Leicestershire Partnership NHS Trust

Infection Prevention and Control Annual Report

2018 - 2019

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FOREWORD

As the chair of the Trust Infection Prevention and Control Committee, I am pleased to introduce our Annual Report for 2018-19. Leicestershire Partnership NHS Trust is committed to ensuring effective prevention and control of healthcare associated infections to ensure that patients, carers and families are cared for in a safe, secure and caring environment.

The report summarises the progress against the 2018-19 key priorities and outlines our continued commitment to promoting best practice in Infection Prevention and Control, with our goal to reduce the number of healthcare associated infections. The report acknowledges the hard work and diligence of all staff, clinical and non-clinical who play a vital role in improving the quality of patient experience as well as helping to reduce the risk of infections.

Our Infection Prevention and Control practitioners work together to provide strong leadership, not only to ensure directorates comply with requirements of the Health and Social Care Act (2008, updated 2015) but to also ensure we can demonstrate learning across the whole Trust through training, education and our understanding of when we don't get things right.

We continue to support and contribute to the whole health and social care economy though partnership working across Leicester, Leicestershire and Rutland (LLR). The LLR network group unites the IPC and Public Health specialists promoting joint working on a number of key developments including Norovirus, Seasonal Flu vaccination, antimicrobial stewardship, Carbapenamase Resistant Organism (CRO) and the management of urinary tract infections. These work streams continue as part of our priorities and future developments for 2019/20 and will report to the Programme Board for LLR.

As in previous years, the report follows the format of the Health and Social Care Act (2008 updated 2015) to demonstrate our progress with the requirements associated with the established criteria.

The infection prevention and control team will continue to work in partnership with staff across all directorates as well as our multi-agency partners to ensure that:-

- No patient, carer or staff member is harmed or disabled by the acquisition of an avoidable infection when receiving healthcare within LPT's services.
- Practice, policies and guidance are developed.
- New and innovative training opportunities are provided.
- Service delivery is quality assured.
- Investigations are conducted when things go wrong.
- Lessons learned are shared to inform changes in practice for continuous improvement.

Finally, the report outlines the priorities and future developments for 2019-20

Emma Wallis
Associate Director of Nursing and Professional Practice

ABBREVIATIONS

CCG	Clinical Commissioning Group
C-diff	Clostridium difficile
CDI	Clostridium difficile infection
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
DIPaC	Director of Infection Prevention and Control
ELRCCG	East Leicestershire and Rutland Clinical Commissioning Group
HAI	Healthcare Associated Infection
IPC	Infection Prevention and Control
IPS	Infection Prevention Society
LPT	Leicestershire Partnership Trust
LLR	Leicester, Leicestershire and Rutland
MRSA	Meticillin Resistant Staphylococcus aureas
MSSA	Meticillin Sensitive Staphylococcus aureas
NHS	National Health Service
NHSLA	National Health Service Litigation Authority
NHSI	National Health Service Improvement
NSC	National Specification for Cleanliness
PHE	Public Health England
PIR	Post Infection Review
PLACE	Patient Led Assessment of the Care Environment
QAC	Quality Assurance Committee
QS	Quality Schedule
RCA	Root Cause Analysis
RCN	Royal College of Nursing
SO	Serious Incidents
UHL	University Hospitals of Leicester

SECTION 1 – INTRODUCTION

The effective prevention and control of healthcare associated infection is a pre-requisite for delivering safe patient care in Leicestershire Partnership NHS Trust (LPT). This annual report summarises the progress made in the prevention and control of infection in 2018/19.

This report demonstrates that LPT complies with the duties set out in the Health and Social Care Act (2008, updated 2015), requiring healthcare organisations to publish details about their progress in implementing programmes for Infection Prevention and Control. This report provides evidence that LPT meets the duties of the Hygiene Code, the NHS Litigation Authority (NHSLA) and the Care Quality Commission (CQC) outcomes.

The work of the Infection Prevention and Control Team, supported by the Director of Nursing, AHP's and Quality and the Associate Director of Nursing and Professional Practice, ensures LPT minimises the risk of healthcare acquired infection to patients in accordance with and taking into account of:

- NICE (2014) Infection: Prevention and Control of healthcare associated infections in primary and community care.
- CQC (2010) Essential standards of Quality and Safety – Outcome 8 cleanliness and Infection Control.
- Clostridium difficile infection objectives for NHS organisations in 2018/19
- Clostridium *difficile* infection: How to deal with the problem (HPA & DH 2009)
- Board to Ward (DH 2008).
- The Health Act (2008) updated 2015 Code of Practice for the Prevention and Control of Health Care Associated Infection (DH 2006).
- DH (2008) Clean, Safe care: Reducing infections and saving lives.
- DH (2007) Saving lives – reducing infection, delivering clean and safe care.
- DH (2004) Revised guidance on contracting for cleaning.
- DH (2003) Winning Ways

During 2018 / 2019, and in common with many other organisations, the requirement for infection prevention and control support, advice, interventions, education, training, audits and reports of progress and performance increased. The amount of advice and support required during this period was particularly high and reflects the greater awareness and engagement of staff groups.

The mandatory reporting requirement, verbal and written is undertaken for the following:

- MRSA and Clostridium *difficile* reporting
- MRSA Post Infection Review and Clostridium difficile Root Cause Analysis investigations
- Serious Incidents relating to increased incidents/outbreaks of infection, death associated with infection and ward closures associated with infection.

SECTION 2 ORGANISATIONAL STRUCTURE

Section 3 – Infection Prevention and Control team

Infection Prevention and Control Team

Lead Infection Prevention and Control Nurse
Amanda Hemsley

Antonia Garfoot
Senior Infection Prevention and Control Nurse

Mel Hutchings
Infection Prevention & Control Nurse

Andy Knock
Infection Prevention and Control Nurse

Infection Prevention and Control is a centralised team, working to support all services across the organisation within the directorates.

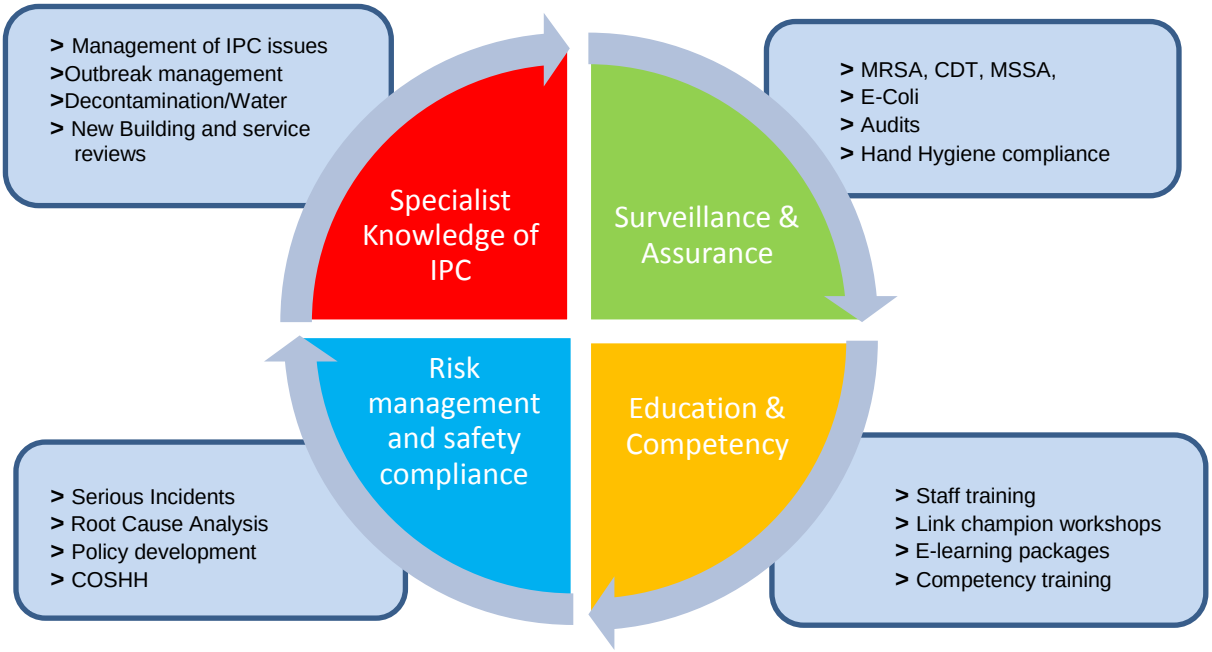
At 31 March 2019 the infection prevention and control team comprised of:

Band 8a x 0.9 wte
Band 7 x 1.0 wte
Band 6 x 2.0 wte

} total wte = 3.9 wte

The Lead Infection Prevention and Control Nurse are managed by the Associate Director of Nursing and Professional Practice. The IPC team are managed by the Lead Infection Prevention and Control Nurse. The IPC team are accountable to the Director of Nursing, AHP's and Quality.

The Infection Prevention and Control team is responsible for a number of functions, some of which are identified below:



- Providing advice on all aspects of infection prevention and control.
- Managing increased incidences and outbreaks of infection.
- Surveillance with regard to incidence of MRSA and Clostridium *difficile.*
- Improving infection prevention and control capability and capacity in service areas.
- Supporting and advising directorates on their responsibilities in relation to local and national IPC requirements.
- Developing and facilitating programmes of education.
- Operating and delivering an Infection Prevention and Control Link Programme.
- Undertaking audit processes and associated report writing.
- Formulating and writing policies and procedures.
- Interpreting and implementing national guidance at a local level.
- Involvement with new service development and other projects.
- Reviewing and advising on building works and facilities.

The infection prevention and control team meet monthly with the Lead IPC Nurse to review infection control issues and any concerns. A co-ordinated annual programme of work was agreed, disseminated and reviewed bi-monthly at the infection prevention and control committee. The Quality Assurance Committee (QAC) received bi-monthly updates, and exception reports were provided to the Trust Board. The Trust board receives reports from QAC which includes Infection Prevention and Control information.

LPT and the Infection Prevention and Control team have continued to support the role of the IPC link champion and have maintained links with these staff members who are employed within the Community Health Service (CHS), Families, Young People and Children (FYPC), Adult Mental Health and Learning Disability (AMH and LD) directorates. The role of the link champion

continues to support the attainment of assurance for IPC practices, which includes hand hygiene compliance scores and cleanliness scores via the top ten markers.

The Consultant for Public Health based within the Public Health England, East Midlands Health Protection team continues to support the IPC team. University Hospitals of Leicester NHS Trust (UHL) employs a Consultant Microbiologist who supports primary care organisations in Leicester, Leicestershire and Rutland. Microbiological support for LPT has been provided by UHL.

