Board of Directors' Meeting
11 August 2022

The Shrewsbury and Telford Hospital NHS Trust

Agenda Item	157/22			
Report Title	Infection Prevention and Control Report			
Executive Lead	Hayley Flavell, Director of Nursing			
Report Author	Kara Blackwell, Deputy Director of Nursing			
	Link to strategic goal:		**Link to CQC domain:**	
	Our patients and community		Safe	√
	Our people		Effective	√
	Our service delivery	√	Caring	√
	Our governance	√	Responsive	√
	Our partners		Well Led	√
	Report recommendations:		**Link to BAF / risk:**	
	For assurance	√		
	For decision / approval		**Link to risk register:**	
	For review / discussion			
	For noting		2077,2158,1749,1456	
	For information		1359,1847,1994,1809	
	For consent			
Presented to:				
Executive summary:	This IPC report has provided a summary of the performance in relation to the key performance indicators for IPC in Quarter 1 of 2022/23. In relation to HCAIs, there has been an increase in C.Diff and MSSA cases in Q1 of 2022/23 compared to Q4. There has also been an outbreak of ESBL Klebsiella on the Neonatal Unit and some associated poor practices in relation to IPC with actions taken to address this. The number of COVID-19 cases being seen in the Trust initially decreased in the first 2 months of Q1 but rose significantly in June. There has been increasing issues identified on the Quality Ward Walks undertaken as part of these outbreaks in relation to compliance with IPC procedures and practices which the DIPC has addressed with the Divisional Teams. The IPC BAF was reviewed in June 2022, the Trust is RAG rated green for 120 of the key lines of enquiry, and amber for 10 items.			
Appendices	IPC BAF June 2022 - In Supplementary Information Pack			

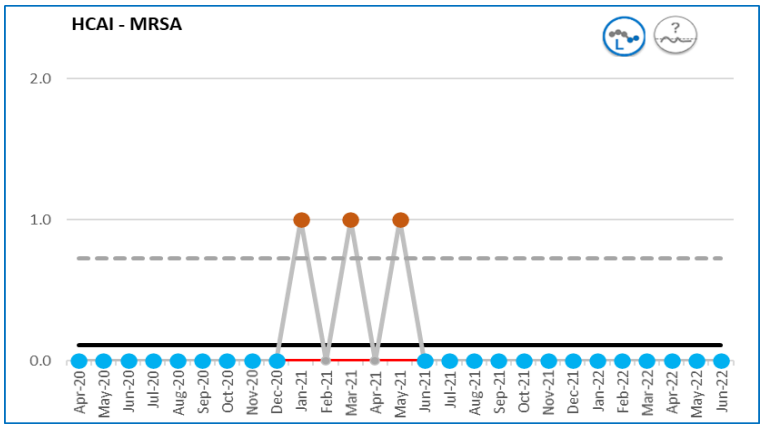
1.0 INTRODUCTION

This paper provides a report for Infection Prevention and Control for Quarter 1 (April to June 2022) against the 2022/23 objectives for Infection Prevention and Control. An update on hospital acquired infections: Methicillin-Resistant *Staphylococcus aureus* (MRSA), Clostridioides Difficile (CDI), Methicillin-Sensitive Staphylococcus (MSSA), Escherichia Coli (E.Coli), Klebsiella and Pseudomonas Aeruginosa bacteraemia for Q1 of 2022 is provided as well as an update in relation to Covid-19. The report also outlines any recent IPC initiatives and relevant infection prevention incidents. The updated IPC BAF is also included.

2.0 KEY QUALITY MEASURES PERFORMANCE

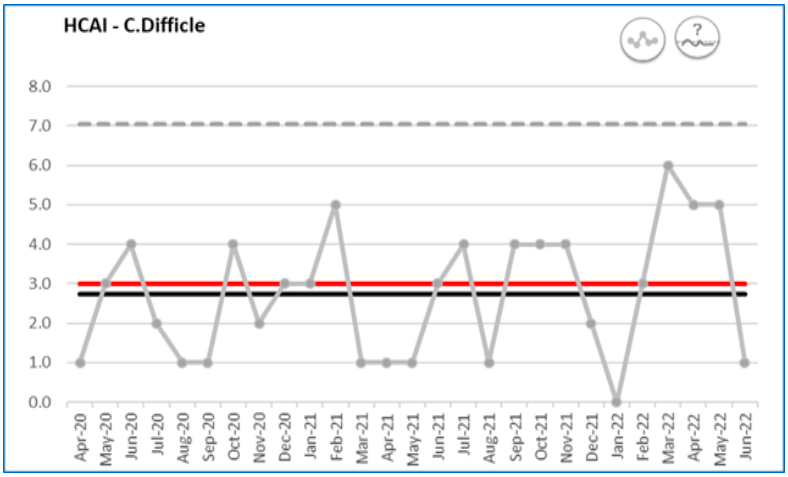
2.1 MRSA Bacteraemia

The target for MRSA bacteraemia remains 0 cases for 2022/23. There were 0 cases in Q1 2022/23. The last cases reported was May 2021.



2.2 Clostridium Difficile

The Trust trajectory for C diff cases in 2022-23 is no more than 33 cases. Total number of C-Diff cases reported per month is shown:



There were 11 cases of C.Diff attributed to the Trust in Quarter 1 (April to June 2022). This is the highest number in a Quarter for over 2 years. 10 of these cases were post 48 hours of admission and 1 case had been an inpatient in the 28 days prior to their positive sample.

