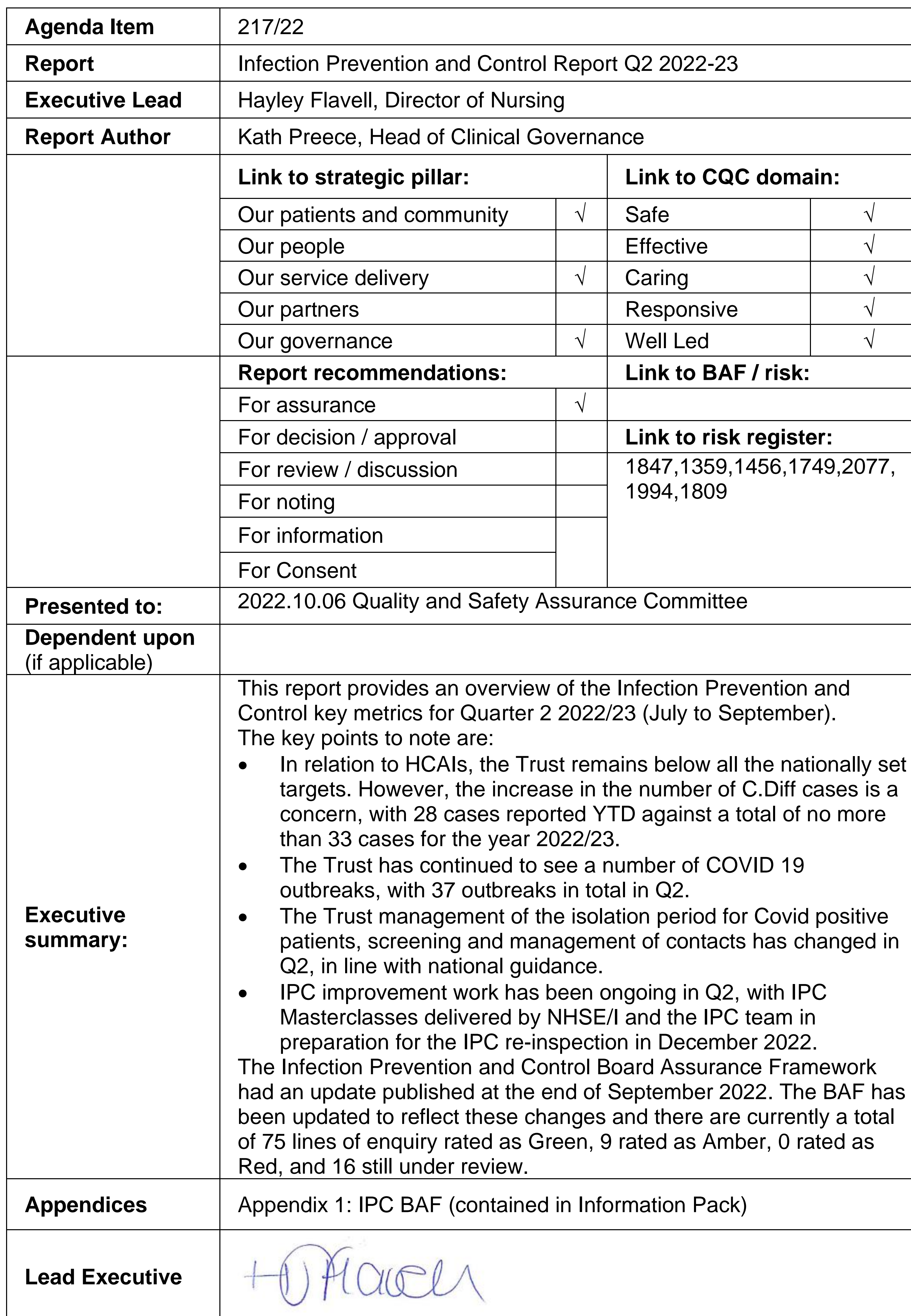
Board of Directors' Meeting
10 November 2022

NHS
The Shrewsbury and Telford Hospital
NHS Trust



Agenda Item	217/22			
Report	Infection Prevention and Control Report Q2 2022-23			
Executive Lead	Hayley Flavell, Director of Nursing			
Report Author	Kath Preece, Head of Clinical Governance			
	Link to strategic pillar:		**Link to CQC domain:**	
	Our patients and community	√	Safe	√
	Our people		Effective	√
	Our service delivery	√	Caring	√
	Our partners		Responsive	√
	Our governance	√	Well Led	√
	Report recommendations:		**Link to BAF / risk:**	
	For assurance	√		
	For decision / approval		**Link to risk register:**	
	For review / discussion		1847,1359,1456,1749,2077, 1994,1809	
	For noting			
	For information			
	For Consent			
Presented to:	2022.10.06 Quality and Safety Assurance Committee			
Dependent upon (if applicable)				
Executive summary:	This report provides an overview of the Infection Prevention and Control key metrics for Quarter 2 2022/23 (July to September). The key points to note are: • In relation to HCAIs, the Trust remains below all the nationally set targets. However, the increase in the number of C.Diff cases is a concern, with 28 cases reported YTD against a total of no more than 33 cases for the year 2022/23. • The Trust has continued to see a number of COVID 19 outbreaks, with 37 outbreaks in total in Q2. • The Trust management of the isolation period for Covid positive patients, screening and management of contacts has changed in Q2, in line with national guidance. • IPC improvement work has been ongoing in Q2, with IPC Masterclasses delivered by NHSE/I and the IPC team in preparation for the IPC re-inspection in December 2022. The Infection Prevention and Control Board Assurance Framework had an update published at the end of September 2022. The BAF has been updated to reflect these changes and there are currently a total of 75 lines of enquiry rated as Green, 9 rated as Amber, 0 rated as Red, and 16 still under review.			
Appendices	Appendix 1: IPC BAF (contained in Information Pack)			
Lead Executive				