Infection prevention and control is incorporated into staff job descriptions as agreed by the Director for Human Resources and is included in the trusts appraisal system for clinical staff.

3.1 LPT Infection Prevention and Control committee

The Infection Prevention and Control committee is chaired by the Associate Director for Nursing and Professional Practice and reports to the Director of Nursing, AHPs' and Quality. A report provides written assurance reports to the LPT Quality Assurance Committee on general matters for IPC and items for escalation. QAC reports to the Trust Board. The committee met four times within this calendar; quarterly.

The Infection Prevention and Control committee provides strategic development of infection control activities on behalf of LPT Trust Board. A lead nurse (or identified representative) for each directorate has provided a highlight report to the committee for assurance and escalation from the directorates.

A review of the function of the committee has been undertaken as part of the year end reporting and identifies both achievements and barriers that have hindered performance. (Appendix 5)

Section 4 – Mandatory requirements

4.1 Annual Programme 2018/19

The annual work programme for 2018/19 was completed over the twelve month period. Infection Prevention and Control Surveillance data was presented monthly to the CQRG with a quarterly report to the quality group providing assurance on key indicators and items for escalation. The cleanliness of the environment has been assessed externally and locally.

The process of audit and assessment as part of the assurance folder requirements (which was introduced in 2015) continues to be reviewed and updated to meet the assurance requirements. The highlight report for each directorate has been developed to provide assurance of compliance with hand hygiene, cleaning and decontamination processes, champion networks and top ten markers for good practice. The development of an electronic app to enhance the data collection of hand hygiene audits and reporting of results is currently underway and will be launched later in 2019.

The cleanliness of the environment is assessed under the remit of Patient Led Assessments of the Care Environment (PLACE), with members of the Infection Prevention and Control team attending the visits as part of the assessment team.

4.2 Monitoring Arrangements

The East Leicestershire and Rutland Clinical Commissioning Group set targets for the management of Clostridium *difficile* and Meticillin Resistant *Staphylococcus aureus* (MRSA) bacteraemias. The trajectory for Clostridium *difficile* was originally set at 7 cases and Meticillin Resistant *Staphylococcus aureas* (MRSA) was set at 0 cases in line with the national requirements. After discussion and negotiation it was agreed that the reduction from the previous year of 12 to 7 was not appropriate and therefore the trajectory was increased back to 12.
LPT completed monthly provider performance monitoring returns; regular reports to the commissioner led CQRG were presented as per the quality schedule.

4.2.1 MRSA

MRSA screening was reported monthly at the Integrated Quality Performance Review Group and is discussed at the Quality Assurance Committee (QAC) and the Trust Board.

There were 0 cases of community acquired MRSA which resulted in a bacteraemia that were attributed to LPT. There were two cases of MRSA bacteraemia that involved an element of care delivery from staff working within LPT. Actions were identified to support the improvement of care for these patients but were not deemed to be a contributing factor to the development of the bacteraemia.

4.2.2 Clostridium *difficile* Infection

Clostridium *difficile* is reported monthly at the CQRG and quarterly to the LPT Infection Prevention and Control Committee, and by exception to the Quality Assurance Committee and Trust Board.

The trajectory for 2018/2019 for Clostridium difficile, EIA positive cases was originally set at 7, which on review by commissioning colleagues was increased to 12. In total 5 patients was tested toxin positive for CDI. All patients received treatment in line with the CDT pathway. Four of the patients were over the age of 65, the fifth patients age was 22. The younger patient was a long term patient on the eating disorders inpatient unit and had a history of self-harm which required a number of antibiotic treatments. All the patients who were over the age of 65 had other co-morbidities.

On review of the patients identified, 4 out of the 5 (80%) patients were admitted from a ward at University Hospitals of Leicester, all 5 (100%) had received or were currently receiving antibiotics for a documented infection, and 4 (80%) were receiving protein pump inhibitors. None of the patients had a previous history of CDT diagnosis. (Appendix 1)

A number of lessons for learning were identified during the root cause analysis reviews with the themes identified in the appendices. Actions have been taken to address these issues and continue to form part of the teaching and training developed and delivered by the IPC team.

Data reporting Figures for 2017/18													
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
CDT	1	0	0	1	1	0	0	0	0	0	1	1	5/12
	Beech wood			Clarendon ward	CV ward 1						Langley ward	North ward (H&B)	
MRSA	0	0	0	0	0	0	0	0	0	0	0	0	0

4.2.3 Mortality data for Clostridium *difficile* Infection

There were a total of 5 EIA toxin positive Clostridium difficile tests reported for LPT. Of the 5 cases patients, 1 patient had died at the time of writing the report, which was outside of the 30 day mortality data capture timeline. This patient death was not attributed to CDI. RCA's were carried out on all positive samples for CDI to ascertain if a lapse in care was the cause of the infection. Whilst some lapses were identified, none were the actual cause of the CDI infection (Appendix 2).

4.2.4 HCAI risks identified on the risk register

Risks for HCAI's are managed in line with the trust risk management arrangements and are escalated accordingly. Risks are identified and reviewed at the LPT infection prevention and control committee and controls and measures are in place to reduce or remove the barriers to achieving compliance. Within the year, the norovirus risk was addressed with planned meetings across LLR to reduce the impact of norovirus and have a streamlined and consistent approach in managing patients at times of high levels of the infection.

Lessons for learning from the staff flu vaccination programme will be taken forward to plan for the coming years campaign, however it must be noted that the vaccination is not mandatory for staff which will always have an impact on uptake if staff choose not to be vaccinated.

Nationally there has been a reduction in the numbers of patients who are diagnosed with a positive toxin CDI; however management and analysis of care given to these patients remain a priority for the trust.

Risk assessments for IPC issues included:

Increase risk of Norovirus infection to patients and staff due to the lack of an overarching and jont plan with the acute trust and the increased number of patients discharges.

Staff flu vaccination programme

The trust would potenially not achieve the national target of 75% uptake of the vaccination by staff. The impact of this could be increased staff sickness, potential illness risks to the patients, loss of finacncial investment and the loss of credibilility of the organisation.

Clostridium difficile infection

The Trust will breach the trajectory of seven cases of Clostridium difficile set by the Leicester, Leicestershire and Rutland Commissioning group.

Section 5 – Prevention and Reduction Strategies

5.1 Post Infection Reviews (PIR)

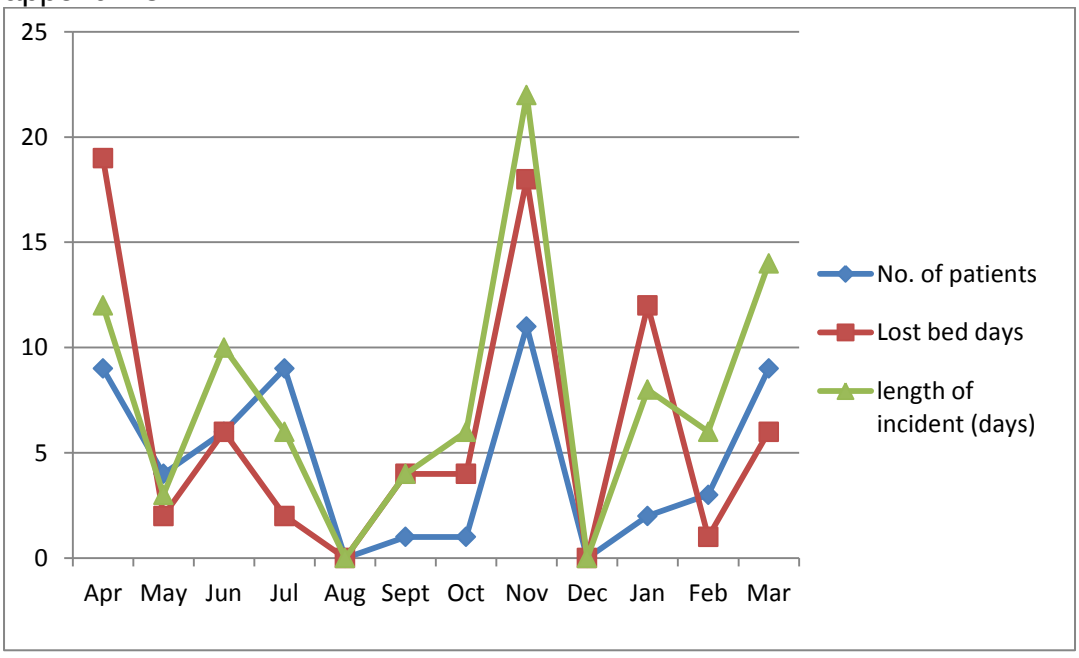
There were 2 case of an MRSA bacteraemia that required a review by organisations across LLR. This review identified that elements of care had been provided to these patients by healthcare staff working for LPT. However whilst elements of care provision were identified for improvement (including omission of documenting the use of ANTT) the bacteraemia was not attributed to any lapse in care by staff within LPT. The lessons from these reviews continue to inform any improvements in care required.

5.2 Increased Incidence of Infection

During the period of 2018/19 the organisation experienced a number of increased incidences of infection which resulted in source isolation requirements and beds closed to prevent the further spread of infection. Infections identified within these incidences include vomiting and/or diarrhoea, CDT, Carbapenemase Resistant Organism infection and Influenza. As part of our programme to prevent an outbreak of infection an infection prevention and control nurse reviewed all reported cases of symptomatic patients, supporting the inpatient areas with the most appropriate process for managing the incidence; if required advice was sought from the consultant microbiologist at UHL.

From 1 April 2018 to the 31 March 2019 there were 15 episodes recorded for increased incidences, 4 of which were confirmed for Norovirus (26% of the total figure). This is a decrease based on figures from the previous year. It is recognised that Leicestershire experienced similar number of cases to the national picture. Whilst the figure is reduced it should be noted that 6 episodes of diarrhoea and vomiting did not identify a specific viral cause, which may have been due to the lack of samples obtained for microbiology analysis.

The table below shows the data captured by the infection prevention and control team for 2018/19 for those patients who were symptomatic with an infection, it should be noted that more than one incidence may have occurred within the same month. A breakdown of the figures can be viewed in appendix 3.



SECTION 6 – Code of Practice for the Prevention and Control of Health Care Associated Infections

LPT's position against the code of practice was monitored and assessed on a monthly basis. Each directorate has been previously assessed against the CQC requirements for Outcome 8 and any remedial actions monitored through the directorate infection prevention and control groups, reporting to the Infection Prevention and Control committee. Further work going forward into 2019/2020 will be undertaken to provide a direct and concise framework and key requirements to meet and maintain compliance with the code. Assurance from this work will be for each directorate will be reported through the IPC committee. This work has been developed in conjunction with discussions with the Lead Nurse for Infection Prevention from University Hospitals of Leicester.