The YTD target for Q1 is no more than 8 cases and although the number of cases fell

significantly in June compared to the previous 2 months, if there is similar performance in future Quarters in 2022/23 the Trust is at risk of breaching its target in 2022/23 so addressing the issues identified from the RCA investigations and ensuring good compliance with IPC procedures and practices.

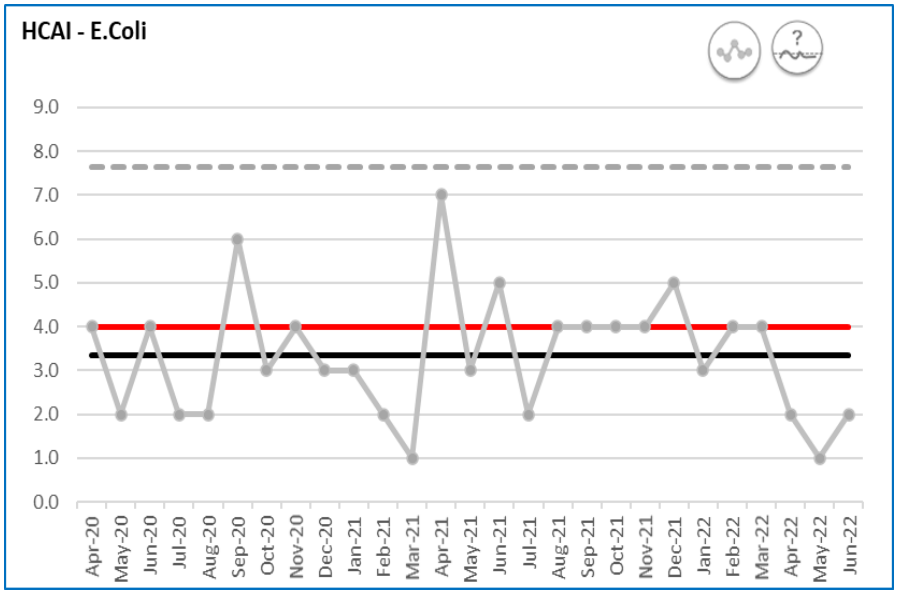
Root cause analysis investigations are undertaken on all C.diff cases. Learning from RCAs undertaken include:

- The timely manner of isolating a patient who was experiencing 2 or more episodes of unexplained type 5, 6, or 7 stool.
- The isolation on admission of a patient who is admitted with type 5, 6 or 7 stool and the timely sending of a stool sample.
- The delay of commencing of a stool chart at the second episode of an unexplained type 5,6, or 7 stool, and the lack of documentation in nursing notes regarding the patient's current bowel habit.

As part of the RCA process, action plans for each case include sharing of the cases with the relevant clinical division in their governance meetings. This is normally undertaken by the consultant attending the RCA meeting so that lessons learnt can be shared and findings of good as well as areas identified for improvement can be discussed and disseminated. Learning from the RCA's are also shared as part of the divisional reports in Infection Prevention and Control Operational Group.

2.3 E.Coli Bacteraemia

The Number of E.Coli cases are shown:



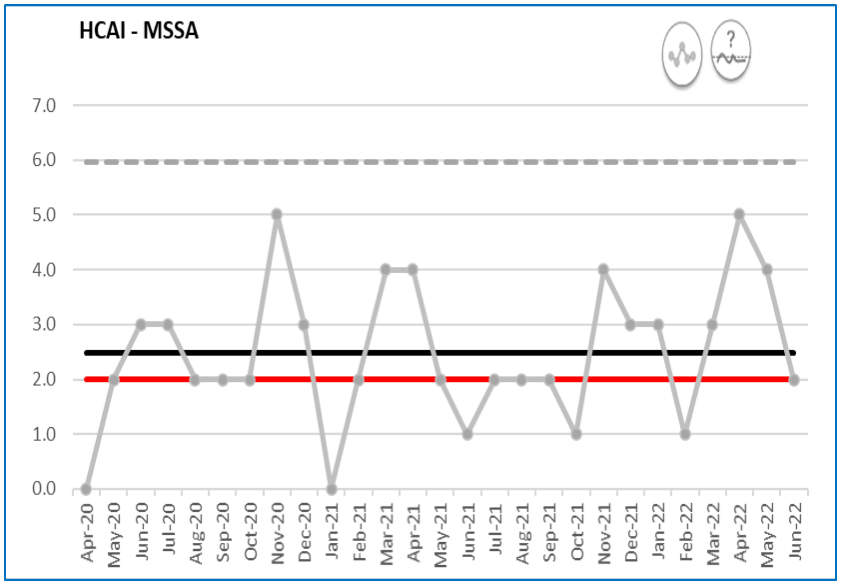
The target for 2022-23 is no more than 96 cases. In Quarter 1 2022/23 there were 5 cases of post 48-hour E.coli bacteraemia which is a significant reduction from the numbers seen in each Quarter of 2021/22.

All cases which are deemed to be device related or in which the source cannot be identified have an RCA completed.

1 case was deemed to be device related, a 2nd case is being reviewed is being reviewed by microbiology to determine the source, and the remaining 3 cases were considered not to be device related.

