

Meeting Title	Board of Directors		
Date	14.07.22	Agenda item	Bo.7.22.20

INFECTION PREVENTION AND CONTROL REPORT: JANUARY - APRIL 2022 (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	<p>This report summarises progress against the infection prevention and control work plan for 2021/22 and sets out the Trust's infection control activities and performance between October 2021 and January 2022. This is the Q4 report for 2021/22 and provides the fourth of 4 reports which comprises the annual report. To provide assurance on compliance with:</p> <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		
	Quality and Patient Safety Committee QA.6.22.16	29.06.22	

Key Options, Issues and Risks

This is the quarterly infection prevention and control report which is required by the Quality and Patient Safety Academy 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) 4 report for 2021/22 and provides the fourth 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.

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Recommendation

The report provides assurance to the Quality Academy 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.

The Academy is requested to note the risks identified and approve the further actions and mitigations as detailed in the main report.

Risk assessment

Risk assessment						
Strategic Objective	Appetite (G)					
	Avoid	Minimal	Cautious	Open	Seek	Mature
To provide outstanding care for patients, delivered with kindness			g			
To deliver our financial plan and key performance targets			g			
To be one of the best NHS employers, prioritising the health and wellbeing of our people and embracing equality, diversity and inclusion					g	
To be a continually learning organisation and recognised as leaders in research, education and innovation				g		
To collaborate effectively with local and regional partners, to reduce health inequalities and achieve shared goals					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"/>

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"/>

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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 - APRIL 2022 (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 Care Quality Commissions (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

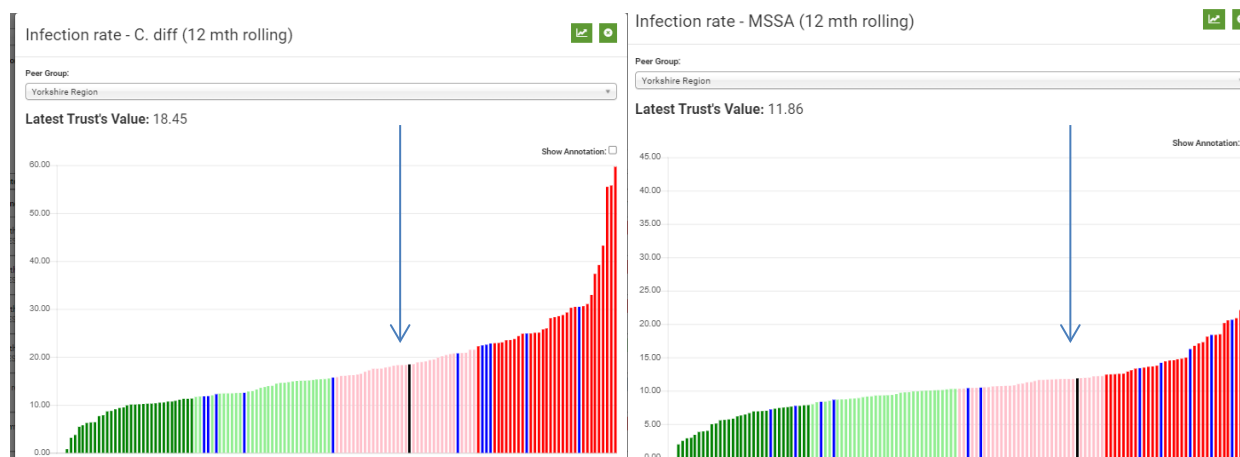
- 3.1 This report will confirm continued assurance systems for compliance against the statutory requirements which will support assurance with corporate strategic objective 1 - To provide outstanding care for our patients.
- 3.2 This is the Q4 report for 2021/22 and provides the fourth of 4 reports which 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 for MRSA and MSSA bacteraemia, Clostridioides difficile (CDI) and E. coli, in relation to the national distribution for each of these infections as at March 2022. 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. The arrows in the graph below indicate the position of BTHFT in relation to National and Regional data.

Standard Indicator Set: Clinical Quality		Trust Performance			Benchmarking		Position	Module Link
Indicator		Current	Previous	Change	Peer	National		
Infection rate - C. diff (12 mth rolling) PHE C. Diff Infection Rates, HES Inpatients (May 2022)		18.45 (Apr 2021 - Mar 2022)	17.58 (Mar 2021 - Feb 2022)	0.87 ↑	-	17.40		
Infection rate - MRSA (12 mth rolling) PHE MRSA Infection Rates, HES Inpatients (May 2022)		2.20 (Apr 2021 - Mar 2022)	2.64 (Mar 2021 - Feb 2022)	-0.44 ↓	-	0.66		
Infection rate - MSSA (12 mth rolling) PHE MSSA Infection Rates, HES Inpatients (May 2022)		11.86 (Apr 2021 - Mar 2022)	13.18 (Mar 2021 - Feb 2022)	-1.32 ↓	-	10.65		
Infection rate - E. coli (12 mth rolling) PHE E. coli Infection Rates, HES Inpatients (May 2022)		107.65 (Apr 2021 - Mar 2022)	108.55 (Mar 2021 - Feb 2022)	-0.90 ↓	-	109.76		



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 and Social Care Act 2008: Code of Practice for the prevention and control of healthcare associated infections and related guidance.

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- NICE [QS61] Infection prevention and control.

5.2 Gaps in compliance during January - April 2022 that have been identified are highlighted below and within the main report (Appendix 1).

6 RECOMMENDATIONS

- 6.1 The report provides assurance to the Quality Academy 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.
- 6.2 The Academy is requested to note the risks identified and approve the further actions and mitigations as detailed in the main report.

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 This report summarises progress against the work plan for 2021/22 and sets out the Trust's infection control activities and performance. This is the Q3 report for 2021/22 and provides the third of 4 reports which comprises the annual report.
- 2.2 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 and 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 NHS Standard Contract 2022/23 includes quality requirements for NHS trusts and NHS foundation trusts to minimise rates of both *Clostridioides difficile* (*C. difficile*) and of Gram-negative bloodstream infections to threshold levels set by NHS England and NHS Improvement. All thresholds are derived from a baseline of the 12 months ending November 2021 as this is the most recent available data at the time of calculating the objectives. Trusts

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are required under the NHS Standard Contract 2021/22 to minimise rates of both *Clostridioides difficile* (C. difficile) and Gram-negative bloodstream Infections so that they are no higher than threshold levels set by NHS England and Improvement. The following table sets out the threshold levels for each trust.