6.1 Compliance

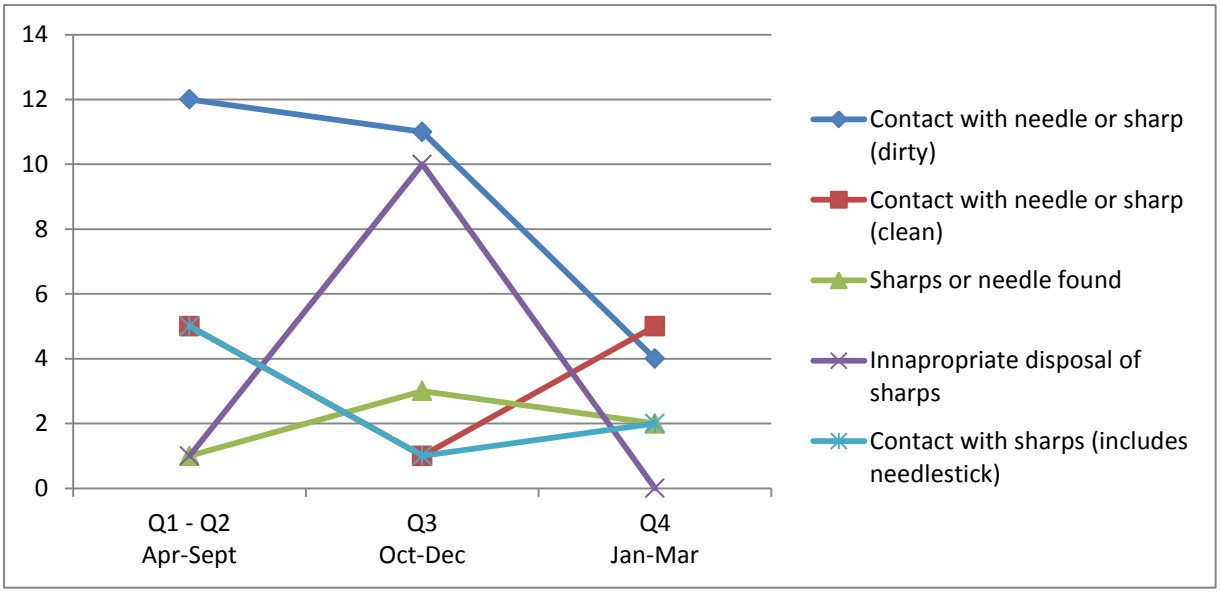
6.1.1 Safer sharps

The Trust has now committed to be fully compliant with the Council Directive 2010/32/EU of 10th May 2010 to prevent injuries and blood borne infections to hospital and healthcare workers from sharp objects, such as needle sticks. Where a safer sharp device is not available or is not practical (due to service delivery) then a risk assessment has been carried out. Updates are provided through the IPC committee or the Health and Safety committee.

6.1.2 Sharps incident data

Needlestick and sharps injuries carry the risk of infection and are an occupational hazard for all healthcare professionals involved in patient care or working in a clinical environment. A quarterly report was presented at the Infection Prevention and Control committee regarding the data aligned to incidents that involved sharps. The purpose of the report was to inform and assure the IPC committee that mechanisms are in place to review, identify themes and trends, share lessons from actions, and monitor progress and performance in themes of sharps incidents across directorates.

The table (1) below shows the incidents reported from 1st April 2018 until the 31st March 2019.



The table below identifies the incidents broken down into the Quarterly timescales of reporting. Q1 and Q2 figures are reported as a single figure due to the reporting system at that time. Future reports will provide breakdown per quarter.

2018/19					
	Q1/Q2		Q3	Q4	Total
Contact with needle or sharp (clean)	5		1	5	**11**
Contact with need or sharp (dirty)	12		11	4	**27**
Sharps or needle found	1		3	2	**6**
Inappropriate disposal of sharps	1		10	0	**11**
Contact with sharps (includes needlestick)	5		1	2	**8**
Total	**11**	**13**	**26**	**13**	**63**

Table 1

The figures below identify the number of incidents generated regarding sharps and needlestick injuries over the last four financial years. Whilst there does not appear to be any significant correlation, the reduction seen in 2018/19 may be due to the confidence in the use of safer sharps and the continual training and education around the causes of the incidents to reduce their probability.

	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total
2015/16	18	25	29	27	**99**
2016/17	31	23	17	23	**94**
2017/18	25	34	25	31	**115**
2018/19	11	13	26	13	**63**

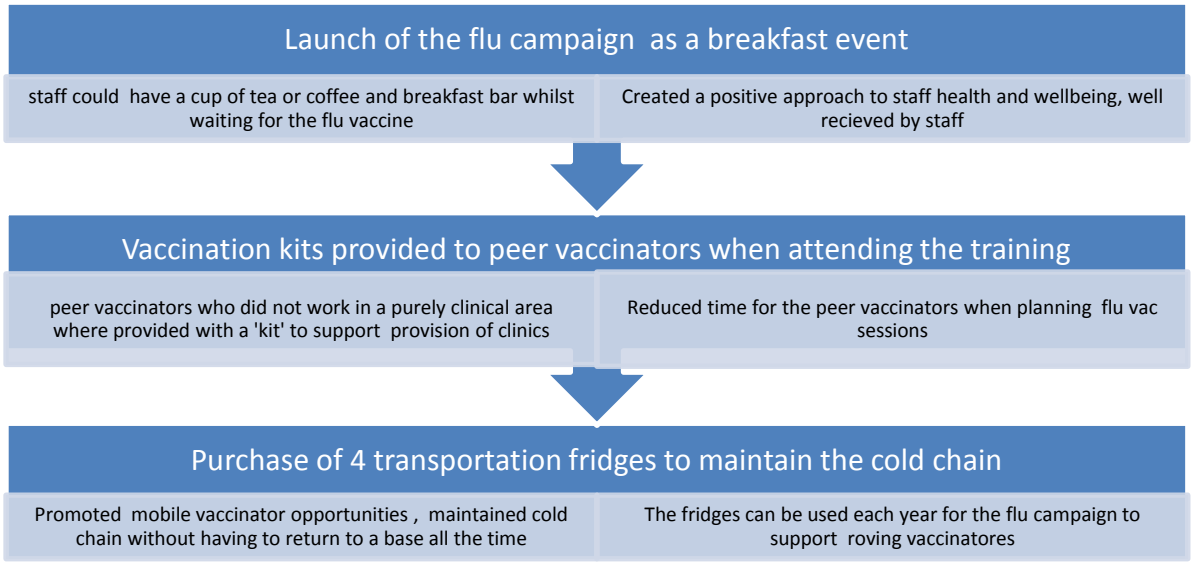
6.1.3 Flu Vaccination for Staff

Leicestershire Partnership NHS Trust (LPT) is required to deliver an annual seasonal flu campaign, offering all staff the opportunity to have the seasonal flu vaccine. The aim of the campaign which runs from October to February is to protect patients and staff from seasonal flu.

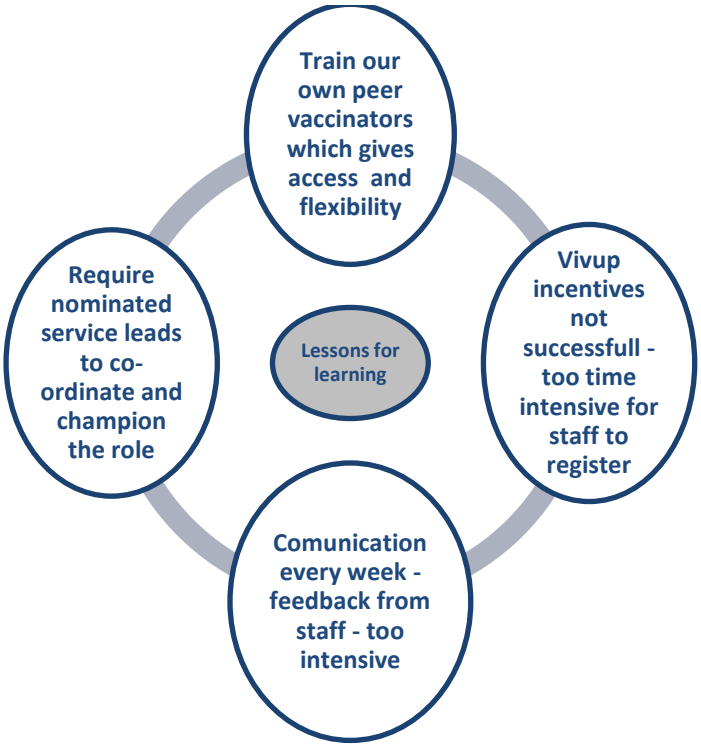
Seasonal Flu Vaccination 2018/19

The 2018/19 seasonal flu vaccination campaign did not achieve an uptake of 75% to achieve the full CQUIN payment. A total of 54% of healthcare workers accessed the vaccine. However whilst the figure remains the same as the previous year, there were approximately 500 extra staff vaccinated in 2018/19 from the previous year.

Successes



Future points for leaning and consideration



It was recognised early on within the campaign that there were a number of challenges which would have an impact on the uptake of the vaccination by clinical staff. A contributing factor in last year's campaign was the delay in securing funding for bank peer vaccinators.

The provision of a flu vaccinator at the LPT training and development centre (NSPCC) on a daily basis improved the access to the vaccine for staff. However this was resource intensive due to a peer vaccinator being required to attend the facility on a daily basis. Midway through the campaign uptake was reviewed and sessions prioritised according to key training events with larger numbers of staff. A recommendation this year is that members of the learning and development team are trained as peer vaccinators, to improve onsite access to a vaccinator.

Target

CQUIN targets for 2019/20 have been increased and the minimal uptake target set at 60% uptake as opposed to 50% the previous year. Full payment has been set at 80%, a 5% increase from 75% on the previous year.

The figures below show year on year comparisons of the flu vaccination figures for healthcare workers in LPT, over the last three years. 2016/17 was the year a full time roving peer vaccinator was employed, who provided daily clinics and flexible access to the vaccination opportunities.

	2016/17	2017/18	2018/19
Totals	3032	2029	2518
	62%	54%	54%

The following figures identify numbers of Frontline Healthcare Workers required to achieve the CQUIN target.