1.0 INTRODUCTION

This paper provides a report for Infection Prevention and Control for Quarter 2 (July to September 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 July - September 2022 is provided. An update in relation to Covid-19 is also provided. The report also outlines any recent IPC initiatives and relevant infection prevention incidents. The updated IPC BAF is also included.

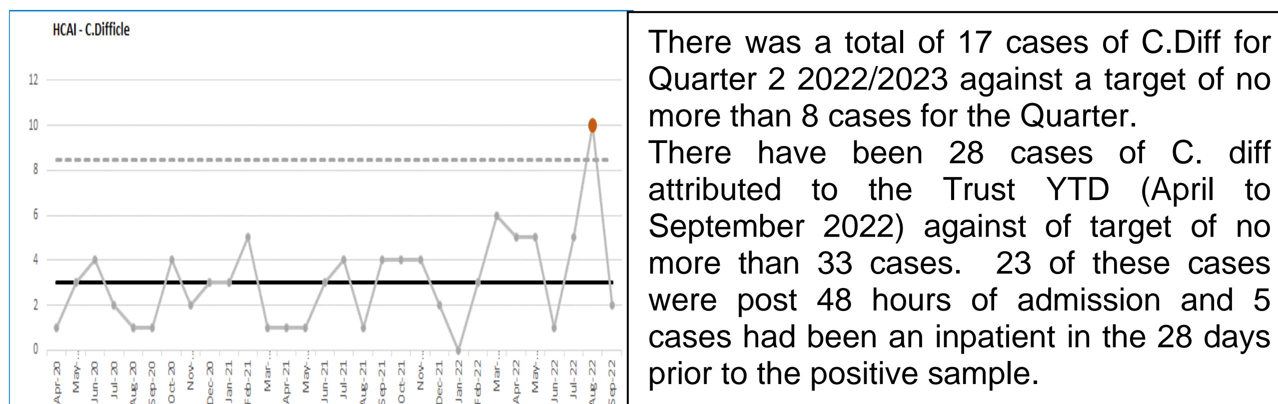
2.0 KEY QUALITY MEASURES PERFORMANCE

2.1 MRSA Bacteraemia

The target for MRSA bacteraemia remains 0 cases for 2022/23. There were 0 cases in Q1 or Q2 2022/23. The last MRSA bacteraemia was May 2021.

2.2 Clostridioides Difficile

The Trust trajectory for C diff cases in 2022-23 is no more than 33 cases.



There was a total of 17 cases of C.Diff for Quarter 2 2022/2023 against a target of no more than 8 cases for the Quarter.
There have been 28 cases of C. diff attributed to the Trust YTD (April to September 2022) against of target of no more than 33 cases. 23 of these cases were post 48 hours of admission and 5 cases had been an inpatient in the 28 days prior to the positive sample.

Root cause analysis investigations are undertaken on all C. diff cases. During Q2 ,17 cases for C. diff being reviewed. Common themes being identified and reported were:

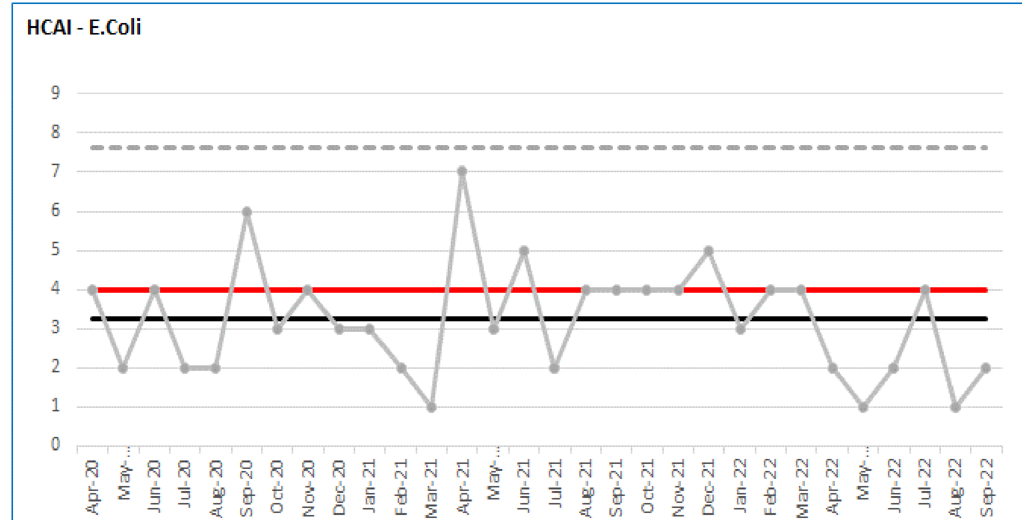
- Delays in isolation of patients experiencing 2 or more episodes of unexplained type 5, 6, or 7 stool.
- Delays in taking a sample from patients experiencing episodes of unexplained type 5, 6, or 7 stool.
- Delays in commencement of a stool chart at the second episode of an unexplained type 5,6, or 7 stool.
- Contaminated sanitary equipment
- Repeat samples being taken when not required

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 so that lessons learnt can be shared and findings of practise which could be done better, and good practice can be identified and shared with other clinicians. Learning from the RCA's are also shared as part of the divisional reports in IPCOG.