Org code	Name	Case thresholds for 2022/23			
		<i>C. difficile</i>	<i>E. coli</i>	<i>P. aeruginosa</i>	<i>Klebsiella spp</i>
RAE	BRADFORD TEACHING HOSPITALS	43	80	10	31

- During August 2020 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).
 - 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 SPC charts presented in this report reflect this change to indicate the re-assignment.

3.2 MRSA bacteraemia

The Trust has reported 5 case during 2021/22 and following post infection review (PIR) investigation. Figure 1 statistical process (SPC) chart highlights the Trust allocated cases from April 2015 to April 2022.

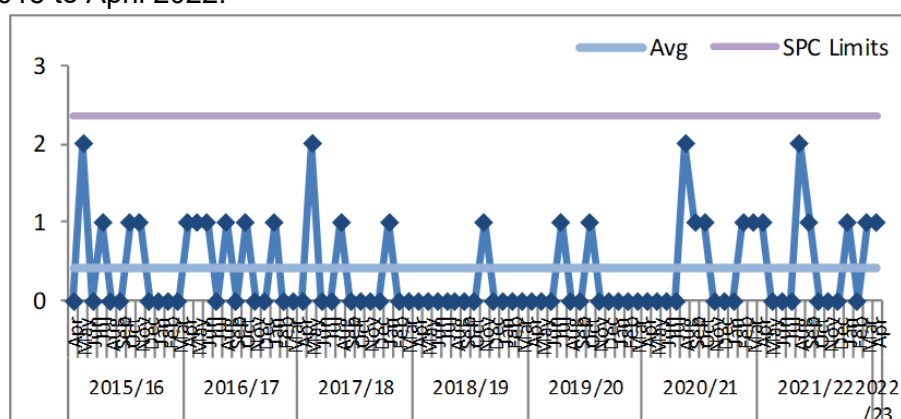


Figure 1

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

- The MRSA bacteraemia case reported in January is summarised below and represent complex case with multiple co-morbidities.
- Multi-disciplinary meetings have taken place to discuss the case and an action plan formulated by the relevant clinical teams.
- The PIRs are presented at monthly Planned Care and Unplanned care Infection Prevention Control (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.

3.2.2 Case Number 5 Review and Root Cause:

- A 72 year old Gentleman was admitted with chest pain at home while walking and was initially picked up by the ambulance service in the community and taken to LGI, however following a cardiac echo in LGI, the gentleman was repatriated to Bradford AED on 31.12.21 with a provisional diagnosis of pericarditis.
- The Gentleman had a past medical history of diabetes, cardiac disease and chronic leg ulcers.
- The Gentleman was admitted to ward 22 Coronary Care Unit (CCU) where the admission assessment was completed and MRSA screening swab taken. There was no previous history of MRSA recorded at the time of admission.
- The assessment noted an itchy rash on the patient's arms with broken skin from scratching and legs dressed with pressure bandages for the treatment of chronic leg ulcers.
- There was no initial record of IV cannulation completed; however visual phlebitis inspections were completed throughout the patient stay.
- The patient became unwell on the 4th January 2022 with a fever and raised inflammatory markers (CRP =115). Blood cultures were taken as per sepsis protocol and wound swabs from the chronic leg ulcers as part of the sepsis screen. A provisional diagnosis of infective endocarditis was reported
- The blood cultures and leg ulcer wound swabs were reported positive for MRSA on the 6th January; however the initial MRSA admission screen was not reported until the 11th January.
- The antibiotics were changed in line with Microbiology advice and repeat blood cultures taken on the 5th and 7th January reported as no growth.
- There was evidence of referral to the TVN Team for guidance with wound care for the leg ulcers; however the patient self-discharged on the 8th January although he was aware of the need for IV antibiotics to continue.
- The patient during admission had also declined assistance with personal hygiene needs and topical MRSA suppression therapy.
- The likely root cause was infective endocarditis originating from the infected leg ulcers. MRSA topical decolonisation was not commenced due to the significant delay in reporting the admission MRSA screen results, which were reported after the blood culture results.
- The quality improvement programme which includes the commencement of a topical antibacterial body wash for all inpatient admissions, is now in place with a patient information leaflet, staff training has taken place and a Trust screen saver produced. This will be

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monitored to evaluate the effectiveness of reducing blood stream infections caused by skin bacterium such as *Staphylococcus aureus* and evaluate staff and patient compliance with the body wash protocol.

3.3 MSSA Bacteraemia

- The Trust has reported 41 hospital attributed MSSA blood stream infections to 31st March 2022. There is no National objective for MSSA.
- Figure 2 statistical process (SPC) chart shows Trust allocated cases from April 2015 to March 2022. However from July 2020 onwards are included in the new criteria.
- The SPC chart indicates a reduction in cases since December 2021. This is being analysed to evaluate the MRSA/MSSA reduction programme with the introduction of Octenisan topical antibacterial body wash for all patient admissions.

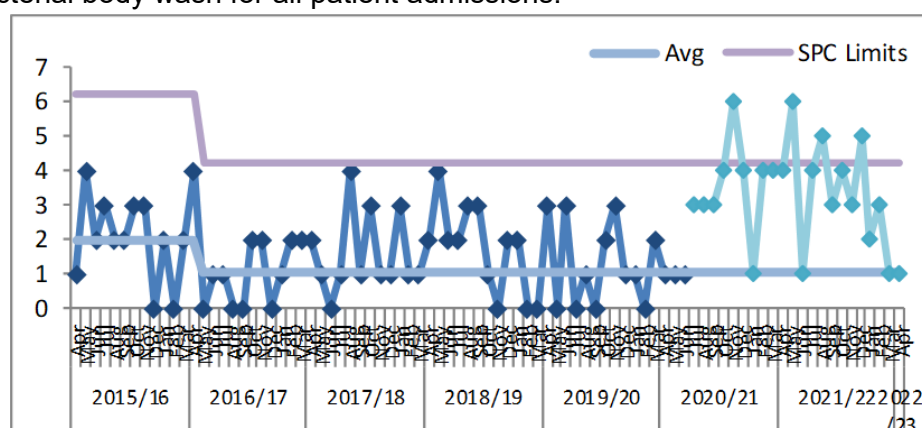


Figure 2

- The cases have been re-assigned under the new categories as listed below:
 - 27 cases of Hospital onset healthcare associated (HOHA).
 - 14 cases of Community onset health care associated (COHCA).