Number of Frontline Healthcare Workers (FHW) – based on 4,610 (as at 28 February 2019)

60% = 2,766
65% = 2,996
70% = 3,227
75% = 3,457
80% = 3,688

Peer Vaccinators

In 2018/19 there were 58 staff members who trained to be peer vaccinators, in total 2337 vaccinations were administered by these staff, which equated to 77% of the total vaccinations carried out, an increase in 16% on the previous year.

Occupational health services continued to offer flu vaccinations via clinics as in previous years. This provides an accessible flexible approach to vaccination and is instrumental in creating opportunities for vaccine access, particularly for staff who are either agile in their working role or community focused and access may be challenging due to time and location constraints.

Feedback received and collated to understand the reasons why some of the peer group did not vaccinate is listed below:

- Lack of time outside of clinical work
- Challenge in accessing the vaccine (non-clinical areas do not have appropriate fridge)
- Time (including collecting the vaccine, cold chain equipment, setting up, and setting up the clinics)
- Peer vaccinator on long term sick
- Peer vaccinators unable to travel outside of their work area and deliver the vaccine
- Peer vaccinator did not respond to communications from Lead IPC nurse to understand the challenges
- Challenge in co-ordination of peer vaccinators as no dedicated role

In order for the flu group to address the actions required to improve the uptake of the vaccine offered to frontline healthcare workers a seasonal flu vaccination plan for 2019/20 has been developed. However it is recognised that this group alone is unable to drive the flu vaccination message and programme for staff and is supported by the executive team within the trust.

6.1.4 Sepsis Awareness

Sepsis is recognised as a life threatening condition that arises when the body's response to an infection injures its own tissues and organs. Sepsis leads to shock, multiple organ failure and death especially if not recognised early and treated promptly. Sepsis kills 44 000 people per year in the UK. Many of these deaths could be avoided if a diagnosis of sepsis is identified early enough to intervene and treat.

Sepsis is a growing concern and is high on the NHS agenda. Much of the work on sepsis diagnosis has focussed on secondary care. However it is recognised that early recognition in primary care is fundamental for rapid response and treatment to reduce mortality rates. The Infection Prevention and Control Team are working with relevant clinical specialists and Learning and Development to raise awareness of sepsis. The Trust wide action plan continues to be actioned and has been developed in line with the overarching sepsis plan for LLR. There is an LLR wide sepsis group which has representation from LPT at the meetings which meet 4 times a year.

LPT has identified that a structured and streamlined approach is required to drive the sepsis agenda forward, and identify gaps and actions required. Therefore a dedicated Sepsis co-ordinator for the trust (who has worked as an IPC nurse) has been employed for 15 hours per week to ensure this work and vital teeaching and training is facilitated. This post will commence on the 29 July 2019.

The following actions have been developed for the coming year which will continue to support and drive the sepsis awareness agenda within LPT:

- A Trust wide Sepsis Policy
- A review of national recommendations for sepsis awareness and training for staff
- The development of safety netting information for patients, relatives and carers
- A trust wide implementation programme to meet the national agenda

Section 7 – Patient and Public Involvement

Recognising that healthcare associated infection is a key concern of patients and the general public, LPT has sought to raise awareness of how this issue is addressed and to highlight the public's role in reducing infections. There has been a set target that 50% of the assessment team for PLACE is made up of patient representatives, with the visits being rescheduled if this is not achieved. The PLACE assessments were completed.

LPT has an established website with dedicated pages regarding health and wellbeing providing information to the public. Infection prevention and control activity has been reported quarterly at the public part of the LPT Board meetings. Board papers are available on the LPT internet site.

Section 8 – Antimicrobial Prescribing

The medical field and the world are facing a threat as a result of antimicrobial resistance. The pace of antimicrobial resistance developing is related to antimicrobial usage. Therefore, reducing its use, where safe to do so, can reduce rate of resistance and thus preserve their effectiveness for longer. Rationalising antimicrobial prescribing along with a wider system-wide approach is referred to as Antimicrobial Stewardship.

Around 80-85% of antimicrobials are prescribed in primary care. LPT prescribe 300 to 350 courses of antimicrobials every month across the inpatient units. This equates to an average of around 11 courses prescribed each day.

8.1 Antimicrobial Stewardship Arrangements

- In response to NICE guidance (Antimicrobial Stewardship: systems and processes for effective antimicrobial medicine use), LPT completed a baseline assessment. We are fully compliant with this;
- LPT has an approved Antimicrobial Stewardship Policy which describes local implementation of national guidance along with roles and responsibility;
- Antimicrobial stewardship within LPT feeds into the LPT IPC meetings and LPT Prescribing Group on a periodic basis;

- One of LPT's quality schedules focusses on antimicrobial prescribing;
- LPT continues to be part of the antimicrobial working party. This group is led by experts in UHL and includes CCGs too;
- The stock for each ward and emergency drug cupboards have been carefully reviewed to ensure that only the necessary antimicrobials are stocked. All other antimicrobials prescribed have to be supplied from pharmacy;
- All wards use electronic prescribing. The local antimicrobial guidelines have been integrated into the ePrescribing system to make it easier to prescribe the correct course of treatment. For instance, if a clinician wanted to prescribe flucloxacillin for cellulitis, they would select 'flucloxacillin (cellulitis) protocol' under drug choice and this would automatically bring up the correct dose, frequency and length of treatment.
- Every prescription for antimicrobial therapy is scrutinised by pharmacy to ensure that the indication and regimen is sensible and as per guidelines. Interventions can be made if needed;
- An annual audit examines antimicrobial prescribing and documentation across all inpatient areas. The audit looks at whether there was sufficient rationale for the prescribing of antibiotic and checks if the regimen was in accordance with the antimicrobial guidance. The audit also looked at the quality of an interim review 48-72 hours after initial prescription (referred to nationally as start SMART, then FOCUS approach).
- Each month, all antibiotic consumption is converted into a standardised unit of measurement (Defined Daily doses/1000 admissions) which allows for future benchmarking of usage against similar Trusts

Section 9 – Decontamination

The healthcare environment demands that all instruments used on patients are safe for use. In order to achieve this, surgical instruments and other similar items may be either disposable or re-usable. If instruments are re-usable they require appropriate reprocessing between patients via defined process of decontamination. Equipment must be cleaned and decontaminated in a managed way that reduces the risk of injury or infection.

The clinical areas where podiatry services are delivered have been upgraded to meet the requirements of the health and social care act, in relation to decontamination. Instrument tracking systems have been implemented to include the instrument marking module to enable single instrument traceability.

9.2. Water Management

The Water Management Group is a multi-disciplinary group which oversees the commissioning, development, implementation and review of the Water Safety Plan. This has the aim of ensuring the safety of all water used by patients, staff and visitors to the Trust. The group meets quarterly or more frequently if there are water safety incidents. In 2018/19 the Trust appointed an Authorised Engineer to support the implementation and monitoring arrangements of the water management policy, who will chair the future water management group meetings.

Section 10 – Policies and Guidelines

There continues to be a range of policies within the remit of infection prevention and control for staff to follow, in line with the requirements of the Health and Social Care Act 2008. The policies

have all been updated when new and relevant information became available. Policies are on a timetable for review as a matter of process (Appendix 4)

Section 11 – Patient Led Assessment of the Care Environment (PLACE) 2018

The facilities management shared service (hosted by UHL) undertook the lead in facilitating the PLACE assessments across Leicestershire Partnership inpatient units in March/April 2018. The results were made available and presented to the Trust in September 2018. In response, an action plan was developed containing the 441 actions as a result of the completed assessment forms. Table 1 below provides a breakdown of the total actions required from 2016-2018 which identifies an improved position against the total number of required actions year-on- year.

Table 1

Domain reference	2016	2017	2018
Cleaning	356	193	35
Condition, appearance and maintenance	403	410	233
Dementia	*	195	37
Disability	*	75	1
Privacy and Dignity	9	103	86
Food	Not recorded	Not recorded	49
Total number of actions identified	**1137**	**976**	**441**

*****_These domains did not exist at the time of these assessments_
Please also note, as a number of actions cover more than one domain, the lead domain as presented in the data from the Health & Social Care Centre is used for the benchmarking exercise in Table 1 above and Table 2 below.

To inform the action planning priorities, the RAG descriptors shown in Table 2 below were considered.

Table 2

	Descriptor	2018 impact
Red	Action immediately, possible risk of safety to patients, staff and visitors.	No actions identified
Amber	Does not meet the current guidance however compliant at time of install – potential to cause risk to patient, staff, and visitor safety.	**28** actions identified – 2 associated with food and 26 associated with condition, appearance and maintenance.
Green	Attention to detail – no risk to patient, staff, visitor safety.	**413** actions identified

Agreed priorities and actions taken in response to PLACE assessments

28 amber priorities were identified following the 2018 PLACE assessment and these were used to inform the spending priorities for monies available in 2018-19.
To inform this decision, all three directorates were asked to consider their top three priorities for spending agreement.

The Patient Carer Experience Group reviewed these priorities with the Property Manager and data sources indicated below to support prioritisation -

- Local Health & Safety audits
- Local infection control audits
- Directorate risk register data
- Incident data
- CQC reports

Table 3 below outlines the agreed spending priorities usable against the available capital funding allowance of £100,000.