2.4 MSSA Bacteraemia

The number of MSSA cases are shown:

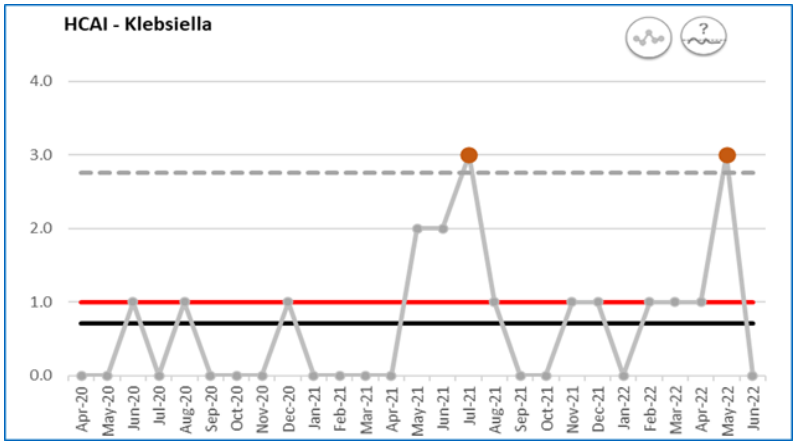


There has been no national target set for MSSA bacteraemia cases in 2022/23. There have been 11 cases of post 48-hour MSSA bacteremia in Q1 2022/23.

All cases deemed to be device or intervention related have an RCA completed.

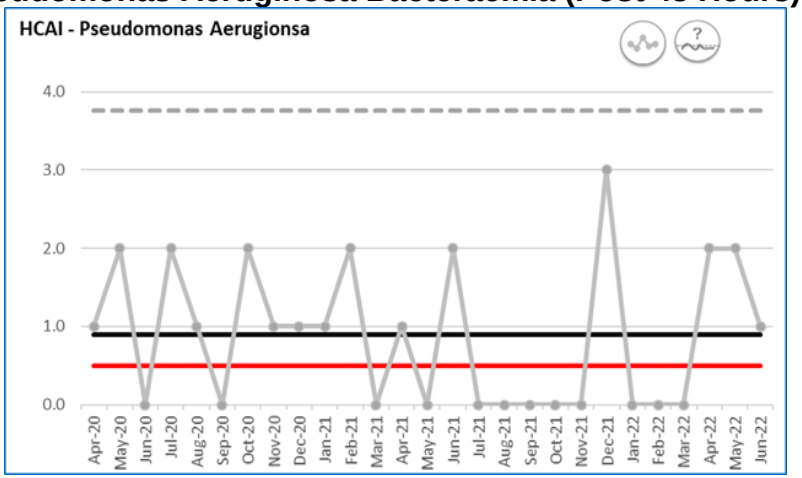
Of the 11 cases of post 48-hour MSSA bacteraemia, 4 were considered to be device or intervention related, and 2 are still under investigation. 1 was a surgical site infection, and 3 were considered to be line infections.

2.5 Klebsiella Bacteraemia (Post 48 Hours)



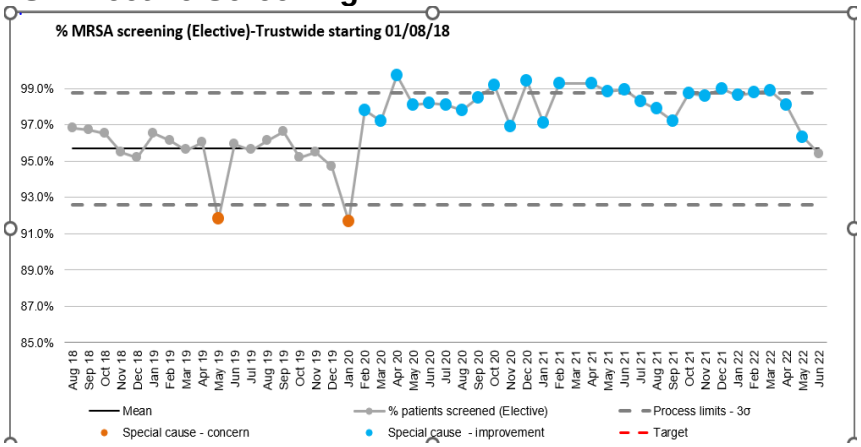
The target for 2022/23 is no more than 23 cases. There was a total of 4 cases of post 48-hour Klebsiella Bacteraemia in Q1 2022/23.

2.6 Pseudomonas Aeruginosa Bacteraemia (Post 48 Hours)



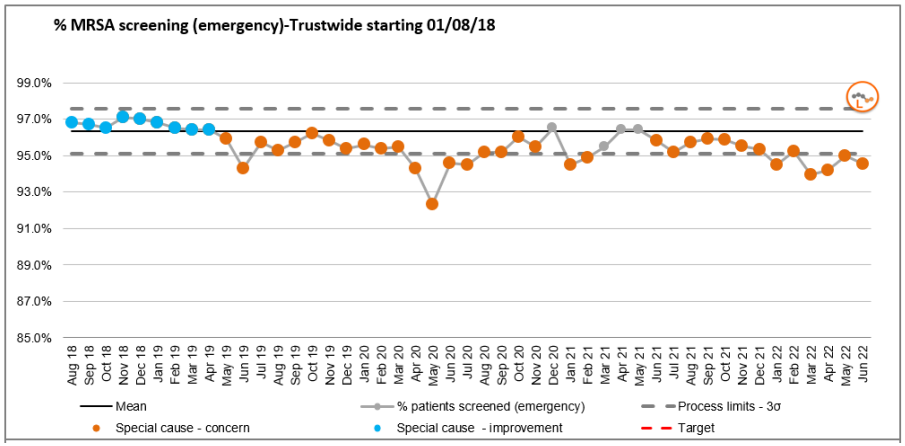
The target for 2022-23 is no more than 19 cases. There have been 5 cases of Pseudomonas Aeruginosa at the end of Q1. 4 of these cases are under review to determine the source, and 1 was considered not to be device related.