3.4 Current Improvement Actions for MRSA/MSSA Reduction Programme:

The MRSA/MSSA improvement plan has been reviewed and updated to continue to the improvement work during 2022/23. The updated plan is attached as Appendix 3.

- Universal skin decolonisation for all inpatients on admission has been implemented with patient information leaflet available and staff training, information screen saver and training video completed.
- Ensuring ANTT is part of mandatory training.
- Interventional Radiology are reviewing their patient checklist to include MRSA results check, empirical antibiotic cover if MRSA and no change of central line over guidewire (review of practice).

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- All known MRSA cases are being reviewed by the IPCT to ensure topical suppression has commenced.
- Trial of new CVC line dressing (antimicrobial) as current use of antimicrobial dressing (Biopatch) has been noted as difficulty in observing the line exit site for signs of infection.
- Also collaborating with the Tissue Viability Team (TVN) to look at best antimicrobial dressing for MRSA patients, especially vascular patients.
- Revision of CVC /MRSA protocols to include topical suppression body wash for all patients with CVC/PICC line
- A delay in prescribing MRSA topical suppression is being reviewed and in collaboration with Pharmacy to make prescribing easier on EPR.
- Review the progress of ANTT assessed staff with the Care Groups and set objectives for delivery, progress and completion.
- Review resources required to deliver ANTT training and assessment with Care Groups to ensure objectives are met.
- There are now 93 ANTT assessors trained and in place. The theoretical component of ANTT has been incorporated into the trust induction. In April and May 2022 the education team and practice educators have delivered training to 167 learners. This includes theory, practical assessment and assessor training.
- Focus training and assessment has been delivered to ICU, NICU, The meadows, Dermatology dept., SLH OPD, maternity unit, Palliative care team, renal dialysis unit at SLH by the education team in addition to training and assessments carried out by the practice educators within their care groups.
- Work has been completed to identify the job roles which will require ANTT competency within ESR and this competency will be mandatory once the ESR team have identified the individual staff members within each job role followed by a go live launch date.
- In preparation for the launch date, the education and IP&C team have created staff training posters, working towards developing screensavers and planning a staff information stall in the concourse. Following the launch, ANTT training compliance will be incorporated into the monthly compliance by refresher training reports. This will assist the care groups with monitoring ANTT compliance within their individual CBU's

3.5 *Clostridioides difficile* infection (CDI)

- Figure 3 statistical process (SPC) chart shows Trust allocated cases.
- There have been 44 cases of CDI attributed to the Trust to 31st March 2022 against an annual trajectory of 37.
- The objective for 2022/23 is 43 cases.

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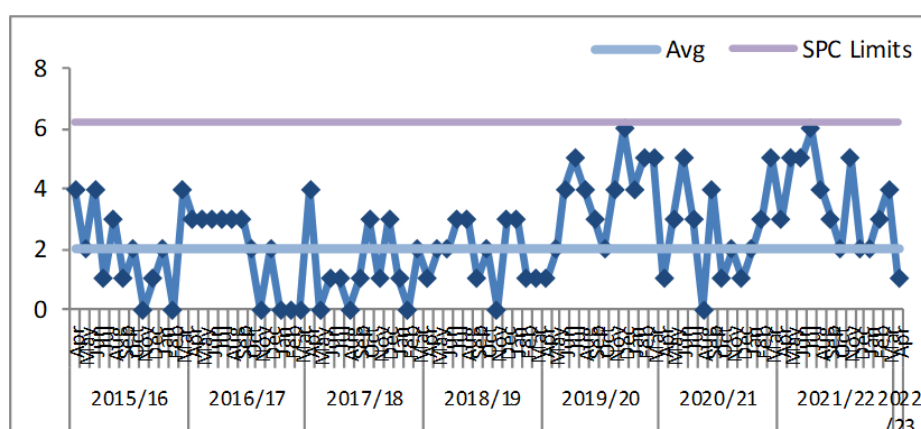


Figure 3

- 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.
- Each CDI case is sent to a UKHSA (previously PHE) reference laboratory for typing; 25 subtypes of *Clostridioides difficile* have been reported during 2021/22 at BTHFT. Where there are any similar typing results, a search is undertaken to identify any potential risks for cross transmission (for example, the same ward either at the same time or at different times). No evidence of cross transmission has been identified.
- Cleaning and decontamination, including hydrogen peroxide vapour (HPV) fogging for any side room following the discharge or transfer of a patient with CDI has continued and clinical wards and departments have maintained their audit programme for hand hygiene and PPE compliance.

