that are used to provide a microbiology service, in connection with arrangements for infection prevention (including cleanliness), have in place appropriate protocols. These laboratories should operate according to the standards required by the relevant national accreditation bodies.	Transcription errors with Microbiology reports – wrong organism/wrong patient (reported on Datix) MRSA, CPE screening taking on average 4 days to report with some taking up to 10 days (incident reported on Datix). Issues with lab reports sent without full details of sensitivities or full microbiology decision. I.e. not stating MRSA, CPE etc.	Datix submitted on any lab reporting issues and discussion at Microbiology Seniors meetings Clinical Incidents to be completed for any significant microbiology issues and liaise with Microbiology Senior Team to support improvement programme		ID/Microbiology team with Senior Microbiology Team (Joint Venture) 31.8.21
8.2	Protocols should include: a microbiology laboratory policy for investigation and surveillance of antimicrobial resistance and HCAs; standard laboratory operating procedures for the examination of specimens and timely reporting	Lab protocols held by Airedale laboratories – unsure of compliance Lab protocols held by Airedale laboratories – unsure of compliance	Meetings with Airedale Microbiology service requested.		

Meeting Title	Board of Directors		
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Criterion 9: Have and adhere to policies, designed for the individual's care and provider organisations					
Standard required		Where we are now	What we need to do to meet the Standard : Actions for 2021/2022	R	Timescale & individual responsibility.
				A	
				Y	
				G	
9.1	All relevant policies should have regular review and revision programme with ratification at IPCC and are available on the Trust Intranet	Rolling programme of policies review and revision programme with ratification at IPCC and are available on the Trust Intranet	1. Continue Programme of policy review where review date is due for expiry or where new national guidance, best practice, lessons learnt from RCAs requires a policy development/review.		DIPC/ IPN team Ongoing as required throughout year.

Meeting Title	Board of Directors		
Date	23 September 2021	Agenda item	Bo.9.21.13

Criterion 10: Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection					
Standard required		Where we are now	What we need to do to meet the Standard : Actions for 2021/2022	R	Timescale & individual responsibility.
				A	
				Y	
				G	
10.1	All staff can access occupational health services;	<p>Policies are in place and receive regular review. Staff Immunisation programme is in place and exceptions reported to IPCC (i.e. shortages of vaccine).</p> <p>Decisions on offering immunisation are made on a local risk assessment as described 'The Green Book'</p>	<p>To review and implement revised BCG vaccination programme for Healthcare staff at risk from TB at BTHFT following discussion at IPCC.</p> <p>BCG records to be updated</p>		Occupational Health Manager – 31.5.21