Table 3

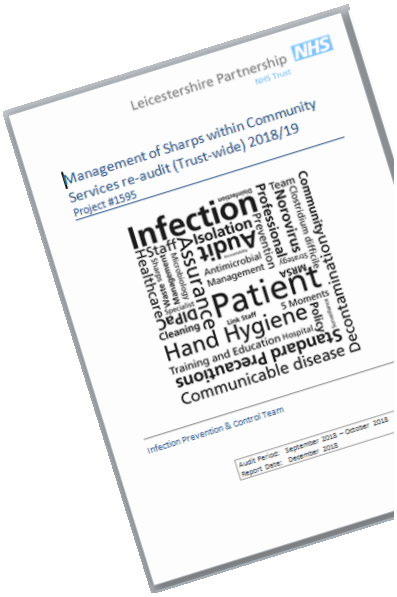
Location	Action	Domain	Open/complete	Spend
Stewart House AMHLD	Replace x4 patient lounge window/door sets	Condition, appearance and maintenance	Complete	£16,000
Coalville Hospital CHS	Ward 2 – replace x2 bathroom flooring	Privacy & dignity Dementia	Complete	£9,500
Evington Centre CHS	Community health wards - Install wall protection at bed head	Condition, appearance and maintenance	Ongoing – will be complete by March 31st 2019	£74,000
			Total Spend	£99,500

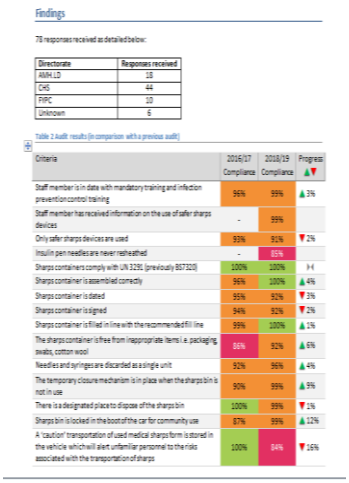
Whilst there is specific capital funding in support of PLACE improvements, it is also worth noting that a number of other capital funded projects and/or day to day maintenance revenue activities have addressed items raised during the PLACE assessments and this progress is captured on the action plan. These projects include;

- ✓ New safe vent windows at BMHU – improves ventilation, environment aesthetics and safety – meets the domain condition, appearance and maintenance.
- ✓ BMHU refurbishment of Ashby & Bosworth wards - meets the domain condition, appearance and maintenance.
- ✓ Stewart House laundry – refurbishment of both male & female laundry and relates to condition, appearance and maintenance and privacy and dignity domains
- ✓ Community wards access control – supports managing patients with dementia and therefore is related to the dementia domain.
- ✓ The Willows quiet room – creation of a quiet room off the wards for patients to have time out, meet support workers and family - supports patients privacy & dignity
- ✓ Sensory room on Aston Ward, Bradgate Unit - creation of a quiet room on the ward for patients to have time out from group areas – supports privacy & dignity
- ✓ Refurbishment of the Gym at the Bradgate Unit – allows patients time away from the wards and supports physical as well as their mental health – relates to the privacy & dignity domain
- ✓ Bradgate Unit – development of internal garden areas and gardening activity – supports condition & appearance and privacy & dignity domains.
- ✓ Bradgate Unit – partial paint of the front fascia boards – meets the requirements of condition, appearance & maintenance domain.
- ✓ Stewart House – painting of external window frames, fascia's and front entrance – meets the actions identified within the condition, appearance and maintenance domain.

Section 12 – Audit

The audit timetable forms part of the overarching annual work programme for IPC, Audits included in this plan include; hand hygiene audits and compliance with the trusts infection prevention and control markers in inpatient areas on a monthly basis. An audit on the management of sharps within community services as part of a re-audit was undertaken in September/October 2018. Key findings and areas of improvement are discussed below.





Findings

78 responses received as detailed below:

Directorate	Responses received
AMH LD	18
CHS	44
PIPC	10
Unknown	6

Table 2 Audit results (in comparison with a previous audit)

Criteria	2016/17 Compliance	2018/19 Compliance	Progress ▲▼
Staff member's in date with mandatory training and infection prevention control training	96%	99%	▲3%
Staff member has received information on the use of safer sharps devices	-	99%	
Only safer sharps devices are used	93%	91%	▼2%
Insulin pen needles are never resheathed	-	85%	
Sharps containers comply with UN 3291 (previously BS7320)	100%	100%	H
Sharps container is assembled correctly	96%	100%	▲4%
Sharps container is dated	95%	92%	▼3%
Sharps container is signed	94%	92%	▼2%
Sharps container is filled in line with the recommended fill line	99%	100%	▲1%
The sharps container is free from inappropriate items(i.e. packaging swabs, cotton wool	86%	92%	▲6%
Needles and syringes are discarded as a single unit	92%	96%	▲4%
The temporary closure mechanism is in place when the sharps bin is not in use	90%	99%	▲9%
There is a designated place to dispose of the sharps bin	100%	99%	▼1%
Sharps bin is locked in the boot of the car for community use	87%	99%	▲12%
A 'caution' transportation of used medical sharps form is stored in the vehicle which will alert unfamiliar personnel to the risks associated with the transportation of sharps	100%	84%	▼16%

Areas of good practice

- There was an increase of 3% in the number of members of staff that were in date with mandatory and infection prevention and control training.
- 99% of staff has received information regarding the use of safer sharps devices.
- The audit showed that insulin pens are never re-sheathed, which remains the same from the baseline audit undertaken 2017/2018.
- 100% of sharps bins were assembled correctly, which is an increase of 4% from last year
- 100% of sharps bins were filled in line with the recommended fill line which is an increase of 1% from the previous audit.
- There was an increase of 4% in the number of needles and syringes are discarded as a single unit, from 92% to 96%.
- There was a 9% increase in the number of sharps bins that had the temporary closure mechanism in place when the sharps bin was not in place, which is an increase of 9% from the audit undertaken 2017/2018.
- 99% of sharps bins used by community staff were locked in the boot of the car, which is an increase of 12% from the previous audit undertaken 2017/18.

Areas for improvement

- The percentage of safer sharps that are used within the organisation reduced by 2%
- 6 out of 67 sharp bins that were not signed or dated, which showed as a reduction of 3% and 2% respectively.
- The main areas for improvement relate to the caution form for transportation of used medical sharps and the carrier registration notice that should be kept in the vehicle with a reduction in compliance of 84% and 76%, relating to 11 and 15 negative answers

respectively. This result is concerning as compliance for the previous audit covering the period 2016/2017 was 100%.

Areas of risk/ mitigation

Although only 4 of the elements achieved a full compliance rating it should be noted that the compliance standard for all questions was set at 100%. 6 other questions received 3 or less negative responses out of 78 in total.

Only 3 elements of the audit resulted in failures. 2 of these are specific to community staff and can be actioned by raising awareness of the required paperwork they must carry. The issue of the insulin pens is one that is a recurring within LPT, but the number of incidents that are submitted by the Trust has significantly decreased from last year. Also this question does not have a baseline from the last years audit to enable a comparison to be made.

Section 13 – Training and Education

13.1. Mandatory Training

All staff receive Infection Prevention and Control level 1 and hand hygiene training at induction and on a 3 yearly basis as part of their core mandatory training. Clinical staff with patient contact receives infection prevention and control level 2 and hand hygiene on a two yearly basis. The following figures identify LPTs compliance by 31 March 2018 split by groups of staff.

	Group	Overall compliance (31/03/2018)	Change in compliance from 12 months (01/04/2017 – 31/03/2018)
Hand Hygiene (2 year update)	Substantive	92.9%	-1.4%
	Bank	74.4%	-4.8%
	Medical Trainees	88.9%	+4.7%
Infection Prevention and Control Level 1 (3 year update)	Substantive	94.2%	-0.2%
	Bank	73.2%	-11.3%
	Medical Trainees		
Infection Prevention and Control Level 2 (2 year update)	Substantive	92.9%	+2.7%
	Bank	73.4%	+0.4%
	Medical Trainees	86.1%	-15.4%

13.2. Link Staff

To support best practice in infection prevention and control there are 209 Infection Prevention and Control Links within the Trust. The role of the link staff is to promote best practice, being a role model for hand hygiene and to monitor clinical areas to ensure that they are clean and safe for clinical use.

The link staff conduct monthly hand hygiene audits within their teams reporting back results to the Infection Prevention and Control Committee. Any poor practice noted during these audits can be

addressed by the link staff directly using their knowledge and presentations supplied by IPC. They are responsible for assessing hand hygiene practice of new starters within their teams.

Top 10 marker data is collected / collated by the Links for clinical areas on a monthly basis which is also fed back to the IPC Committee.

13.3. IPC Awareness/Promotion

A number of roadshows have taken place over 2018/19 to promote the infection prevention and control agenda, with quizzes and prize draws for the highest score. The campaign was well received and shared with the wider LPT audience via the communications processes within the trust. The collage below shows a number of staff involved in the campaign, including the Infection Prevention and Control Team.

Section 14 – Priorities for the coming year

- Implementation of the hand hygiene app for Leicestershire Partnership Trust to support compliance with the Hygiene Code
- Continued working across LLR in relation to the managing patients with multidrug resistant organisms, with specific reference to CRO
- Audit and management regarding urinary tract infections for patients with or without a catheter in support of the E-coli bacteraemia reduction targets
- Further development of the Sepsis plan for the Trust
- Review and redevelopment of the elearning training for Level 1 and Level 2 IPC
- Compliance with the CQUIN for staff accessing and receiving the influenza vaccine
- Review and revise IPC intranet page in line with trust changes
- Continuation of working relationships to support new works and building reviews for the LPT estate
- Supporting the continued implementation of the LLR network group plan
- Supporting further development and implementation of the 5 year plan for antimicrobial stewardship
- Continued implementation of the urinary catheter passport and improved patient leaflet
- Continuation of MRSA screening for emergency admissions (mental health)
- Review of the surveillance and management of emerging infections with specific emphasis on MSSA, E-coli and Multi drug resistant organisms.
- Review of information for patients, carers and family, including admission and discharge information for infection prevention and control.
- Development of a Quality Improvement plan

Section 15 – Summary

This report demonstrates the continued commitment of the Trust and evidences the successes and service improvements achieved through the leadership of a proactive and dedicated IPC team. It is also a testament to the commitment of a Trust workforce dedicated to keeping IPC high on everyone's agenda. A key priority for the IPC team is to work to a Trust wide approach for all IPC activity.

The Trust remains committed to preventing and reducing the incidence and risks associated with HCAIs and recognises that we can do even more by continually working with colleagues across the wider health system, patients, service users and carers to develop and implement a wide range of IPC strategies and initiatives to deliver clean, safe care in our ambition to have no avoidable infections.

Looking forward to 2019-20, LPT staff will continue to work hard to embed a robust governance approach to IPC across the whole organisation and the IPC team and all staff will continue to work hard to improve and focus on the prevention of all healthcare associated infections.