3.5.1 Antibiotic Stewardship

- Antibiotic usage is the most common risk factor associated with *Clostridioides difficile* infection; the antibiotics most commonly reported nationally as being associated with *Clostridioides difficile* infection were cephalosporins and quinolones, however prescribing of cephalosporins and quinolones have decreased nationally over the past decade. Yet over the same period, the prescribing of combination penicillins has increased: co-amoxiclav prescribing has increased in primary and secondary care and piperacillin-tazobactam prescribing increased in secondary care. With further clarification of the epidemiology following the establishment of the *Clostridioides difficile* ribotyping network service, these combination penicillins have become the antibiotics most frequently reported as being associated with *Clostridioides difficile* infections.
- The Trust antimicrobial stewardship group has developed an AMS strategy with the objective to meet the ambitions and targets of the government's current national action plan and 20 year vision to tackle antimicrobial resistance (AMR) and to ensure that BTHFT can meet the antimicrobial stewardship criteria described in the English Antimicrobial Stewardship Peer Review Inspection Tool. (Ref: <https://www.networks.nhs.uk/nhs-networks/thames-valley-wessex-regional-antimicrobial/documents/e-of-england-ams-pharmacy-peer-review-tool>)

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- The strategy key objectives include :
 - The trust will aim reduce overall antimicrobial use by 15% and reduce the use of 'watch' and 'reserve' antibiotics (as defined in the WHO AWaRe categories⁽⁶⁾) by 10% by 2024 compared to the 2017 baseline.
 - Regularly review local antimicrobial prescribing guidance and update as necessary to ensure that local guidelines align with national guidelines whilst ensuring local resistance patterns are considered to ensure suitable treatment options are recommended. All updates to prescribing guidelines will be publicised to ensure prescribers are made aware of changes
 - Members of the Antimicrobial Stewardship Group will continue to work collaboratively with our nearest neighbour (Airedale NHSFT) as partners in our Joint Antimicrobial prescribing Review group, with acute trusts across West Yorkshire (as part of West Yorkshire Association of Acute Trusts (WYAAT), and the local primary care organisation Bradford and Craven Clinical Commissioning group to ensure a consistent approach to antimicrobial prescribing and with the Yorkshire and Humber Antimicrobial Pharmacists Network to ensure best practice with regard to antimicrobial use and antimicrobial stewardship.
- A programme of audits, reports and other activities will be followed to demonstrate that the objectives of this strategy are being met. This programme forms the basis of the Antimicrobial Stewardship Group's annual programme of work as described in the Trust's Antimicrobial Prescribing Policy and be reported through the Infection Prevention and Control Committee (IPCC).

3.6 Gram-negative Blood Stream Infections (BSI)

- Figure 6 SPC chart highlights the Trust attributed E Coli BSI cases per month from April 2016 to Jan 2022. 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.

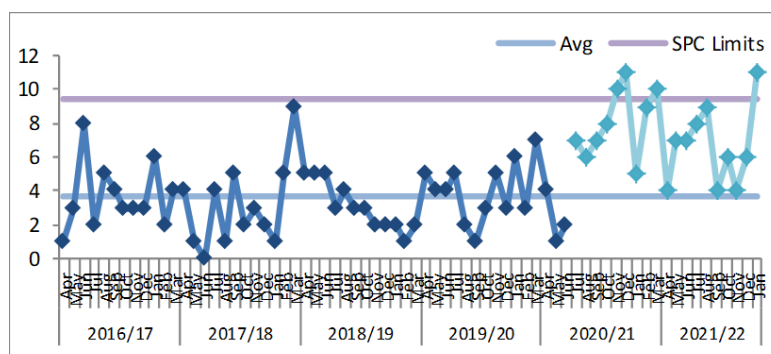


Figure 4

- There have been 83 cases of E.Coli bacteraemias attributed to the Trust to 31st March 2022 against an annual trajectory of 107. The objective for 2022/23 is 80 cases

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- 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 through the PIR process.
- For 2022/23 objectives have been set in addition for Klebsiella sp. And Pseudomonas sp. Blood stream infections and these will form part of the annual work programme for the year.

4. IPC Programme of work

- As Covid inpatient cases decline, the 2022/23 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.
- 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 2022/23.
- See appendix 2 and 3 for the MRSA/MSSA improvement plan and the annual programme.
- Much of the IPC Team proactive programme of work has been halted or delayed due to the Covid pandemic and outbreak management taking priority. However the Team have continued to utilise quality improvement methodology and innovative ways of supporting ward and department clinical teams to support their knowledge and skills in infection prevention and control:

4.1 Delivering Alternative Methods for IPC Mandatory Training

- All healthcare staff must do mandatory training in infection prevention and control. The IPC Team developed an alternative approach to delivering training during the Covid-19 pandemic.
- Using a quality improvement initiative, the infection prevention and control team developed a set of floor-standing retractable information banners to enhance mandatory training. Knowledge was then assessed using multiple-choice questions.
- The banners were piloted in one clinical division in the trust, with feedback providing the opportunity to revise and improve banner content and questionnaires.
- The approach has now been rolled out across the trust with plans to add online options to increase accessibility. The banners also have a QR code so that staff can download the training onto their phone.
- There is an assessment document to complete as part of the training and it is hoped that this will be available via a QR code in the future.
- This quality improvement programme was published in the nursing times (see images below) and presented to the NEY NHSE infection prevention leads meeting.

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Clinical Practice Innovation Infection prevention

Keywords: Infection prevention and control/Quality improvement/Training
This article has been double-blind peer reviewed

In this article...

- Why NHS staff have to do mandatory infection control and prevention training
- How banners provided an alternative way of delivering training during the Covid-19 pandemic
- Result of a pilot to assess the effectiveness of using this approach

Using banners to deliver mandatory infection control training in acute care

Key points

All healthcare workers must do mandatory training in infection prevention and control

A new approach using banners was devised to improve training compliance during the Covid-19 pandemic

Three floor-standing banners were designed and placed in dedicated areas for staff to access

A questionnaire was developed to test staff understanding after viewing the banners

After a successful pilot, this approach is being rolled out across the trust and has proven to be a useful addition to face-to-face and e-learning options

Authors Andrea Denton is independent nurse consultant and control nurse adviser, Faye Piker is senior infection prevention and control nurse, both at Bradford Teaching Hospitals NHS Foundation Trust.

Abstract All healthcare staff must do mandatory training in infection prevention and control. This article details an alternative approach to delivering training at one NHS acute trust during the Covid-19 pandemic. Using a quality improvement initiative, the infection prevention and control team developed a set of floor-standing retractable information banners to enhance mandatory training. Knowledge was then assessed using multiple-choice questions. The banners were piloted in one clinical division in the trust, with feedback providing the opportunity to revise and improve banner content and questionnaires. The approach has now been rolled out across the trust with plans to add online options to increase accessibility.

Citation Denton A, Piker F (2022) Using banners to deliver mandatory infection control training in acute care. *Nursing Times* [online], 19:1, 38-41.