2.7 MRSA Elective Screening



MRSA Elective screening compliance has been above the 95% target throughout Q1 2022/23. YTD average performance is 96.6%.

2.8 MRSA Emergency Screening



The MRSA emergency screening compliance has not reached the required 95% target for Q1 with compliance at 94.57%. This has been discussed with the clinical teams to ensure improvements

Root Cause Analysis Infections for MSSA and E.Coli Bacteraemia

All MSSA and E.coli post 48-hour bacteraemia are reviewed by the microbiology team, those deemed to be device related or where the source of infection cannot be determined have a Root Cause Analysis (RCA) completed. In Quarter 1, there were the following device related confirmed cases:

- 1 E. Coli bacteraemia
- 2 MSSA

Learning from completed RCAs include:

- Management of urinary catheters including documentation and plans for removal is poor in E. coli bacteraemia
- Lapses in management of peripheral cannula including recording of VIP scores identified in MSSA bacteraemia
- Appropriate clinical specimens are not sent in a timely manner to enable correct antibiotic prescribing choices

Actions implemented in relation to improvements include:

- The sharing and discussion of the RCA and its findings through the relevant clinical governance teams
- Discussion and practice during IPC and induction training with FY1's regarding Blood culture best practice. Blood culture 'top tips' poster distributed to all clinical areas to highlight best practice
- Ward managers monitor the VIP scores and compliance monitored at monthly nursing metrics meetings, and also reported by division through their IPCOG reports
- Urology specialist nurses now linking with clinical practise educators to provide catheter care training as part of the statuary training requirement.

3.0 PERIODS OF INCREASED INCIDENCE/OUTBREAKS

During the April to June 2022 there were 20 COVID outbreaks declared at the Shrewsbury and Telford Hospital NHS Trust.

The most common issues identified during the outbreak management are:

- Missed routine and contact COVID screens
- Environmental / equipment contamination
- PPE non-compliance

There were 2 cases of ESBL Klebsiella linked in place and time on the Neonatal Unit, the typing confirmed these 2 cases were the same strain, therefore an outbreak was confirmed

3 other periods of increased incidence were declared in Q1, as below:

- C.diff on Ward 23, typing confirmed these cases were not the same and therefore not an outbreak
- Pseudomonas on Ward 23, typing confirmed these cases were not the same typing and therefore not an outbreak
- C.diff on the Surgical Assessment Unit (SAU), the typing of the cases confirmed this was not an outbreak

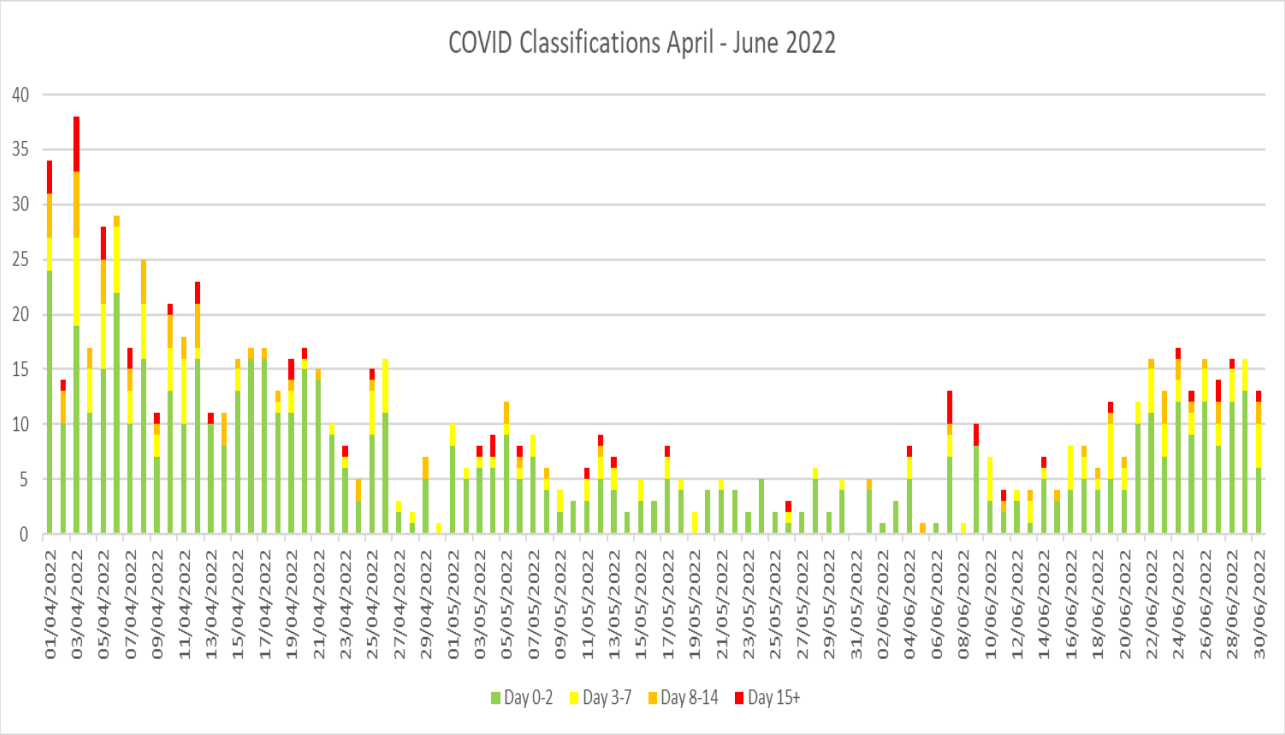
The periods of increased incidence/outbreaks are shown for Quarter 1 2022/2023 in the table below.