A C.Diff gap analysis has been undertaken by the IPC team and action plan developed.

2.3 E.Coli Bacteraemia

The Number of E.Coli cases are shown:



The target for 2022-23 is no more than 96 cases. YTD (April to September 2022/23) there have been 13 cases of post 48 E.coli bacteraemia.

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

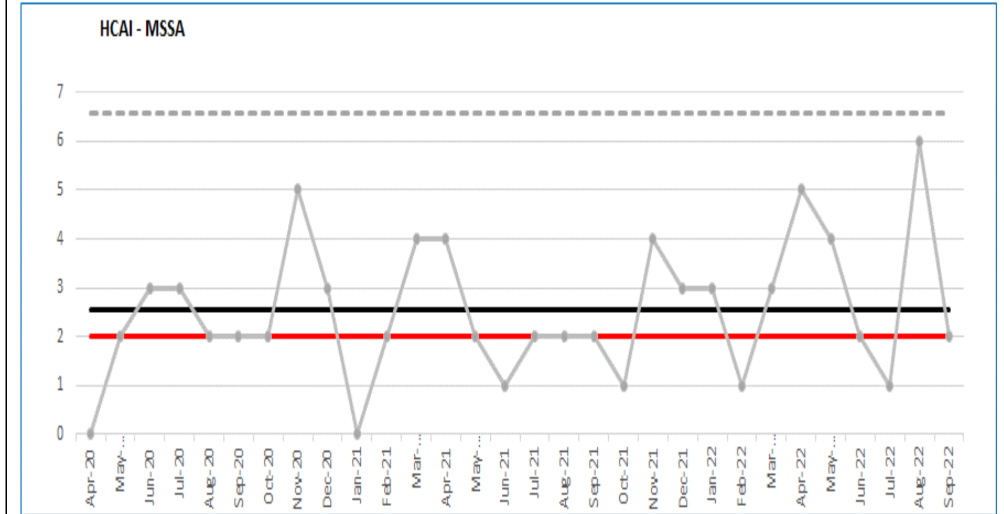
In total YTD, there were 3 cases which were considered to be device or intervention related, with the sources being:

- Two cases of catheter associated urinary tract infections (CAUTI)
- One case related to a central line
- One case is being reviewed to determine the source,
- The remaining 9 cases were considered not a HCAI.

Ongoing improvement actions include ensuring the catheter insertion documentation and care plan is completed and in place.

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. YTD there have been 20 cases of post 48-hour MSSA bacteremia against the Local Trust target of no more than 28 cases.

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

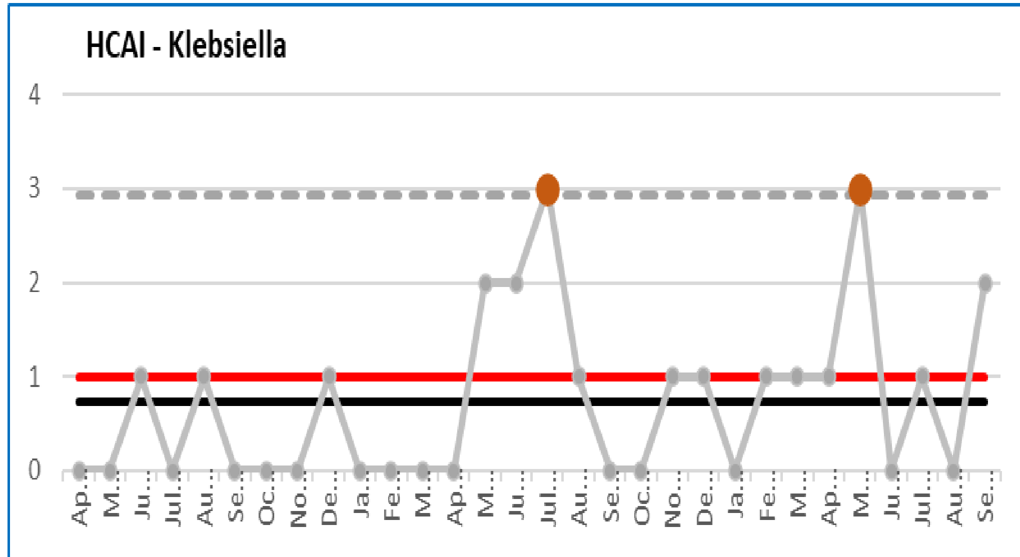
- 8 were considered to be device or intervention related
- The source was considered to be an intravenous cannula infection in 6 cases and a central line in one case
- One case related to a surgical site infection
- One case is currently under review
- The remaining 12 cases were considered not to be a HCAI.