Section 16 – References

Department of Health (2008) *The Health and Social Care Act. Code of Practice for Health and adult social care on the prevention and control of infections and related guidance* (Revised 2015). London

Department of Health (2013) UK five year Antimicrobial Resistance Strategy 2013 to 2018

Public Health England. (2015). *Toolkit for managing Carbapenemase-producing Enterobacteriaceae in non-acute and community settings*. London: Public Health England

Department of Health (2014) *Implementation of modified admission MRSA screening guidance for NHS 2014.* London. Department of Health

National Institute for Health and Care Excellence (2014) *Infection Prevention and Control. NICE Quality Standard 61.*

Pratt R, Loveday H, Wilson J, Golsorkhi M, Tingle A, Bak A, Browne J, Prieto J, Wilcox M (2014) Epic3: national evidence-based guidelines for preventing healthcare-associated infections in NHS hospitals in England. *Journal of Hospital Infection*. 86. Supp 1. S1-70

Public Health England. (2014). *Patient Safety Alert 'Addressing rising trends and outbreaks in Carbapenemase-producing Enterobacteriaceae' NHS/PSA/Re/2014/004.*

Department of Health (2013) *Water systems Health Technical Memorandum 04-01: Addendum Pseudomonas aeruginosa – advice for augmented care units*. London

Health and Safety Executive (2013) *Health and Safety (Sharp Instruments in Healthcare) Regulations 2013. Guidance for employers and employees.* London

Section 17 – Acknowledgments

The following individuals have been instrumental in providing specialist information for this report;

- Infection Prevention and Control Team
- Associate Director of Nursing
- Project Officer for Professional Practice
- Lead Pharmacist for Families, Young People and Children
- Property Manager, Estate and Facilities
- Head of Health, Safety and Security

Appendix 1

Summary of Key Findings for Internal Root Cause Analysis on reported cases of Clostridium *difficile* within LPT April 2018 – March 2019

Clostridium difficile infection (CDI) is defined by the presence of symptoms (usually diarrhoea) and either a stool test positive for *C. difficile* toxins or toxigenic *C. difficile,*

Trajectories for CDI for LPT was originally set at 7 for the year 2018/19, this was reviewed mid-year by commissioning colleagues was increased to 12 for the year. As part of the on-going commitment to support a zero tolerance to this infection an internal root cause analysis is carried out for each CDI that is attributed to LPT. The content of this report covers those CDI's that are deemed as reportable (i.e. toxin positive).

Up to and including the 31 March 2019 there were 5 reportable cases of CDI out of a trajectory of 12. The internal RCA reports have been tabled at the identified meetings (locality IPC groups) and divisional SI groups as appropriate. This is a review of those cases to provide assurance to the Infection Prevention and Control Committee that the cases have been managed appropriately, including lessons for learning

Case 1- Beechwood ward
Admitted to the ward from ward 23 UHL 23/03/18
Date commenced diarrhoea – 12/04/18
Sample sent – 12/04/18
Positive result – 14/04/18

Potential Contributory Factors
- No previous history of CDI
- Protein pump inhibitors prescribed
- Antibiotics – Trimethoprim, previous co-amoxiclav

Issues identified for learning
- Nil to note

Lapse in care: No
CDI Attributed to lapse: N/a

Patient Outcome
Patient discharged 10/05/18

Case 2 – Clarendon ward, Evington Centre
Admitted to the ward from UHL on 30/05/18
Date commenced diarrhoea – 13/07/18
Sample sent – 14/07/18
Positive result – 16/07/18

Potential Contributory Factors
- Previous CDI –ve result on 02/5/18 and 23/06/18 (prescribed Metronidazole)
- No protein pump inhibitors prescribed
- Antibiotics – Ceftriaxone and Merepenem

Issues identified for learning

- Nil to note

Lapse in care: No
CDI Attributed to lapse: N/a

Patient Outcome
Patient discharged on 19/07/18

Case 3 – Ward 1 (Snibston) Coalville
Admitted from LRI Stroke ward on 17/07/18
Date commenced diarrhoea – 30/08/18
Sample sent – 30/08/18
Positive result – 31/08/18

Potential Contributory Factors

- No Previous history of CDI
- Protein pump inhibitor Lansoprazole
- Previous antibiotics – co-amoxiclav at UHL

Issues identified for learning

- SIPSs commenced at bedspace on 30/08/18 but not moved into a single room until 31/08/18

Lapse in care: Yes
CDI Attributed to lapse: No

Patient Outcome
Patient died 18/10/18 – not attributed to CDI

Case 4 – Langley ward, Bennion centre
Patient admitted from home on 04/12/18
Date commenced diarrhoea – 13/02/19
Sample sent: 13/02/19
Positive result: 14/02/19

Potential Contributory Factors

- No previous history of CDI
- History of self-harm, treated with antibiotics
- Protein pump inhibitor prescribed – Lansoprazole
- Antibiotics prescribed – Amoxicillin 4/7, Flucloxacillin

Issues identified for learning

- Nil to note

Lapse in care: No
CDI Attributed to lapse: N/a

Patient Outcome
Patient on home leave (23/05/19)

Case 5 – North Ward, Hinckley and Bosworth

Patient admitted from UHL on 08/03/19
Date commenced diarrhoea – 15/03/19
Sample sent – 15/03/19 and 18/03/19 (initial sample not labelled correctly)
Positive result 18/03/19

Potential Contributory Factors

- No previous history of CDI
- Protein pump inhibitors prescribed – Lansoprazole, changed to Ranitidine
- Antibiotics prescribed previously for urinary tract infection

Issues identified for learning

- Treatment for CDI initially delayed due to sample bin

Lapse in care: Yes
CDI Attributed to lapse: No

Patient Outcome
Patient discharged 29/04/19

Summary
To date 5 patients have tested toxin positive for CDI, with one retest taking the figure to 13. All of the patients were over the age of 65 and a number of the patients had extensive co-morbidities.

On review of the patients identified, 10 out of the 12 (83%) patients were admitted from a ward at University Hospitals of Leicester, 10 (83%) had received or were currently receiving antibiotics for a documented infection 4 (33%) were receiving protein pump inhibitors. 1 patient had a previous history of CDT diagnosis.

A number of lessons for learning were identified during the root cause analysis reviews with the themes identified below. Actions that have been taken to address these issues and continue to be; are also listed below.

Lessons for Learning

- Specimens to be clearly and accurately labelled
- Documentation including normal bowel movements need to be addressed
- Timely source isolation precautions commenced and documented in line with faecal sampling
- Consideration of infection when diarrhea/loose stool of unknown origin identified.
- Top ten markers to be in date
- Cleaning issues to be addressed

Actions undertaken to date

- Face to face training by the IPC team to ward staff
- Development of posters and leaflets to address issues identified
- Clinical supervision within teams around this subject
- Monthly matron walk rounds with the IPC team

Appendix 2

Clostridium difficile – Case reviews regarding 30 day mortality

Leicestershire Partnership Trust continues to work hard to tackle healthcare-associated infections and support the reduction of these incidences. With regards to the management of Clostridium difficile (EIA toxin positive) the guidance: Clostridium difficile infection: How to deal with the problem, 2007; identifies in section 10.3 '*Published data suggest 30 day all-cause mortality of C. difficile to be 21% (Morgan et al., 2008) and secondary care trusts should maintain comparative data on this. Assessment of criteria for attributing death to CDI is urgently needed.'* 10.5 states '*trusts should consider urgent medical action manage cases if their audited 30-day mortality rate approaches 20%.*

The following information identifies the patients who were diagnosed with toxin positive CDI whilst an inpatient within LPT. There were a total of 5 EIA toxin positive Clostridium difficile tests reported. Of the 5 patients, 2 patients have died at the time of writing this summary, 1 of which was within 30 days of being diagnosed with CDI. This equates to 20% of patients who were tested positive for EIA toxin CDT.

Where CDI is indicated on the death certificate a Serious Incident review was carried out to ascertain where lapses in care may be a contributory factor. There were no serious incident reviews for 2017/18

Patient 1
Admitted: 24/03/18
Positive sample: 14/04/18
Discharged: n/a
Died 10/05/18 (26 days post result)
Attributed to lapse: No

Patient 2
Admitted: 30/05/18
Positive sample: 14/07/18
Discharged: 19/07/18
Attributed to lapse: No

Patient 3
Admitted: 17/07/18
Positive sample: 30/08/18
Discharged: n/a
Died 18/10/18 (49 days post result)
Attributed to lapse: No

Patient 4
Admitted: 04/12/18
Positive sample: 14/02/19
Discharged: remains an inpatient with home leave
Attributed to lapse: No

Patient 5
Admitted: 08/03/19
Positive sample: 18/03/19
Discharged: 29/04/19
Attributed to lapse: No

Appendix 3

Increased Incidences of Diarrhoea and/or Vomiting 2018-2019

Month	patients	Bed days lost	Days	of Norovirus	
April	7	15	6	Norovirus	
April	2	4	6	Norovirus	
May	4	2	3	Not Identified	
June	4	0	5	Not Identified	
June	2	6	5	CDT	
July	3	2	3	Not Identified	
July	6	0	3	Not Identified	
September	1	4	4	CRO	Patient admitted from Home CRO +ve, all patients in the same bay screened and found to be negative.
October	1	4	6	CRO	Not an increased incident but a bay has been closed to admissions. CRO colonised patient admitted into Bay 10 Bed 4, 2 other patients within the bay. Colonised patient has now been moved to a single room. The two patients in the bay are to be screened for CRO. Bay 10 is to remain closed until screening is complete, 1 empty bed at present.
November	5	1	8	Not Identified	
November	6	17	14	Influenza	
January	2	12	8	Norovirus	
February	3	1	6	Not Identified	
March	6	1	8	Norovirus	
March	3	5	6	Influenza	

Appendix 4

Infection Prevention and Control Policy Profile

Policy Name	Status	Document Type	Required under the Health & Social Care Act	Adopted by QAC	Agreed at IPCC	Review Date	Expiry Date
Overarching Infection Prevention and Control Policy		Policy	yes	Aug 2018	Aug 2019	Feb 2021	Aug 2021
Animals and pets		Policy	Yes	Oct 2018	Aug 2018	April 2021	Oct 2021
Aseptic non-touch technique and clean technique		Policy	Yes	May 2018	April 2018	Dec 2020	June 2021
Chicken pox/shingles		Policy	Yes	Oct 2018	Aug 2018	April 2021	Oct 2021
Cleaning and decontamination		Policy	Yes	Aug 2018	Aug 2018	Feb 2021	Aug 2021
Collection, handling and transport of specimens		Policy	Yes	Aug 2018	Aug 2018	Feb 2021	Aug 2021
Diarrhoea and/or vomiting that is of a suspected or confirmed infectious nature		Policy	Yes	Feb 2016	Jan 2016	May 2018	July 2019
ESBL producing organisms		Policy	Yes	Jan 2015	Jan 2015	Aug 2017	Aug 2019
Food hygiene for ward kitchens		Policy	Yes	Aug 2018	June 2018	Feb 2021	Aug 2021
Hand hygiene		Policy	Yes	Nov 2017	Aug 2017	May 2019	Nov 2019
Head lice		Policy	Yes	May 2020	April 2018	Dec 2020	June 2021
Linen and laundry		Policy	Yes	Nov 2017	Nov 2017	July 2019	Jan 2020
The clinical management of patients nursed as an inpatient within LPT with an increased incidence or outbreak of diarrhoea and/or vomiting		Policy	Yes	Feb 2018	Jan 2018	Aug 2020	Feb 2021
Escalation process to be followed when there is a suspected or known increased incidence or outbreak of diarrhoea and/or vomiting policy		policy	Yes	Feb 2018	Jan 2018	Aug 2020	Feb 2021