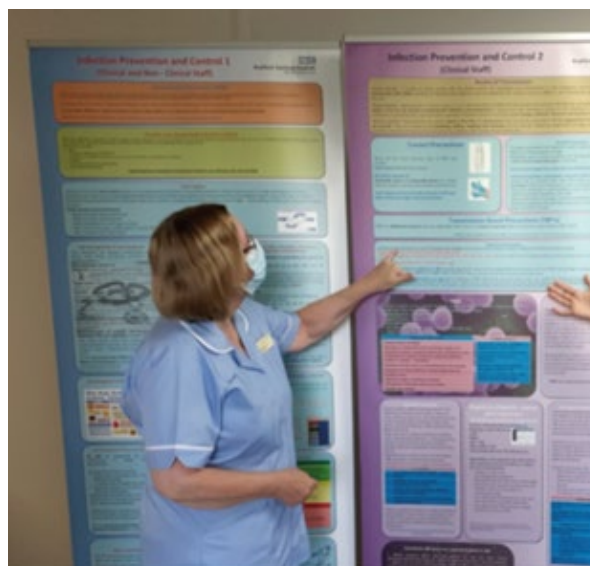
In June 2020, after the UK experienced its first wave of the Covid-19 pandemic, the infection prevention and control team at Bradford Teaching Hospitals NHS Foundation Trust was asked to explore alternative ways of delivering mandatory training. The number of staff who had completed mandatory training had fallen and, during the pandemic, there had been a temporary discontinuation of face-to-face infection control training; other methods of delivery, such as e-learning, were increasingly accepted. With a novel virus and an evolving healthcare situation, it was felt that any methods to reinforce good practice and provide up-to-date guidance would be beneficial. The then Department of Health's (DoH) code of practice in relation to the Health and Social Care Act 2012 specifies that a programme of infection prevention and control education must be in place for all healthcare workers as part of induction and ongoing development. This is reinforced by guidance published

by the World Health Organization (WHO) in 2019.

The team proposed introducing floor-standing retractable information banners incorporating mandatory training information. There was anecdotal evidence from another trust that this approach, used for both clinical and non-clinical staff, had been successful.

Aims Mandatory training in infection prevention and control consists of a mixed approach, with face-to-face, lecture-style presentations and e-learning methods. WHO (2019) suggested that any training should include team and task-based strategies that are participatory and include bedside and simulation training.

Health Education England's e-Learning for Healthcare (e-LH.org.uk) incorporates the national requirements for infection prevention and control at level 1 (Bia, 2017; HEE Learning Hub) and at level 2. This provided an outline for the content of the banners.



Nursing Times [online], January 2022 / Vol 118 Issue 1

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www.nursingtimes.net

4.2 Development of an IPC Link Practitioner Competency Book

- The IPC Team have developed, tested and evaluated a training and competency book for infection prevention link practitioners. The link practitioners are ward or department based clinical staff; the majority being nurses but the book has been developed with the intension of also being accessible to other professionals such as AHPs.
- The book has now been printed with sponsorship from an external company and is currently being implemented across the Trust. The intension is to allow the link practitioners to complete the book with regular drop in webinars from the IPC Team for support; once completed the link practitioner will receive a certificate and badge.



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4.3 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.

5. Progress Reports from Infection Prevention and Control Committee Sub Groups

5.1 Water Safety Steering Group (WSSG) Report:

5.1.1 Key Risks:

- The key regarding water safety are as follows :
 - Patient wipes have been associated with blocked drains causing sewage overflows and disruption to clinical services and their operations; the WSSG are reviewing possible alternative wipes as well as continued reminders to wards and departments regarding correct disposal.
 - WARDS 20/21 – Change of clinical hand wash basin (CHWB) trial. Following investigation of a cluster of patients identified with a multi-resistant gram negative infection where the sink drains were identified as contaminated with the identical organism despite change of the drain proximal pipes and repeated chemical disinfection. The IPC Team have also identified that the clinical handwash basin approved by the Estates department is not compliant with Health Building Note (HBN 08) recommended CHWB. Therefore the contaminated CHWBs have been replaced with compliant basins and subsequent environmental swabs have now been negative. No further cases are related to these CHWB.

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- Four water outlets at Shipley Hospital have been identified with Legionella contamination following routine water sampling. These outlets have been taken out of use and put on a daily flushing regime until chlorinated and then fitted with point of use (POU) filters. The outlets were resampled and tested clear. Due to the age of the premises and plumbing complications (unknown dead legs) in the hot and cold water systems, approval was sought to replace the water systems in the entire building, even though only the ground floor is occupied, completion is due to finish mid-May. NHSPS have managed the process.
- No further water contaminations have been detected in the other community properties including the augmented hospitals in Eccleshill (Cancer Day Cases) and at Skipton (Renal).
- Covid-19 has impacted on remedial works being carried to outlets in some areas due to access restrictions and therefore to mitigate this there has been installation of POU filters to clinical water outlets within Covid-19 cohort wards where access for sampling can be restricted.
- There has been an increase in the number of Legionella water testing on unoccupied wards or prior to reoccupation of patients with very few positive results reported and are localised and not systemic.

5.1.2 Lessons Learnt

- The WSSG have identified the following key lessons learnt following incidents and routine inspections and these have been communicated to clinical teams:
 - Users to ensure Water outlets (Inc. showers) are in regular use and are being flushed for a minimum 3 minutes. Showers must be flushed on a daily basis
 - To ensure WHBs are used correctly for their intended purposes – Hand Washing only.
 - To ensure the standard of cleaning is being maintained to water outlets & hand wash basins, to assist with the management of waterborne bacteria, i.e. pseudomonas and legionella.
 - To assist with the identification of 'Little used water outlets' (defined as outlets not being in regular use for 7 or more days) to ensure a recorded flushing regime is in place or removal of the outlet (free of charge) by the Estates team.