Ongoing improvement actions include:

- ANTT training

- Daily completion of VIP (Visual Infusion Phlebitis score)

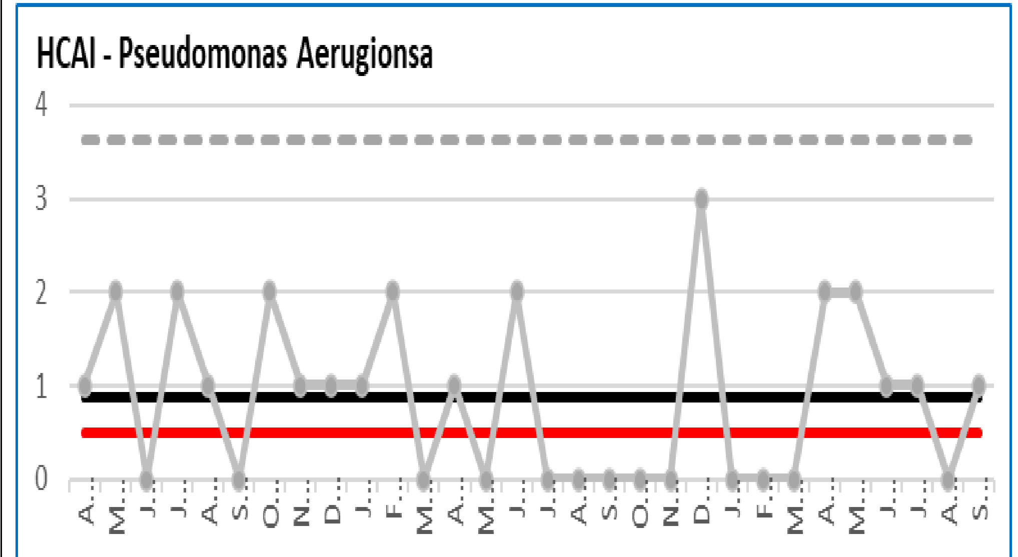
2.5 Klebsiella Bacteraemia (Post 48 Hours)



The target for 2022/23 is no more than 23 cases. There were 3 cases of post 48-hour Klebsiella Bacteraemia in Q2 and a total of 7 cases YTD.

Two of these cases were considered to be a HCAI with the sources being a CAUTI. The remaining 5 cases were not considered to be a HCAI.

2.6 Pseudomonas Aeruginosa Bacteraemia (Post 48 Hours)



The target for 2022/23 is no more than 19 cases. There were 2 cases of post 48 Pseudomonas Aeruginosa in Q2 and a total of 7 cases YTD.

Three cases were considered not to be a HCAI the other four cases are under review to determine the source of the infection.

2.7 MRSA Elective Screening

MRSA Elective screening compliance has been above the 95% target throughout Q1and Q2 2022-23. Q1 compliance was 96.9%.and 97.3% in Q2.

2.8 MRSA Emergency Screening

The MRSA emergency screening compliance has not reached the required 95% in either Q1 or Q2 in 2022/23. The average performance in Q1 was 94.0% and 93.6% in Q2

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.

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 the consistency between inflammatory signs and VIP scores signs, identified in MSSA bacteraemia
- Additional clinical specimens not sent in a timely manner to enable correct antibiotic prescribing choices
- Skin integrity issues (pre-admission) not documented consistently and accurately in E. coli bacteraemia

Actions implemented in relation to improvements include:

- Lessons learned from all cases have been cascaded to staff in huddles, handovers, and clinical governance meetings
- Discussion and practice during IPC and induction training with junior doctors regarding blood culture best practice. Blood culture 'top tips' poster distributed to all clinical areas to highlight best practice
- Ward managers and nurses in charge monitoring the VIP scores. Compliance is also monitored at the monthly nursing metrics meetings as well as being reported by the Divisions through their Infection Prevention and Control Operational Group reports each month.
- Urology specialist nurses linking with clinical practice educators to provide catheter care training as part of the statuary training requirement.
- HOUDINI catheter care plan implemented to better guide catheter care and accurate documentation

3.0 PERIODS OF INCREASED INCIDENCE/OUTBREAKS

Outbreaks

During Quarter 2 (July to September 2022) there have been 37 COVID outbreaks declared in the Trust.

The most common issues identified during the outbreaks are:

- Missed routine and contact COVID screens
- Environmental / equipment contamination
- Personal Protective Equipment (PPE) non-compliance

There was also one C.Diff outbreak confirmed on Ward 10.