	Ward	Infective Organism	Typing	Learning
April 22	34	COVID	NA	Long stay patient had been having visitors- visitors had tested positive but continued to attend ward
	24	COVID	NA	Bay of contacts that converted to positive cases, long stay patients were isolated throughout admission but had been having regular visitors- no contact with anyone else known to be positive
	DSU (PRH)	COVID	NA	2 bays affected, both had index cases creating bay of contacts who converted. Issues noted with PPE and HH
	Ward16	COVID	NA	Positive cases not isolated in a timely manner and no escalation. PPE and HH compliance issues.
	Ward 6	COVID	NA	Contacts converted to positive cases.
	Ward 7	COVID	NA	2 index cases who caused contacts who converted to positive cases, missed routine admission screens. Issues with contaminated equipment
	Ward 35	COVID	NA	Patient positive on day 3 caused a bay of contact who converted to positive cases
	Ward 4	COVID	NA	Compliance with routine COVID swabbing poor. Staff LFT compliance poor Issues with PPE compliance
	Ward 28	COVID	NA	Index case caused a bay of contacts who converted to positive cases. Issues noted with contamination of equipment and environment and non-compliance with PPE
	Ward 23	C. diff	Different	Issues with contaminated commode noted IPC care plan not being used for patients with infections
	Ward 23	Pseudomonas	Different	Pseudomonas found in water samples including shower of one of the side rooms. Estates work needed to improve bathrooms undertaken
	Neonates	ESBL Klebsiella	Same	Issues noted with contamination of equipment and environment, poor compliance with good infection prevention practice including PPE and hand hygiene.
May 22	Ward 6	COVID	NA	Index case caused contacts in 2 bays due to movement within the ward, who converted to positive cases, unable to isolate in a timely manner due to patients needing to stay in cardiology

	Ward	Infective Organism	Typing	Learning
	Ward 33	COVID	NA	Issues with contamination of equipment and compliance with PPE
	Ward 24	COVID	NA	Thought to be due to visitors as index case had frequently, caused contacts who converted to positive
June 22	Ward 25	COVID	NA	Issues noted with HH and PPE compliance
	Ward 24	COVID	NA	Patient positive on admission created bay of contacts who converted to positive cases- all patients in bay 5/6
	Ward 26	COVID	NA	Initially an index case followed by a bay of contacts converting to positive cases. Issues noted with contamination of equipment and environment, PPE compliance, compliance with routine COVID swabs. Staff LFT compliance poor
	Ward 23	COVID	NA	Index case caused bay of contacts who converted to positive cases. LFT compliance amongst staff poor
	Ward 28	COVID	NA	Initially an index case followed by contacts converting to positive cases. Issues with contamination of equipment and environment, hand hygiene and PPE non-compliance. Compliance with routine COVID swabs poor, staff LFT compliance poor
	Ward 6	COVID	NA	Issues notes with environmental contamination and BBE compliance of medical staff
	DSU (PRH)	COVID	NA	Index case transferred into a bay whilst symptomatic, without COVID result. Caused a bay of contacts who converted to positive cases. Routine COVID swabbing compliance poor
	Ward 22TO	COVID	NA	Contacts who converted to positive cases. Issues noted with hand hygiene, PPE and environmental cleanliness, compliance with day 3 screen poor
	SAU	C. diff	Different	Contamination of equipment including commodes and mattresses

4.0 COVID 19 UPDATE

The number of Covid-19 cases in the Trust in Quarter 1 (April to June 2022) started to decrease, before increasing again in the latter part of Q1has begun to rise again. The graphs below demonstrate the increase in cases seen in the Trust in Quarter 1.



In October 2020 NHSEI provided definitions of apportionment of COVID 19 in respect of patients diagnosed within hospitals as below:

Community Onset – Positive specimen date <=2 days after hospital admission or hospital attendance

Hospital-Onset Indeterminate Healthcare-Associated – Positive specimen date 3-7 days after hospital admission

Hospital-Onset Probably Healthcare-Associated – Positive specimen date 8-14 days after hospital admission

Hospital-Onset Definite Healthcare-Associate – Positive specimen date 15 or more days after hospital admission

In Q1 2022/23 there were 77 'Probable' Healthcare Associated cases, and 48 'Definite' Healthcare Associated cases. Most of these cases have been involved in COVID outbreaks on the wards, however any case that tests positive after day 8 of admission that is not involved in an outbreak will have an RCA completed.

Analysis of cases in Q1 showed that 64% of all cases were contacts of covid positive patients who went on to convert to positive cases and that 90% of cases converted by day 4, an indicator of the higher transmissibility of the current variant.

Trust Compliance with the National Covid Guidance

Throughout the pandemic the Trust has reviewed and implemented practices based on the most recently published national guidance. In relation to the most current guidance the Trust in collaboration with the advice from its microbiology team are going beyond the national guidance to ensure the safety of our patients/staff is maintained and has actions in place to address some other aspects of the national guidance as outlined below:

National guidance	In place (Yes/No/Partial)	Reason
No longer required to isolate contacts of COVID	**Partial** Contacts cohorted until has had a negative PCR on identification. Isolated period reduced from 7 days to 5	High conversion rate of contacts to positive (64% of patients involved in outbreaks were initially identified as contacts)
No longer requirement for universal mask wearing	**Partial** Universal masking ceased in non-clinical areas only	Masks kept in clinical areas due to increasing community levels of COVID- for review As of July 2022, Trust made the decision to strongly advise that masks were also worn in non-clinical areas due to the high prevalence of the virus in the local community
Elective admissions to be swabbed using LFT on admission rather than PCR 72 hrs prior	**Partial** All General anaesthetics are being PCR tested, Local anaesthetics are being LFT tested. RSH Endoscopy still using PCR testing for Upper GI endoscopy. A paper has been submitted to move to LFT	Decision made by microbiology to keep PCR for general anaesthetics due to increased community numbers and increased morbidity and mortality rates for COVID positive patients following general anaesthetic LFTs are not as sensitive as PCR testing
Revert to pre pandemic social distancing	**Yes** Unable to achieve 2m distancing in most wards, plastic curtains were used as mitigation. Curtains removed week commencing 22nd June	-
Able to reduce isolation of COVID positive patients to 7 days following negative LFT on days 5 &6	**No**	Issues with the governance and reporting process for undertaking LFTs on wards. IPC team currently working through a process to enable this to be implemented
Visiting to inpatient areas	**Partial**	Currently 1 visitor per day for 1 hour, Revised Policy being ratified for implementation when community rates decline.

Staff Lateral Flow Testing

There is an expectation that staff will undertake lateral flow tests twice weekly and report the results through on the Trust lateral flow app. The results are shown below and highlight there is further work required across all staff groups to encourage compliance with this. Managers receive this information weekly.

LFD Compliance 01/07/2022			
Division	**% Yes, Reporting Results**	**% No Not Reporting Results**	**Total Frontline Headcount**
Trust	7%	93%	5830
Medicine and Emergency Care	7%	93%	1629
Surgery, Anaesthetics and Cancer	9%	91%	1998
Women and Children's	4%	96%	895
Clinical Support Services	8%	92%	963
Corporate	5%	95%	345
Bank Workers	3%	97%	1031

5.0 SERIOUS INCIDENTS (SI) RELATED TO INFECTION PREVENTION & CONTROL

There were no IPC serious incidents reported in Quarter 1 of 2022/23.

6.0 IPC INITIATIVES

The IPC team conducted 36 full QWW in Q1 (April to June 2022).

The accepted standard is for QWW compliance of 90% and above. If compliance is between 100% and 90% the area will be re-audited quarterly in line with current schedule and the action plan should be returned to the IPC team within two weeks. If the compliance achieved is between 80-89%, the area will be reviewed in 1 month, and the action plan should be returned to the IPC team within a week. If an area scores less than 80%, a repeat audit will be completed in a week and action plan should be returned immediately.

Compliance scores ranged from 74% - 97%. Of the 36 QWWs completed, 20 areas (61.7%) were over 90% compliant, 12 audited areas (33.3%) scored between 80% - 89% and 4 areas (11%) achieved a score below 80%.

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During the same period, the IPC team has also conducted 56 QWWs as part of the Outbreak investigations, of which 51 were related to Covid-19 Outbreak and 5 were connected to a C diff outbreak.

The most frequently non-compliant elements were:

- Cleanliness of sanitary equipment including commodes, toilet seat frames& bed pans – 40%
- Cleanliness of the general ward environment and equipment – 35%
- PPE not being worn according to current guidelines – 35%
- Storage and clutter– 31%

Action plans

Following each QWW Assurance Audit conducted by IPC the Action plan is sent to Ward Managers, Matrons and Heads of Nursing. Depending on the compliance the time scale for completion of the action plans is set and communicated to departments. Only 53% of all action plans are returned within the given time and the majority of the actions that are completed lack details of the processes that are implemented to ensure the issue identified will be resolved, this is being addressed with the Divisional Directors of Nursing by the DIPC.

7.0 IPC NHSE/I REVIEW

There is a planned visit to the Trust by the NHSEI IPC lead on 05.07.2022 to undertake a supportive review as part of our ongoing improvement work and assurance processes.

8.0 RISKS AND ACTIONS

The Risk register for IPC is held by the Director of Nursing as the DIPC. The Risk register is updated monthly.

There are 9 risks on the register, 1 risk remains red after mitigating controls have put in place as outlined below:

Risk 2077: Decontamination assurance for medical devices

Ongoing work continues led by the Head of Estates as the Trust Decontamination lead for the Trust to ensure all recommendations from the Decontamination review undertaken by University Hospitals Birmingham are addressed.

Actions taken in relation to this decontamination risk include:

- Standard Operating Procedures for all services undertaking decontamination, these are reviewed at the Decontamination Group and ratified at the IPC Assurance Committee chaired by the DIPC
- Review of Decontamination Policy to ensure it reflects best practice, this has now been finalised for ratification
- Proposal for the centralisation of decontamination service
- Appointment of a Decontamination Clinical Lead, a business case has been developed and is awaiting approval.

9.0 IPC BOARD ASSURANCE FRAMEWORK

This Prevention and Control Board Assurance Framework (IPC BAF) was last updated by NHSE/I in December 2021 and consists of 10 domains and 130 key lines of enquiry (See Appendix 1). The Trust is RAG rated green for 120 of the key lines of enquiry, and amber for 10 items. The BAF has been reviewed and updated following the changes in guidance whilst we await an updated version to be published by NHSE/I.