5.1.3 Governance Arrangements:

- The Water Safety Policy was ratified on 18 December 2019 and is due to be reviewed by December 2022.
- The Water Safety Plan (Procedures Document) is in date, and is managed of any changes through the WSSG. Work is progressing to develop the Water Safety Plan in line with BS

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8680:2020 Water Quality - Water Safety Plans – Code of Practice. WSSG meets on a quarterly basis and attendance is good.

- WSWG meets monthly in between the WSSG meetings (8 times per year); attendance is good from Estates, IPC, and the cleaning services team.

5.1.4 Management of Waterborne Pathogens:

- An externally appointed contractor undertakes the water sampling and laboratory testing of water outlets (Inc. showers) for the Trust. The laboratory is UKAS 4065 and Public Health England approved testing facility.
- April results for legionella and pseudomonas sampling tests figures are being tabulated and updated on the spreadsheets and will be presented at the Water Safety Working & Steering Group.

5.2 Ventilation Safety Group Report;

- The updated Health Technical Memorandum (HTM) 03-01 Specialist ventilation for healthcare premises Parts A & B is now published and distributed for implementation. There are some significant changes which will change certain departments' ventilation requirements; this may impact on compliance standards.
- The Ventilation Systems Procedures and Ventilation Systems Policy are complete. The document has been reviewed by the VSG and the Compliance Risk Assurance Committee (CRAC) and forwarded to the Policy & Development Team to be formally issued and populate the Trusts' library.
- Estates are identifying areas within the Trust that are undertaking invasive and critical procedures/treatments that necessitate adequate ventilation requirements. A review of all the clinical services is being carried out so that a robust ventilation strategy can be in place.
- ADU (Renal – BRI) currently has no means of adequate ventilation; this is a consequence of the AED scheme. Estates have distributed x7 IQAir air-purifiers in ADU as a pilot, in an attempt to improve air quality by HEPA filtration and increased air-change.

5.2.1 Management of Ventilation Systems:

- Estates have completed an extensive capital programme consisting of several ventilation system replacements/upgrades. This includes:
 - ENT Theatres 1-3 ventilation system upgrade
 - AED siderooms (with negative pressure)
 - Ward 10 (ICU overspill currently)
 - Maternity Theatre 1&2 extension
 - Ward 2/5 upgrade/refurbishment
- Estates are continuing with the series of controlled ventilation drawings and schematics for all Trust specialist ventilation systems. This is to provide assurance and control around any

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verification/validation exercise that is to be undertaken, and to apply benchmarked figures to assess system compliance. These are being developed for existing and new systems.

- Ward 1 PPVL & negative pressure rooms upgrade was on-hold; however, plans were progressing to develop the scheme and relocate patients/services whilst works being undertaken etc.
- Room 6 (Radiology) ventilation is due to be upgraded pending completion of the Room 4 (Radiology) ventilation upgrade funded by the Radiology team. Room 4 will support Room 6 whilst works are being undertaken, both systems are to deliver >20ACH and designed to achieve theatre standard, this will allow an increase in service resilience as well as controlling risks aspects of HAIs etc.
- Clinical air-conditioning unit (ACU) schedules across the Trust have been amended so that all cleaning and servicing is undertaken on a quarterly basis, rather than the contracted bi-annual servicing schedule. This is in light of the COVID-19 secure assessments and risks associated with equipment recirculating air within clinical environments.
- The Maintenance Contractor (Air Projects) has completed a review of all the wards and departments across the BRI site. This was to develop an understanding and consensus of what areas are performing various clinical treatments/procedures, to progress and populate the existing verification schedule. This has been completed and escalated to IPCC for review. The intention of this schedule is to identify areas with significantly poor ventilation that may benefit from air-purifiers.
- The ongoing Maternity Theatre Extension scheme is complete and has been handed over. The 2nd phase of the scheme is to include a HDU facility
- AED HDU side rooms are now fully operational and populated on the annual verification schedule.
- Manufacturing Pharmacy's aseptic is currently under review with the intention to relocate aseptic services to SLH via temporary site accommodation. This is currently with the Local Planning Authority to seek approval for new building on our site. Services have been scoped and anticipated delivery/approval end of May with on-site start in June 2022.

5.3 Cleaning, Waste and Patient Environment Group Report

This group meets bi-monthly and is made up of representatives from Facilities, Estates, Infection Control, Risk and clinical teams. Its overall purpose is to provide assurance to IPCC that the organisation is meeting its legislative responsibilities in relation to Health and Social Care Act 2008, Food Safety Act 1990, Waste regulations 2011, and other similar and associated legislation as below:

5.3.1 Cleaning

The group reviews cleaning audits on a monthly basis, exceptions and action plans are shared. The biggest piece of work has been the implementation of the new national standards for healthcare cleanliness.

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A separate implementation group was set up which reported to the cleaning, waste & patient environment group. These standards are now live, with all areas having a star rating on display in addition to a signed copy of the cleaning charter. New schedules are in place on each area to reflect the new functional risk categories. A new audit tool has been purchased and is being configured to ensure fit for purpose reports are available for clinical teams. The standards have specified audit frequencies for each functional risk category, and as a result, it has been determined that additional audit staff are required, there is a current risk that not all audits are currently being completed to the required frequency, however there is a plan in place to address this.

5.3.2 Catering

The catering team completed its annual ward kitchen hygiene inspection and reported its findings back to the group. There was an overall improvement in standards. An independent auditor completed an audit of the Hazard Analysis and Critical Control Point system, and advised of minimal changes. Finally the Environmental Health Officer completed audits at both BRI and SLH awarding both 5 stars.

5.3.3 Waste

Every year an annual pre-acceptance audit is undertaken which forms the basis of the work plan for waste and advises by area any themes or issues to be dealt with by the clinical teams or waste services. Unfortunately due to Covid whilst the audit was undertaken, this wasn't a normal year and it was hard to provide a full assessment. An overall theme was that the Trust should try to re-introduce the offensive waste stream as soon as possible, and this is being monitored through the group.

A key area of risk for waste and indeed other service areas has been the disposal of sharps in soft waste bags. Work has been completed to update the SOP for when this happens and this has recently been approved through this group and the Sharps Injury Prevention Group.