The outbreaks are shown for Quarter 2 2022/2023 in the table below:

	Ward	Infective Organism	Typing	Learning
July 2022	Ward 7	Covid-19		Movement within SATH (6&7). Movement within the ward. Missed routine swabs
	Ward 10	Covid-19		PPE issues. Pt movement within the ward. Missed routine swabs.
	Ward 6	Covid-19		Movement within SATH (6&7). Repatriations from UHNM
	Ward 11	Covid-19		Missed screening swabs. Intra ward movement of patients. PPE issues
	Ward 36	Covid-19		Pt movement from outbreak areas to Ward 36 (after -ve test) and later became positive a few days later
	Ward 22RE	Covid-19		Missed screening swabs. PPE issues
	Ward 23	Covid-19		No clear index case. Patients in same bay.
	Ward 21	Covid-19		Patients were contacts of each other. 2 Staff involved worked the same shift.
	Ward 24	Covid-19		Missed routine swab. Contacts became positive
	Ward 4	Covid-19		Missed routine swabs. Contacts became positive
	Ward 9	Covid-19		Admission swab not completed (positive patient)
Aug 2022	Ward 23	Covid-19		Missed routine screen. Asymptomatic spread
	Ward 21	Covid-19		Inappropriate movement of patients. Contact patient becoming positive
	Ward 24	Covid-19		Missed routine swab. Contacts became positive
	Ward 28	Covid-19		Missed routine swabs
	Ward 22SS	Covid-19		Missed screen on index case. Contacts became positive.
	Ward 27	Covid-19		Admission screens missed. Contact patients became positive.
	Ward 22RE	Covid-19		Inappropriate patient movement
	Ward 25	Covid-19		Missed routine swabs. Index case missed admission swab
	Ward 10	C Diff	Both cases type 339. Outbreak declared	No evidence of deep cleaning space between patients
	Day Surgery	Covid-19		Missed swabs on admission and

	Ward	Infective Organism	Typing	Learning
	Telford			days 5 to 7
	Ward 6	Covid-19		Insufficient side room capacity. Insufficient space for redirooms.
	Ward 9	Covid-19		Unknown. Conversion of positive patients.
	Ward 8	Covid-19		PPE non-compliance. Possible cross infection with visitor.
	Ward 4	Covid-19		Inappropriate placement of positive patients. PPE non-compliance.
	Ward 11	Covid-19		Index case moved into ward before result available. Some missed routine screens.
	Ward 36	Covid-19		Patients moved to area after initial negative screen.
Sep 2022	Ward 26	Covid-19		Unclear how index patient became positive. Contacts all became positive.
	Ward 25	Covid-19		Contacts becoming positive.
	Ward 23	Covid-19		Routine screen missed. Contacts became positive.
	Ward 6	Covid-19		2 nosocomial contacts of each other both tested positive. No other pts involved.
	Ward 7	Covid-19		Missed swabs at day 3.
	Ward 9	Covid-19		Index case created contacts. Unknown cause.
	Ward 10	Covid-19		Positive patient unable to comply with PPE use and/ or isolation.
	Ward 15/16	Covid-19		(16) admission swab missed. (15) open visiting. No requirement to LFT as visitor.
	Ward 15/16	Covid-19		Open visiting. No requirement for visitors to LFT.
	Ward 28	Covid-19		Unclear index case. Bay of contacts became positive.
	Ward 17	Covid-19		None found. 1 day 3 swab missed.

Period of Increased Incidence

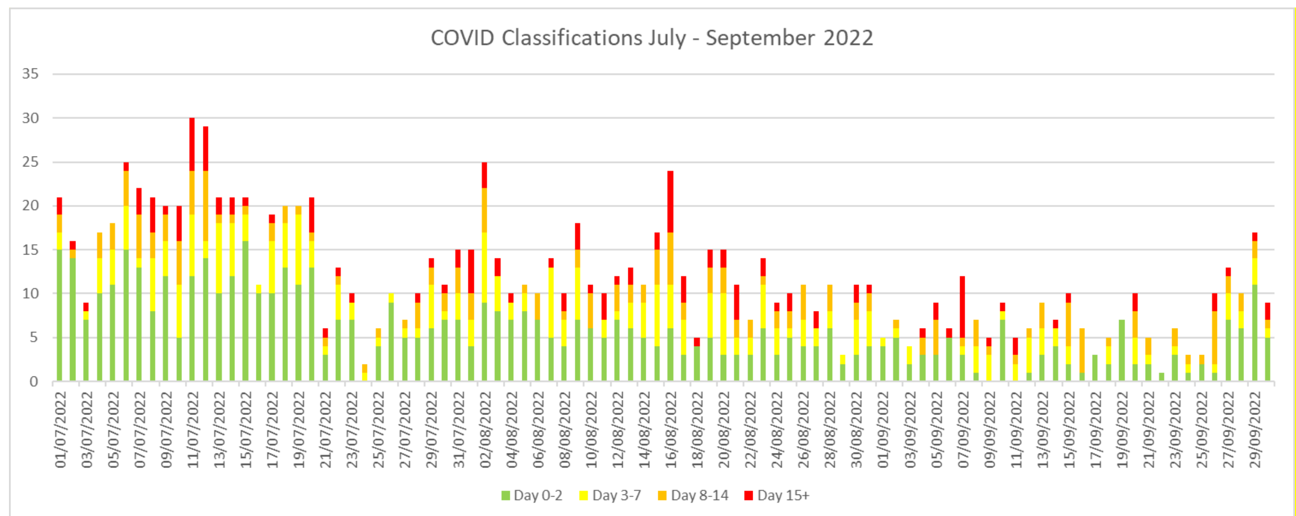
3 other periods of increased incidence (PII) were declared in Q2, as below:

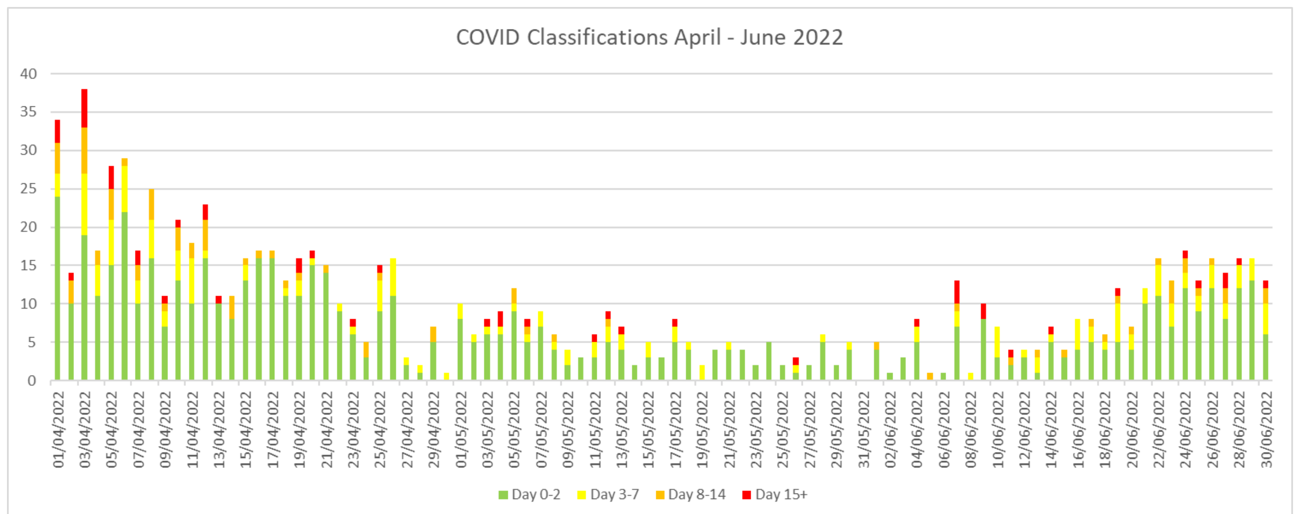
	Ward	Infective Organism	Typing	Learning
Aug 2022	Ward 4	C.Diff	Different Types	Period of Increased Incidence (PII)
	Ward 11	C Diff	1 case same as Ward 10 (type 339)	Period of Increased Incidence. 4 linked cases. 1 case also linked to Ward 10. Handwashing and PPE issues. Kitchen cleanliness issues (shared kitchen)
Sep 2022	Neonatal Unit	ESBL	Different Types	PPE issues. Contaminated equipment. Dust in environment

4.0 COVID 19 UPDATE

The number of Covid-19 cases in the Trust in Quarter 2 (July to September 2022) reached a peak in July 2022 and then started to even off.

The graphs below demonstrate the trends of cases seen in the Trust per Quarter.





NHSEI provide definitions of apportionment of COVID 19 in respect of patients diagnosed within hospitals as below:

Indeterminate – diagnosed at 3 - 7 days

Probable Healthcare Onset – diagnosed at 8 - 14 days

Definite Healthcare Onset – diagnosed at 15+ days

In Q2 2022/23 there were 180 ‘Probable’ Healthcare onset, and 126 ‘Definite’ Healthcare onset cases. Most of these cases had been involved in COVID outbreaks on the wards.

The below guidance changes were made in Quarter 2 2022-23:

4.1 Ending Isolation Early

From 22nd August 2022, patients who were COVID-19 positive could end isolation early if they had a negative Lateral Flow Test (LFT) test on two consecutive days. The first LFT must have been taken no earlier than day 6. Isolation could end the day following the second negative LFT which must have been completed no less than 24 hours after the first. For example, if the patient had a negative LFT on day 6 and 7, isolation could end on day 7.

4.2 COVID Testing

From the 1st of September 2022, vast majority of asymptomatic COVID-19 testing paused in line with new national guidance from NHSE/I.

COVID-19 testing should continue only in these circumstances:

- All symptomatic patients (on admission or during their stay) by PCR test, (have a particularly low threshold for testing high-risk patients identified for COVID-19 MAB and antiviral treatment).
- All immunocompromised patients if admitted as an emergency or for maternity care, by PCR test.
- All patients (symptomatic or asymptomatic) who are being transferred to the Oncology Ward (Ward 23), Ward 20, Paediatric Oncology or Ward 35 by PCR

To aid staff in helping to identify patients that require screening the IPC team created a guide, which was sent to all departments

test.

- All patients who are being discharged to care homes/hospices by PCR test (or LFT if COVID-19 positive in the last 90 days).
- All symptomatic or immunocompromised elective care patients by LFT in the 72 hours prior to admission (or on admission if unable to do so before). Please note, all pre-admission PCR testing will cease for general anaesthetic, maternity, endoscopy etc.
- All symptomatic staff by LFT at home.
- For COVID-19 outbreaks, as directed by IPC Team.
- LFT tests to continue for COVID-19 positive patients on day 6 and 7, to reduce isolation period.
- LFT tests continue for COVID-19 positive staff on day 5 and 6, to reduce isolation.