Policy Name		**Document Type**	**Required under the Health & Social Care Act**	**Adopted by QAC**	**Agreed at IPCC**	**Review Date**	**Expiry Date**
Management of infectious events and exclusion from childcare and school for childhood infections		Policy	Yes	June 2018	May 2018	Dec 2020	June 2021
Meningitis		Policy	Yes	Nov 2018	Nov 2018	March 2021	Sept 2021
MRSA		policy	Yes	Sept 2017	Aug 2018	Jan 2020	July 2020
The Management of MRGNO	**AWAITING PHE**	policy	yes	May 2016	May 2016	Nov 2017	Aug 2019
Notifying known or suspected infectious diseases		Policy	yes	AWAITING	Nov 2018	July 2018	Nov 2021
Patient requiring source isolation		Policy	Yes	Nov 2017	Jan 2018	Aug 2020	Feb 2021
Personal protective equipment		Policy	Yes	Feb 2018	Jan 2018	Aug 2020	Feb 2021
Scabies		Policy	Yes	Aug 2018	Aug 2018	Feb 2021	Aug 2021
Sharps and exposure to blood borne viruses		Policy	Yes	Jan 2019	Jan 2019	Sept 2020	March 2021
Staff health	Awaiting agreement at IPCC	policy	Yes	Nov 2017	Aug 2017	May 2019	Nov 2019
TSE including CJD and vCJD		policy	Yes	Nov 2017	Aug 2017	May 2020	Nov 2020
Tuberculosis		Policy	Yes	May 2016	May 2016	Sept 2020	Mar 2021

Leicestershire Partnership NHS Trust

Infection Prevention and Control Committee

Terms of Reference

References to "the Committee" shall mean the Infection Prevention and Control (IPC) Committee

1.0 Purpose of Committee

1.1 The purpose of the committee is to ensure that Infection Prevention and Control (IPC) performance standards and compliance of the Health and Social Care Act (2008, updated July 2015) are upheld and monitored within the Trust. The committee will receive updates, exception reporting, assurance and any actual or potential risks, actions to mitigate risks from the Directorates / services. The governance framework will require that the committee provide an overview and assurance to Trust Board through direct reporting to the Quality Assurance Committee on all relevant aspects of IPC agenda identified as below.

1.2 The committee will:

1.2.1 Identify key performance standards and compliance requirements of IPC as part of the Trust's Quality Assurance strategy and disseminate.
1.2.2 Ensure that the IPC annual programme is developed and disseminated to the directorates and monitor progression of standards, compliance and actions.
1.2.3 Ensure that appropriate IPC policies are in place in line with the Health and Social Care Act 2008 and Care Quality Commission compliance.
1.2.4 Receive and monitor compliance figures for staff mandatory IPC training, development programmes and actions to address exceptions.
1.2.5 Receive assurance of the completion of IPC surveillance, analysis of such and progress of any required improvements, including risks, actions to mitigate risk and escalation to the QAC as appropriate.
1.2.6 Receive the audit programme and identify the evidence required for assurance needs.
1.2.7 Monitor improvement measures and receives assurance that IPC standards are being met following increased incidences, outbreaks and Serious Incidents in relation to IPC.
1.2.8 Receive assurance of compliance with antimicrobial stewardship arrangements and monitoring of antimicrobial consumption.
1.2.9 Approve the annual IPC report to Trust board.

2.0 Clinical Focus and Engagement

2.1 The Trust considers clinical engagement and involvement in Board decisions to be an essential element of its governance arrangements and as such the Trust's integrated governance approach aims to mainstream clinical governance into all planning, decision-making and monitoring activity undertaken by the board.

3.0 Authority

3.1 The committee is authorised by the Quality Assurance Committee to conduct its activities in accordance with its terms of reference.

3.2 The committee is authorised by the Quality Assurance Committee to seek any information it requires from any employee of the Trust in order to perform its duties.

4.0 Membership

4.1 The Infection Prevention and Control Committee is chaired by the Chief Nurse.

4.2 Deputy Chair/s will be the Associate Director of Nursing and Professional Practice and Lead Infection Prevention and Control Nurse

4.3 The membership of the committee is listed in the Annex.

4.4 The membership of the committee will comprise of the necessary persons to ensure that operational practices across the trust comply with the Health and Social Care Act 2008 (updated 2015) and all other pertinent NHS best practice standards e.g. CQC,

4.5 The committee will be made up of members who must attend regularly Non-members of the committee will attend the meeting as requested when they have papers to present,

4.6 Only members of the committee have the right to attend committee meetings. However, other individuals and officers of the Trust may be invited to attend for all or part of any meeting as deemed appropriate.

4.7 Membership of the committee will be reviewed and agreed annually with the Quality Assurance Committee.

5.0 Secretary

5.1 Secretarial support will be provided from the Quality and Professional Practice Directorate.

6.0 Quorum

6.1 The quorum necessary for the transaction of business shall be six members; representation of this group must include; Chair/Deputy Chair, Lead Nurse from each directorate (or designated other), and IPC nurse. A duly convened meeting of the Committee at which a quorum is present shall be competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the Committee.

6.2 Any meetings that are not quorate will continue and any decisions made will be ratified by those absent within 10 days of the meeting. A record of these agreements made to be held by the secretary of the meeting.

7.0 Frequency of Meetings

7.1 The Committee shall normally meet quarterly and at such other times as the Chairperson of the Committee shall require at the exigency of the business.

7.2 Members will be expected to attend at least three-quarters (75%) of all meetings. (Attendance will be reported in the annual report).

8.0 Agenda/Notice of Meetings

8.1 Unless otherwise agreed, notice of each meeting confirming the venue, time and date together with an agenda of items to be discussed, shall be forwarded to each member of the Committee, and any other person required to attend, no later than 5 working days before the date of the meeting. Supporting papers shall be sent to Committee members and to other attendees as appropriate, at the same time.

8.2 Members of the committee who submit papers for the meeting must do so within the allotted timescales. Delay in the process significantly impacts on papers being sent out for the meeting on time.

9.0 Minutes of Meetings

9.1 The secretary shall minute the proceedings and resolutions of all Committee meetings, including the names of those present and in attendance.

9.2 Minutes of Committee meetings shall be circulated promptly to all members of the Committee and, once agreed, to the secretary of the Quality Assurance Committee. The Committee's minutes will be open to scrutiny by the Trust's auditors. The minutes will be shared for information to other identified committees including the health and safety committee.

10.0 Duties

The Committee shall:

10.1 Receive summaries and action points from the Directorates to seek compliance in line with local and nationally agreed priorities, and provide support to these groups where necessary.

10.2 Receive assurance from each directorate regarding the annual work programme for infection prevention and control.

10.3 Receive assurance from each directorate regarding the annual audit programme for infection prevention and control.

10.4 Communicate level of assurance, exceptions and risks to the Quality Assurance Committee on a quarterly basis.

10.5 Receive and support dissemination of the annual report

10.6 Receive and agree infection prevention and control policies for review

10.7 Receive, review and agree the work plan, surveillance data incidents and risk and identify actions that are timely and focused in achieving the identified outcomes.

11.0 Reporting Responsibilities:

11.1 The Committee shall provide assurance to the Quality Assurance Committee on a quarterly basis with regard to annual work programme, annual audit programme and any area of responsibility of infection prevention and control within the remit of the committees' duties.

11.2 The Committee shall make whatever recommendations to the Quality Assurance Committee that is deemed appropriate on any area within its remit where action or improvement is needed.

11.3 The Committee shall produce an annual report for the Quality Assurance Committee on the work it has undertaken during the course of the year.

12.0 Annual Review

12.1 The Committee shall, at least once a year, review its own performance, constitution and terms of reference to ensure it is operating at maximum effectiveness and recommend any changes it considers necessary to the Quality Assurance Committee for approval.

13.0 Risk Responsibility

13.1 The risk areas the Committee has special responsibility for will be those that fall within the remit of this Committee, and that require monitoring as identified by external verifiers or

assessors of the service including the CQC.

Annex – Membership of the Committee

Director of Nursing and Professional Practice
Associate Director of Nursing and Professional Practice
Lead Infection Prevention and Control Nurse
Infection Prevention and Control Nurse(s)
Estates & Facilities shared service representative
Occupational Health Practitioner
Directorate Lead Nurse (or delegated deputy) to represent inpatient and community services for:

- Community Health Service (inclusive of MHSOP)
- Families, Young People and Children
- Adult Learning Disabilities/Adult Mental Health

Property Manager, LPT estates & facilities
Head of Health and Safety Compliance
Therapy Lead
Medical Lead
Head of infection control - CCG

Adhoc representation

Public Health England East Midlands
Emergency Planning Lead
Medicines Management – possibly remove this as a rep is mentioned above
Tissue Viability Lead
Training Delivery Manager
Consultant Microbiologist
Podiatry Manager
Antimicrobial Prescribing Lead

Leicestershire Partnership NHS Trust

ANNUAL REPORT
Year 2018-19

Committee/Group	Infection Prevention and Control Committee
Date	4 March 2019
Chair of Committee	Chief Nurse (Chair) Associate Director of Nursing and Professional Practice (Deputy chair)

Section A – Fulfilling Terms of Reference

- All duties of the Infection Prevention and Control Committee as outlined in the ToR have been satisfied through the teams annual work plan and associated agendas.
- The current membership is reflective of the expertise, experience and competencies required to suitably and sufficiently carry out the duties and fulfil quoracy.
- There is a robust Infection Prevention and control framework in place, with escalation and communication processes in place. Each directorate has a reporting process via a quarterly highlight report and Terms of reference which is reviewed by the group and outlines the function to the IPC committee.
- The Infection Prevention and Control committee work to address pertinent areas of responsibility on delivery of strategic objectives.
- The ToR of the Infection Prevention and Control committee have been considered by the membership of the committee with a recommendation that both medical and therapy leads should be included in the membership to ensure representation.

Section/Term	Current wording	Proposed revised wording
Purpose		Strengthened risk and assurance section

Assurance

- The assurances received at the IPC committee have been considered to be robust by the committee, and whilst there is evidence of local management of issues, the group requested further evidence required in meeting strategic and organisational objectives, this has been evidenced in the highlight reports provided by the directorate leads and specialist groups
- Assurances are required to meet IPC trajectories regarding the management of patients experiencing loose stools and CDT toxin positive results.
- The nationally set zero target for MRSA bacteraemias has been achieved within LPT. Throughout 2018/19 no bacteraemias have been aligned to LPT.
- The membership of the committee has the expertise to validate, challenge and scrutinise the reports received to ensure that adequate and appropriate arrangements are in place.