	A respiratory season/winter plan is in place:	**Draft plan in place**			Amber
1.1a	That includes point of care testing (POCT) methods for seasonal respiratory viruses to support patient triage/placement and safe management according to local needs prevalence, and care services	The Trust undertake Radi/POCT which are run from the lab	The Trust do not have a POCT, so this does not take place in emergency care	Rapid test takes place in the laboratory Discussions are taking place to see if there is an opportunity to have POCT in ED	Amber
1.2	Health and care settings continue to apply COVID-19 secure workplace requirements as far as practicable, and that any workplace risk(s) are mitigated for everyone.	Covid-secure risk assessments are supported by the H&S Team. See SaTH Intranet - New Ways of Working for supporting information and records of risk assessments received and approved by the H&S Team.	The H&S Team map risk assessments received to ESR cost codes to ensure 100% coverage of workplaces. This exercise reveals a very small number of areas not addressed, some of which are likely to be included within other risk assessments. Most now require review and updating to current guidance, given recent changes.	Templates and supporting information are published at SaTH Intranet - New Ways of Working and review dates are monitored by the H&S Team, and reports on current status monitored by the HSSF Committee	Amber
1.8	Ensure that patients are not transferred unnecessarily between care areas unless, there is a change in their infectious status, clinical need, or availability of services.	All patients are screened on admission to the Trust as per national guidance – patients that are identified as high risk of COVID are cohorted on designated wards. Patients who are confirmed as positive are isolated in side rooms.	It has been identified that the trust has a lack of side rooms that will be addressed by the Hospital Transformation Plan	Patients who have been identified as positive COVID 19 will only be moved if they are being transferred to one of the COVID high risk wards.	Amber
3.1	Arrangements for antimicrobial stewardship are maintained	• Antibiotic Policy in place. • A pharmacist reviews antibiotic	Antibiotic policy in place. Pharmacy medicines	Pharmacy seeks to prioritise	Amber

	A respiratory season/winter plan is in place:	**Draft plan in place**			Amber
		prescriptions wherever possible. • E-Script pharmacy program used to record antibiotic prescriptions, data entered by pharmacy staff and occasionally doctors when undertaking discharge summaries. • Prescriptions are screened to ensure compliance with Trust Antibiotic Policy and Stewardship, including choice, course length, and review periods. • Monthly internal snapshot audits undertaken and fed back to care groups. • Antimicrobial Management Group (AMG) should meet every 2 months	management under increasing pressure, not all antibiotic prescriptions are able to be reviewed daily or seen at start of course meaning possible delay in querying prescribing. E-Script program still in use and antibiotics are entered and recorded when seen by pharmacy staff and doctors undertaking discharge summaries, no electronic prescribing so some antibiotic prescriptions may be missed. All reviewed antibiotic prescriptions are checked against the antibiotic policy, where not in line they are queried with the medical team, course lengths and route are also queried. Regular AMG meetings have been difficult to hold and often not quorate due to lack of clinical representation.	undertaking a full Medicines Reconciliation as soon as possible after admission and to see all patients at discharge. Restriction of stock antibiotics on wards to guide prescribing. Antibiotics not stocked must be requested through a pharmacist and be reviewed against antibiotic policy/microbiologist recommendations. Continue to seek engagement from clinicians to attend AMG from care groups.	
6.2	Training in IPC measures is provided to all staff, including: the correct use of PPE including an initial face fit test/and fit check each time when wearing a filtering face piece (FFP3) respirator and the correct technique for putting on and removing (donning and doffing) PPE safely	All staff should have received training on hand hygiene, PPE usage relevant to their roles. Further training is provided as required.	There are some members of staff who have not accessed this training or have not recorded their compliance. The Heads of Nursing report that the specific COVID data	Ward managers, Matrons are to ensure that staff have completed the required training. All managers have been contacted by the IPC team to ensure their staff have completed the training and that the details of staff who have completed training has been provided to the education department, so records are correct Corporate Education Department	Amber

	A respiratory season/winter plan is in place:	**Draft plan in place**			Amber
			provided by corporate education does not match the monthly mandatory training report.	Manager is reviewing data for accuracy and to feedback to Divisions in relation to compliance. Local records being held by departments of staff trained, Divisional Leads ensuring managers send this information to Corporate Education	
6.3	All staff providing patient care and working within the clinical environment are trained in the selection and use of PPE appropriate for the clinical situation and on how to safely put it on and remove it	All staff should have been trained in the use of and donning and doffing of PPE. There are posters available for this and all staff should have access to the Trust intranet which also has this information accessible. http://intranet.sath.nhs.uk/coronavirus/ppevideos.asp Matrons audit PPE usage as part of their monthly audits	As above	As above Donning and doffing training has been provided by IPC Team and videos are available on the Trust intranet	Amber
9.3	Safe spaces or staff break areas/changing facilities are provided	Welfare arrangements are compromised by space constraints. Mitigations (maximum occupancy posters, staggered breaktimes, provision of external seating areas etc.) are addressed in covid-secure risk assessments.	The Trust has insufficient changing facilities which comply fully with the Workplace (Health, Safety and Welfare) Regulations 1992, as identified via H&S audit.	Issue considered by Health, Safety, Security and Fire Committee January 2022, discussed at Silver and for SLC-O consideration of potential solutions including mobile changing units next.	Amber
10.6	Where there has been a breach in infection control procedures, staff are reviewed by occupational health	Occupational Health does not provide anti-Viral treatment and have no facilities to do so. However, do implement vaccination programmes, excluding covid	Occupational health does not currently provide anti-viral treatment	As part of reviewing future service provision requirements this will be considered in service specification going forward.	Amber
10.20	Consistency in staff allocation should be maintained, reducing movement of staff and the crossover of care	Medicine and Emergency Divisions – due to the current vacancies and the staff sickness this can be a challenge. Surgery Division –there is some	There is still some movement of staff between areas to ensure safe provision of staffing due to gaps	Matrons are responsible for ensuring daily staffing plans are in place which mitigate the movement of staff between areas but maintain safety and that these	Amber