Update to COVID-19 Testing: From 1st September 2022

NHS The Shrewsbury and Telford Hospital NHS Trust

Who to Test and How	PCR	LFT
Patients with COVID symptoms	✓	
Immunocompromised patients if admitted as an emergency or for maternity care	✓	
All patients being admitted to ward 23 or paediatric oncology/ haematology, ward 35 nephrology and all patients on renal dialysis being admitted to beds elsewhere	✓	
All patients being discharged to care homes/hospices	✓	If known positive in last 90 days ✓
Symptomatic or immunocompromised patients for elective admission		✓
Symptomatic staff		✓
COVID outbreaks	As directed by IPC	As directed by IPC
COVID positive patients on day 6 & 7 to reduce isolation		✓
COVID positive staff on day 5 & 6 to reduce isolation		✓

Who is symptomatic?	Who is immunocompromised?
Fever	Anyone being admitted to ward 23 OH or paediatric oncology
A new and continuous cough	Solid cancer on chemotherapy or radiotherapy
Anosmia (loss of smell) or ageusia (loss of taste)	Leukaemia and lymphoma and stem cell transplant recipients
Shortness of breath	Solid organ transplant recipients
Fatigue	Congenital immune deficiencies
Loss of appetite	HIV/AIDS if causing severe immunosuppression
Myalgia (muscle ache)	Those on immunosuppressive biological therapy eg anti TNF therapy such as alemtuzumab, ofatumumab and rituximab. Those on other immunosuppressive therapy eg adults and children on high-dose corticosteroids (>40mg prednisolone per day or 2mg/ kg/day in children under 20kg) for more than 1 week - adults and children on lower dose corticosteroids (>20mg prednisolone.
Sore throat	
Headache	
Nasal congestion (stuffy nose)	
Runny nose	
Diarrhoea	
Nausea and vomiting	

No more testing:

- *Routinely on admission, day 3 or day 5-7 if asymptomatic*
- *COVID contacts if asymptomatic*
- *Staff LFTs twice weekly if asymptomatic*
- *Elective admissions/ procedures if asymptomatic and not immunocompromised*

PACT

4.3 Management of COVID contacts

- From 26th September 2022 most COVID-19 contacts are no longer flagged on SemaHelix
- Covid-19 contacts are only flagged on high-risk areas, such as Ward 23 Oncology, Ward 35 Renal and Ward 20 Paediatric Oncology. In these areas patients are flagged and the Bay where contacts are located is closed to new admissions
  - COVID-19 positive patients are still flagged (red diamond over black background).
  - The IPC team continues to maintain a record of the COVID contacts to monitor possible outbreaks.

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

There were no IPC serious incidents reported in Quarter 1 or 2 of 2022/23.

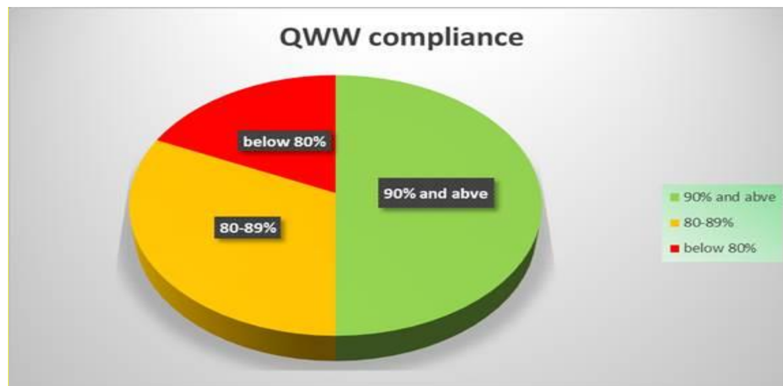
6.0 IPC INITIATIVES

The IPC team conducted 22 full Quality ward Walks (QWW) in Q2 (July to September 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 one 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 55% - 97% in Quarter 2.

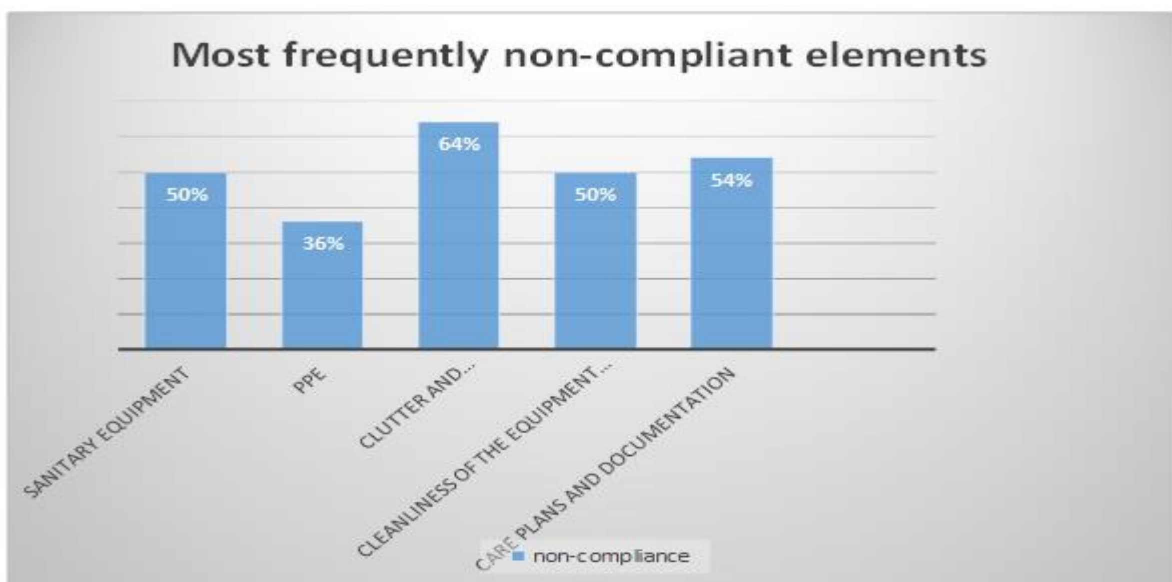
Of the 22 QWWs completed, 11 areas (50%) were over 90% compliant, 7 audited areas (32%) scored between 80% - 89% and 4 areas (18%) achieved a score below 80%.