Analysis of Risks

- Risks relevant to the committee are reviewed at each meeting (quarterly) via the highlight reports from the directorates
- A risk manager from the Risk management team has attended the committee meeting since November 2018; a risk log is included as an agenda item for discussion, with a risk

reviewed in detail at each meeting. This continues to be work in progress with recognition that there is room for improvement. Actions and closure of risks are also identified during the meetings.

Work plan

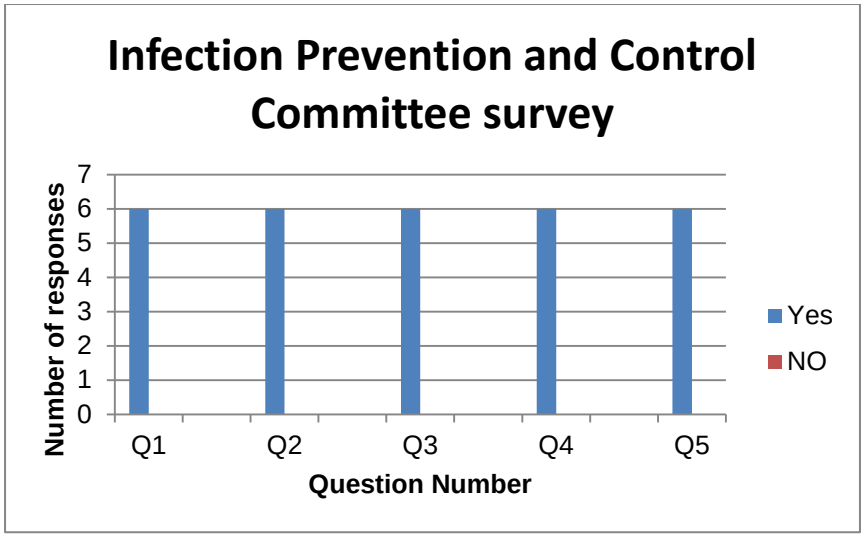
- The work plan evidences the duties of the ToR, it informs the agenda's for the meeting.
- The reporting of fulfilment of work in the plan all objectives were completed, although continues to be a working process.
- The annual work programme for 2019/20 is inclusive of assurance and reporting requirements for the directorates, hosted services and specialist groups.
- The work plan is used to inform the agendas of the sub-groups of the committee and individual specialist work streams. Further work streams may be developed on an ad hoc basis, due to further recommendations on a national or local level may not be evidenced at the commencement of the annual programme.

Section B – Reflection upon Working Practices

Effectiveness of Committee discussion

- The Group is effectively chaired, has the ability to discharge its agendas within the time allowed, and with discussions managed.
- Matters Arising are effectively dealt with, with items remaining on the action log until sufficient assurance has been supplied.
- The meeting is always checked to be Quorate at the start of the meeting.
- All members are actively encouraged to participate, and where this is a specific need for an individual to attend or present, they will be invited to attend.
- Discussion is summarised in order to be clear of agreed outcomes and actions, including timescales and responsibilities. This supports clearness of the minutes and overview report to QAC.
- An attendance log is maintained, this shows that the majority of members attended 4 out of the 6 meetings (which equates to 66%). For the future attendance this will be 3 out of 4 meetings (equating to 75%) as the meetings are now quarterly.
- Members are required to ensure an appropriate representative attends on their behalf if unable to attend the meeting themselves.
- Those individuals representing a formal committee member are identified as an attendee (on behalf of the formal member), and is logged in the minutes.
- Review of the membership has also supported the appropriate attendance requirements as this ensures that members who are required to attend 'ad hoc' are not identified as 'poor attenders'.

A survey monkey was sent to all committee members which could be filled in anonymously. Out of the thirteen regular members, six returns were submitted. The questions and results are shown below.



Q1: Overall the Infection Prevention and Control Committee is a productive meeting?
Q2: Our agenda has a sense of priority to it. We focus on the most important things?
Q3: People generally feel that they can influence the decisions made in this group?
Q4: Commitments made at our meetings are followed up with designated time scales and responsible person/s?
Q5: The meetings are chaired in a professional manner according to the Terms of Reference?
Q6: Please make suggestions about ways in which we can improve the effectiveness of our meetings

Within the free text box, a number of suggestions were made to enhance the meetings and these will be considered and shared at the next meeting scheduled in May 2019.

Communication channels

a. Communications to and from members
   Draft agenda's and a call for papers are circulated in good time to enable authors' time to prepare their reports or add items to the agenda. Papers are disseminated 2 weeks prior to the meeting to support the reading and preparation for the meeting. Draft minutes are produced and shared, within the two week timescale (subject to the workload of the administrative support).

b. Quality of papers
   Papers are of a good standard and are usually presented by the author. Front sheets accompany the reports which support the summary and overview of the paper.

c. Quality of minutes
   There is evidence of appropriate challenge, scrutiny, validation and assurance included in the minutes. Matters arising are captured in an action log with an implementation date and review date included.

d. Information flows with Parent Committee
   Key actions/risks and assurance points are noted at the end of very IPC committee meeting to ensure pertinent information is provided to QAC. QAC receives regular Overview reports from IPC committee; these are within the month of the meeting taking place. With regard to communication from QAC, feedback is not routinely received and therefore this does not appear as an agenda item.

Achievements and Barriers

- There is a robust process for supporting agenda items, ensuring papers are produced on time and the minutes evidence the content of the meetings. Actions are carried over until they are achieved and assurance received.

- Membership of the meetings reflects the specialist groups that have input into the committee with representation from Occupational Health, and other agencies if required.
- Collaborative work has been undertaken to ensure the Trust continues to comply with its duties in relation to the Hygiene Code; by providing a safe and secure environment for services to be delivered within, and ensuring this supports a good experience for patients and staff.

A number of specific achievements have been identified below:

- Development of an electronical app which can be used to record audit results for hand hygiene audits and trust top markers.
- Representation for LPT at a National level to develop a policy for Hand hygiene
- Development and launch of the urinary catheter passport and updated patient leaflet
- Review and increased content for level 1 and 2 IPC elearning training for staff
- Improvement of the uptake of IPC training for hand hygiene for medical staff

Were there any barriers perceived to the work of the Committee

- Perceptions of staff regarding infection prevention and control practices within various clinical settings can at times be challenging. Understanding the requirements and evidence around practices such as BBE, Hand washing and environmental factors can be lacking.
- Attendance at the meetings by trust representatives can be limited or sporadic which impacts on the function of the committee. Membership continues to be reviewed and requests to individuals to attend or send representation made by the chair as appropriate. This includes specific reporting from individuals in attendance.
- Timely updates and follow-up of actions on the action log has not always been within the identified timescales, work to improve these outputs has shown an improvement.

<u>Future Plans</u>

- A continued focus on Outcome 8 – Cleanliness and Infection Control
- A continued focus on reducing Clostridium difficile (against set trajectory)
- A continued focus on maintaining 0 MRSA figures
- A continued focus to improve the uptake of the flu vaccine for all frontline healthcare workers
- A continued focus on the awareness and management of patients with potential or known sepsis with a strategy to inform the processes required
- A continued focus to work with external agencies across LLR to support the reduction of Healthcare Associated Infections across the healthcare economy.
- A continued focus to reduce infections associated with urinary tract infections and develop and implement a strategy to support this.
- Membership of the committee has been reviewed to include a representative from the CCG who is Head of Infection Prevention and Control.

Appendix 7

Attendance compliance – Infection Prevention and Control Committee

Risk Manager	Enabling	N/A	N/A	N/A	Apologies	Yes	20%
Chief Nurse	Enabling	Yes	Yes	Yes	Left	Left	60%
Senior Matron	AMH/LD	N/A	Apologies	N/A	N/A	N/A	0%
Senior Infection Control Nurse	Enabling	Yes	Yes	Yes	Yes	Yes	100%
Head of Infection Prevention & Control (CCG)	External (CCG)	N/A	N/A	Yes	Apologies	Yes	40%
Lead Infection Prevention and Control Nurse	Enabling	Yes	Yes	Apologies	Yes	Yes	80%
Head of Facilities	External (UHL)	N/A	N/A	N/A	N/A	Yes	20%
Infection Prevention & Control Nurse	Enabling	Yes	Yes	Yes	Yes	Yes	100%
Ward Sister (Representing CHS)	CHS	Yes (SL)	Yes (SL)	N/A	N/A	N/A	40%
Head of Trust Health and Safety Compliance	Enabling	Yes	Yes	Apologies	Yes	Apologies	60%
Lead Pharmacist for Families, Young People and Children's Service	FYPC	Apologies	No	Apologies	Apologies	No	0%
Infection Prevention & Control Nurse	Enabling	Yes	Yes	Yes	Yes	Yes	100%
Head and Safety Advisor	Enabling	N/A	N/A	Yes (BK)	N/A	N/A	20%
CHS Lead Nurse	CHS	Apologies	Apologies	Yes	Yes	Yes	60%
Property Officer	External (UHL)	N/A	N/A	N/A	N/A	Yes	20%
Senior Matron – AMH/LD	AMH/LD	Yes	Yes	Yes	Apologies	Yes	80%
Governance and Quality Lead	FYPC	N/A	N/A	N/A	Yes (KW)	N/A	20%
Head of Learning & Development	Enabling	N/A	N/A	N/A	Yes (PB)	Apologies	20%
Occupational Health Nurse	External (UHL)	Yes	Yes	Apologies	Apologies	Yes	60%
Project Officer – Professional Practice	Enabling	Yes	Yes	Yes	Yes	Apologies	80%
Advanced Nurse Practitioner	CHS	N/A	N/A	N/A	Apologies	Yes	20%
Infection Prevention and Control Nurse	Enabling	Yes	Yes	Yes	Left	Left	60%
Senior Heath Safety & Security Advisor	Enabling	N/A	N/A	N/A	N/A	Yes (BK)	20%
Deputy Chief Nurse	Enabling	N/A	Yes	Apologies	Apologies	N/A	20%
Senior Zone Coordinator	External (UHL)	Yes	Yes	Apologies	Apologies	Left	40%
Property Manager	Enabling	Yes	No	Apologies	No	Yes	40%
FYPC Senior Nurse	FYPC	Yes	Yes	Apologies	Apologies	Yes	60%
Associate Director of Nursing and Professional Practice	Enabling	Apologies	Yes	Yes	Yes	Apologies	60%

**Where attendance is indicated as not applicable N/A, this for specialists who have attended ad hoc, as per terms of reference.