Poor segregation of waste has been a theme over a number of years, and this group has looked at ways to improve the position. An e-learning package has been developed that has been signed off, and is due to be launched in the near future. It is hoped that this with targeted support at department level, will help to improve the segregation of waste.

A final key objective for this group with relation to waste is to improve recycling. The cardboard waste stream has been introduced and is seen benefits in terms of cardboard waste that has been segregated and removed from the other general waste stream (which is recycled, or goes to energy from waste schemes.)

6. Report Recommendations

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

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- 6.2 The Academy is requested to note the risks identified and approve the further actions and mitigations as detailed in the main report.

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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: 2022/23

Infection Prevention & Control Annual Work plan: 2022 -23					
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 2022/23	R A Y G	Timescale & individual responsibility.
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 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 30.5.22 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 practice</p>	<p>Training programme currently covers mandatory infection control and complies with National Core Skills Framework. 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>30.5.22 and ongoing</p>

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	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. Collaboration with Learning & Development Team to implement ANTT as part of mandatory training</p>		IPN Team /Education Team 30.12.22

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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 30.12.22
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 including audit report and recommended actions to the IPCC and the IPCC work plan. Progress on compliance with decontamination protocols for all scopes and probes within the Trust reported to IPCC on completion of audit.</p>		Decontamination Lead 30.9.22
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 person	<p>Tackling antimicrobial resistance 2019–2024 The UK's five-year national action plan</p>	<p>HCAI improvement programme: to include Gram Negative Bacteraemia improvement</p>		IPN team ,

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	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.)		30.10.22
		Post Infection Reviews (PIR) is undertaken for MRSA, MSSA, E.Coli bacteraemias and hospital associated C. 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. Completed PIRs reviewed at PIR Review panel and level of harm agreed with feedback to Datix 3. 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 4. Ensure key themes and lesson learnt are shared through Care Group Governance processes.		Care Group/CBU DADNS continuing to be undertaken.

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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. Develop outbreak summary report to IPCC		IPC Team, Lead Nurse IPC 30.9.22
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 30.7.22
1.5.	An infection prevention infrastructure should encompass:				

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1.5.1	<p>Mechanisms are in place to ensure that sufficient resources are available to secure the effective prevention and control of infection.</p> <p>An infection prevention team consisting of an appropriate mix of both nursing and consultant medical expertise (with specialist training in infection prevention and cleanliness),</p> <p>24-hour access to a nominated qualified infection control doctor (ICD) or consultant in health protection/communicable disease control.</p>	<p>Infection Prevention Nursing Team with recognised qualifications, knowledge and experience is in place.</p> <p>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)</p> <p>Loss of Infectious Diseases (ID) Consultant Team and only 1 substantive Consultant Microbiologist – additional locum in place (May – Aug 2019)</p> <p>Risk due to lack of Senior specialist Medical support to Infection Prevention and Control service.</p>	<p>Risks Noted for risks associated with loss of ID Consultant service and limited Consultant Microbiologist support to IP& C service.</p> <p>Risk assessment to be completed outlining the risks.</p> <p>Loss of 24/7 on call for ID/Micro consultants to be risk assessed and mitigations agreed to support IPC Team</p>		<p>DIPC/Medical Director /Nurse Consultant/Gen Manager for Pathology</p> <p>30.8.22</p>
1.6.	Movement of service users				
1.6.1	<p>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.</p>	<p>Good working relationship with Clinical Site Team. Risk assessment for sideroom prioritisation completed and revised posters distributed.</p> <p>Alert flagging system in place on EPR.</p>	<p>Liaise with Clinical Site Team to develop systems to ensure appropriate isolation placement for patients with HCAs and communicable infections.</p> <p>Joint MDT Review of BTHFT clinical isolation requirements to ensure best use of sideroom capacity</p>		<p>DIPC/Lead Nurse IPC/CST Lead</p> <p>30.7.22</p>

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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 2022/2023	R	Timescale & individual responsibility.
				A	
				Y	
				G	
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 take an active role. Assurance reports to IPCC.		Assistant General Manager Facilities 30.7.22
2.2	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 30.7.22
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 1.7.22 Matrons/ADNS 1.8.22

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2.4	<p>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;</p>	<p>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.</p> <p>. Governance arrangements for assurance processes to support ventilation validation reports and escalation processes are needed to ensure patient safety.</p>	<p>Ventilation</p> <ol style="list-style-type: none"> 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 systems through the IPCC and Patient Safety Sub Committee. 		<p>Assistant Director Estates/ DIPC / 31.10.22</p>
	<p>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.</p>		<p>Water Safety:</p> <p>Ensure water sample results, actions and recommendations communicated to relevant CBU Leads</p>		<p>Assistant Director Estates 30.6.22 and ongoing</p>
2.5	<p>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;</p> <p>Policies on the environment should take account of infection prevention team expert advice.</p>	<p>National cleaning standards require full implementation with assurance of compliance to IPCC.</p>	<p>Cleaning Standards:</p> <p>Report on progress with implementation of National Cleaning Standards as standing item on IPCC Agenda</p>		<p>Facilities Team/ Estates Team/ 30.12.22</p>

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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 2022/2023	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 strategy and agree audit programme for 2022/23.		Consultant Microbiologist, ID Consultant Antibiotic Pharmacist 30.8.22
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 audit program to be drafted -		Lead pharmacist antimicrobial therapy – 30.8.22

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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 – 30.8.22
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 2022/2023	R	Timescale & individual responsibility.
				A	
				Y	
				G	

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4.1	Areas relevant to the provision of information include: <ul style="list-style-type: none">principles on prevention of infectionimportance of appropriate use of antimicrobials;compliance by visitors with hand hygiene;reporting concerns relating to hygiene and cleanliness including hand hygieneexplanations 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 30.10.22
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 2022/2023 .	R	Timescale & individual responsibility.	
			A		
			Y		
			G		

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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>Implementation of National IPC Manual requires review and alignment with Trust IPC protocols</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> <p>3. Ensure Review of IPC Manual and alignment of Trust protocols</p>		Nurse Consultant 30.3.23
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 2022/2023	R	Timescale & individual responsibility.
				A	
				Y	
				G	