During the same period, the IPC team have also conducted a number of outbreak QWWs related to Covid-19 outbreaks and C.diff PIIs

The most frequently non-compliant elements were:

- Storage and clutter
- Care plans and documentation
- Cleanliness of sanitary equipment including commodes, toilet seat frames& bed pans
- Cleanliness of the general ward environment and equipment
- PPE not being worn according to current guidelines



The non-compliance with storage and clutter was identified as a most frequent issue. Other areas of non-compliance included: care plans and documentation, cleanliness of sanitary equipment and environment. The quality ward walks also identified that staff were not compliant with PPE requirements showing gaps in knowledge in this area.

Following each QWW Assurance Audit conducted by IPC team the action plan is sent to ward managers, matrons and divisional directors of nursing. Depending on the compliance the time scale for completion of the action plans is set and communicated to departments.

Unfortunately, only a small number of all action plans are returned within the given time.

7.0 IPC NHSE/I REVIEW

Following a peer review completed by NHSEI on 5th July 2022, issues identified during an NHSEI Masterclass on the 19th of July 2022 and concerns raised in relation to compliance with IPC practices raised as part of an external COVID Outbreak meeting on the 26th of July 2022, NHSEI downgraded the Trust's IPC Green RAG rating to Amber.

NHSEI have provided a further masterclass in September 2022, this was provided to ward staff, Matrons and Divisional Directors of Nursing and focused on key areas of IPC concerns that NHSEI review when assessing IPC compliance. The IPC Team have also provided similar masterclasses three times a week during Q2 to ensure that the IPC standards are taught and understood.

Following these masterclasses and our improvement work, NHSEI are going to visit the Trust on the 6th of December 2022 to perform a formal re-inspection and assessment of the Trust's IPC RAG rating.

8.0 RISKS AND ACTIONS

The Risk register for IPC is held by the Director of Nursing as the Director for Infection Prevention and Control (DIPC) and is updated monthly.

There are 7 risks on the risk register. Of the 7 risks, 5 risks are RAG rated Red prior to risk controls. Following application of the risk controls and mitigation these are 4 risks are rated as Amber.

One risk remains rated as red after mitigation:

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.

9.0 IPC BOARD ASSURANCE FRAMEWORK

The Infection Prevention and Control Board Assurance Framework had an update published at the end of September 2022. As part of this update there were 46 updated or new lines of enquiry. The 10 domains remain, with a total of 99 lines of enquiry. The BAF is currently being updated to reflect these changes and there are currently a total of 75 lines of enquiry rated as Green, 9 rated as Amber, 0 rated as Red, and 16 still under review.

10.0 HEALTH AND SOCIAL CARE ACT COMPLIANCE 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 97.0% compliant, being RAG rated 'Green' for 233 elements, 'Amber' for 10 and RAG rated 'Red' for 0. 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 Divisions 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.	96%	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 Decontamination group to ensure satisfactory assurance is provided. This is currently under review by the

	What the Trust must demonstrate	Current compliance	Current Gaps	Actions Required/Target date
				decontamination lead for the Trust.
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 appointment of sepsis nurse and development of sepsis boxes to speed up access to critical antibiotics.	Sepsis E-prescribing system required
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

	What the Trust must demonstrate	Current complian ce	Current Gaps	Actions Required/Target date
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. Bioquell Pods installed in ITU and redirooms 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 infections.	99%	The Trust has a relatively low percentage of side rooms such that patients requiring isolation may exceed the numbers of side rooms available. Require assurance from CPE's that competency-based assessments for aseptic technique are in place	None
10	Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection	100%	None	None

10.0 CONCLUSION

This IPC report has provided a summary of the performance in relation to the key performance indicators for IPC in Quarter 2 of 2022/23.

In relation to HCAIs, the Trust remains below all the nationally set targets. However, the increase in the number of C.Diff cases is a concern, with 28 cases reported YTD against a total of no more than 33 cases for the year 2022/23.

The Trust has continued to see a number of COVID 19 outbreaks, with 37 outbreaks in total in Q2. The Trust management of the isolation period for Covid positive patients, screening and management of contacts has changed in Q2, in line with national guidance.

IPC improvement work has been ongoing in Quarter 2.