	A respiratory season/winter plan is in place:	**Draft plan in place**			Amber
	pathways between planned/elective care pathways and urgent/emergency care pathways as per national guidance	movement of staff to cover sickness/gaps in rosters, however this is kept to a minimum. Women's and Children's Division – Paediatrics and Neonates allocate staff between Covid /Non covid/symptomatic areas. Gynae – there are only 2 RNs on shift, so can be a challenge where joint RN input is required. Maternity – this area is challenging as there are women on the planned and unplanned pathways in the same areas. There is a dedicated team running the planned Caesarean Section		are communicated to the Clinical Site Team out for out of hours. Monthly staffing report provided to Workforce assurance committee Clinical staff are trained in the appropriate donning and doffing techniques to reduce the risk of contaminating oneself Staff are required to complete a Datix report if looking after both COVID positive and negative patients during the same shift	

10.0 HYGIENE CODE UPDATE

The Health and Social Care Act (2008) Code of Practice on the prevention and control of infections, applies to all healthcare and social care settings in England. The Code of Practice sets out the 10 criteria with 243 elements against which the Care Quality Commission (CQC) will judge a registered provider on how it complies with the infection prevention requirements, which is set out in regulations. To ensure that consistently high levels of infection prevention (including cleanliness) are developed and maintained Trusts complete a self-assessment. The Hygiene Code is reviewed quarterly by the IPC team and presented at the IPC Operational Group. The Trust is 96.9% compliant, being RAG rated 'Green' for 233 elements, 'Amber' for 9 and RAG rated 'Red' for 1. The Trust self-assessment compliance against each of the 10 domains and the current gaps and actions are shown:

	What the Trust must demonstrate	Current compliance	Current Gaps	Actions Required/Target date
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.	97%	IPC arrangements & responsibilities policy in place and found in every JD. All staff should receive Mandatory update & induction training. Contractors receive IPC training via estates (part of their induction to the Trust) Uptake of training for 2021-22 was 77% which is a reduction of 7% in compliance since 2020-21	Continue to monitor attendance and report quarterly to IPCOG Care Groups to report compliance with training on report to IPCOG monthly
2	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.	95%	Decontamination of the environment – including cleaning and disinfection of the fabric, fixtures, and fittings of a building (walls, floors, ceilings, and bathroom facilities) or vehicle.	This is currently not in the remit of the Decontamination Group and therefore Decontamination Lead (AD Estates). The TORs have been agreed to exclude these items which remain in the remit of IPC group.
			a record-keeping regime is in place to ensure that decontamination processes are fit for purpose and use the required quality systems	Following TRUS probe investigation (following outbreak) an audit is underway of all invasive devices requiring all departments to ensure they have adequate decontamination records, SOPs, and training records. The responsibility is with the departments to ensure they have adequate processes and share information with the Decon group to ensure satisfactory assurance is provided.
3	Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance	94%	All antibiotic prescriptions are reviewed by a pharmacist. Overall antibiotic usage is lower than average see Fingertips Portal. No e-prescribing system Proactive work being undertaken relating to sepsis with	Sepsis E-prescribing system required

	What the Trust must demonstrate	Current compliance	Current Gaps	Actions Required/Target date
			appointment of sepsis nurse and development of sepsis boxes to speed up access to critical antibiotics.	
4	Provide suitable accurate information on infections to any person concerned with providing further support or nursing/medical care in a timely fashion.	100%	None	None
5	Ensure that people who have or develop an infection are identified promptly and receive the appropriate treatment and care to reduce the risk of passing on the infection to other people.	100%	None	None
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.	100%	None	None
7	Provide or secure adequate isolation facilities.	83%	The Trust has a relatively low percentage of side rooms such that patients requiring isolation may exceed the numbers of side rooms available. Patients may need to be cohort nursed if demand is high for example at outbreaks of norovirus or influenza during high activity periods. On risk register risk level 12.	Long term solution = Isolation facilities to be considered as part of planning regarding "Future Fit" and moving to possibly 50% of capacity being side rooms. April 2022 risk register score 15 - lack of -VE pressure isolation rooms. Estates currently looking at the feasibility of having drop in pod to ITU & also side room capacity. Bio quell Pods installed in ITU and Redi rooms in use.
8	Secure adequate access to laboratory support as appropriate.	100%	None	None
9	Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control	99%	The Trust has a relatively low percentage of side rooms such that patients requiring isolation may exceed the numbers of side rooms available.	None

	What the Trust must demonstrate	Current compliance	Current Gaps	Actions Required/Target date
	infections.		Require assurance from CPE's that competency-based assessments for aseptic technique are in place	
10	Providers have a system in place to manage the occupational health needs of staff in relation to infection	100%	None	None

11.0 CONCLUSION

This IPC report has provided a summary of the performance in relation to the key performance indicators for IPC in Quarter 1 of 2022/23.

In relation to HCAIs, there has been an increase in C,Diff and MSSA cases in Q1 of 2022/23 compared to Q4. There has also been an outbreak of ESBL Klebsiella on the Neonatal Unit and some associated poor practices in relation to IPC with actions taken to address this.

The number of COVID 19 cases being seen in the Trust initially decreased in the first 2 months of Q1 but rose significantly in June. Outbreak meetings are held twice weekly, with the involvement of PHE and NHSEI. There has been increasing issues identified on the Quality Ward Walks undertaken as part of these outbreaks in relation to compliance with IPC procedures and practices which the DIPC has addressed with the Divisional Teams.