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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 sideroom 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 are risk assessed and mitigations in progress.</p> <p>Lack of adequate sideroom facilities with safe functioning ventilation, en-suite facilities that are safe for both patients and staff from risk of airborne diseases. Cross transmission of TB from inadequate sideroom design raised as SI and escalated to Execs.</p> <p>Risk assessment of inadequate isolation facilities escalated to Execs during 2021 -22</p>	<p>The Built Environment:</p> <p>Sink to bed ratio/sideroom capacity and bed spacing review to be completed. Above review shared with Care Groups and Execs.</p> <p>Trust wide risk assessments required to understand sideroom capacity and sink to bed ratio requirements and develop plans for increasing capacity.</p> <p>Task and Finish group established with Estates, Risk & Governance and Clinical colleagues to risk assess sideroom safety and quantity of isolation facilities</p> <p>Development of capitol scheme & undertake a Trust wide feasibility study for placement of isolation rooms with presentation to Execs.</p>		<p>Assistant Dir Estates/DIPC./Director Ops for Care Groups/Dir. Transformation/CMO</p> <p>30.9.22</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 2022/2023	R	Timescale & individual responsibility.
			A	
			Y	
			G	

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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.	<ul style="list-style-type: none"> Lab results, 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. No CDI results being reported to ICNet 	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) 31.8.22
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. Changes in Lab protocols not shared with BTHFT Lab protocols held by Airedale laboratories – unsure of compliance	Meetings with Airedale Microbiology service requested.		

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	

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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.
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	<div>R</div> <div>A</div> <div>Y</div> <div>G</div>	Timescale & individual responsibility.
10.1	All staff can access occupational health services;	Policies are in place and receive regular review. Staff Immunisation programme is in place and exceptions reported to IPCC (i.e. shortages of vaccine). Decisions on offering immunisation are made on a local risk assessment as described 'The Green Book'	To review and implement revised BCG vaccination programme for Healthcare staff at risk from TB at BTHFT following discussion at IPCC. BCG records to be updated		

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

Appendix 3: MRSA & MSSA Bacteraemia Improvement plan 2021/22 (Updated June 2022)

Control Objective		Reduction in MRSA / MSSA Bacteraemia					
	1						
No.	Description	Lead	Date Assigned	Scheduled completion	Status	Actual Completion	Progress Comments:
1	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	01.10.2022	C	14.6.2022	Non-compliance continues to be reported via Datix SOP in EPR developed, staff training in progress on SDEC using PDSA cycle. Point prevalence audit completed and will be repeated again following training followed by wider roll out to clinical areas
2	All admission wards to use the MRSA screening Protocol	Matron/IPCT	27/03/2021	01.10.2022	C	14.6.2022	
3	All new inpatients with MRSA will receive a IPC review (Monday-Friday)	Lead IPCN	15/03/2021	01.10.2022	C	14.6.2022	

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Control Objective		Reduction in MRSA / MSSA Bacteraemia					
1							
No.	Description	Lead	Date Assigned	Scheduled completion	Status	Actual Completion	Progress Comments:
							to protocol <ul style="list-style-type: none"> ○ Body was continues for duration of stay if greater than 5 days ○ Referral to TV team if required ○ Urinary catheter care ○ Datix completed for non-compliance
4	Antibiotic prescriptions within EPR are in line with prescribing policy or agreed variation with ID or Consultant Microbiologist	Antimicrobial Pharmacist	22/03/2021		C	1.4.2022	Audit compliance will be reported to Drug and therapeutic committee and IPCC
5	Octenisan antimicrobial body wash to be prescribed for all acute inpatients at the time of admission	DIPC	1.3.2022	01.10.2022	O		SOP, patient information leaflet and screensaver developed. Tool box awareness sessions performed. Point prevalence audit May 22 highlighted variance in practice due to difficulties with medical prescribing. SOP revised but awaiting confirmation from Director of Pharmacy that can be allocated as a nursing task to support improved

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Control Objective		Reduction in MRSA / MSSA Bacteraemia					
1							
No.	Description	Lead	Date Assigned	Scheduled completion	Status	Actual Completion	Progress Comments:
							compliance.
6	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	1/07/2022	C	01.05.2022	Frepp discontinued by manufacturer but substituted by Cloraprep containing 4% CHG 70%IPA
7	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	C	14.06.2022	Staff members are taught using safety blood collection sets and ANTT
8	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	C	14.06.2022	93 ANTT assessors in place and trained. Focus training completed on ICU, NICU, The meadows, ward 26 Training and assessment being led by the Education team supported practice educators supported by IPC team
9	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	01/08/2022	O		Discussed at local care group IPC meetings and will be supported by IPC team to ensure VIPs recorded at least daily and then focus on achieving 3 times daily

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Control Objective		Reduction in MRSA / MSSA Bacteraemia					
1							
No.	Description	Lead	Date Assigned	Scheduled completion	Status	Actual Completion	Progress Comments:
10	Explore feasibility of creating MRSA care plan in EPR	IPCT	20/04/2021	01/10/2022	O		Discussion with CHFT IPC team with request to EPR to provide care plan for both trusts.
11	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/ matron	27/04/2021	01/07/22	O		Audit compliance against Vascular access device policy. VIP audits restart March 22
12	Remove peripheral cannula within 24 hours of cannula being inserted in emergency situations where aseptic technique cannot be assured	IPCT	22/03/2021	01/07/22	O		VIP audits restarted March 22.
13	Relaunch the 'Gloves are off Campaign' to support hand hygiene compliance and reduce unnecessary glove use	IPCT	27/04/2021	1/10/2021	C	05.05.2022	Relaunched on 05.05.2022, stall on concourse with good staff engagement; tool box exercises delivered to clinical areas with revised posters and inclusion in 'Let's talk'
14	Restart matron IPC audit programme; results and actions to be monitored by the individual care groups at local IPC meeting and included in report to IPCC	Matron/ ADNs	27/04/2021	1/8/2022	C	1.5.2022	Audit has resumed, action plan created for areas of non-compliance and monitored at local IPC meeting. Summary included in care group report to IPCC