Berkshire Healthcare NHS Foundation Trust

INFECTION PREVENTION AND CONTROL ANNUAL REPORT APRIL 2023 - MARCH 2024

Formal Executive Meeting

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Executive Summary

The Annual Report for Infection Prevention and Control (IPC) provides an overview of the infection prevention and control service, the status of healthcare associated infections (HCAI) in Berkshire Healthcare NHS Foundation Trust and summarises the work of the IPC Team in preventing avoidable harm from HCAI.

The Director of Nursing and Therapies is the Accountable Board Member responsible for infection prevention and control and undertakes the role of Director of Infection Prevention and Control. The IPC Team are responsible for providing an infection prevention and control service to support staff.

The Infection Prevention and Control Strategic Group undertake its functions in order to fulfil the requirements of the statutory Infection Prevention & Control Committee. It meets four times per year and reports into the Quality Executive Governance group.

All Trusts have a legal obligation to comply with 'The Health & Social Care Act (2008) - part 3 A Code of Practice for the Prevention and Control of Health Care Associated Infections (HCAI)' which was reviewed and updated in December 2022. The act clearly sets criteria to help NHS organisations plan and implement strategies to prevent and control HCAI.

The Infection Prevention and Control Annual Programme articulates the organisation's development needs in relation to the Act; this report acknowledges progress in delivering this.

The Infection Prevention and Control Programme and overarching Infection Prevention and Control Strategy sets clear objectives for the organisation to achieve; this is supported by the IPC Team.

The IPCT supported both clinical and non-clinical teams and strategic workstreams, in addition to collaborating with key stakeholders in regional and national health economies in reduction of HCAI.

The IPC Board Assurance Framework is a live document and is reviewed by a number of forums within the Trust and presented regularly to the Quality Assurance Committee.

Prevention and appropriate management of infection is of paramount importance in the quality and safety of the care of patients and to the safety of staff and visitors. As a core element of the trust's clinical governance and risk programmes, all staff are required to be aware of their responsibilities and comply with infection prevention and control policies and guidelines.

Our plans and key priorities remain to support staff to deliver the highest infection prevention and control standards to prevent avoidable harm to patients from HCAI and help maintain an outstanding CQC rating.

Debbie Fulton

Director of Nursing and Therapies / Director of Infection Prevention and Control (DIPC)

Introduction

This Annual report covers the period 1 April 2023 to 31 March 2024 and is to provide an overview of assurance for Berkshire Healthcare with the ten criteria outlined in the Health and Social Care Act 2008 Code of Practice in the Prevention and Control of Infection (updated 2022). The ten criteria outlined in the code are used by the Care Quality Commission to judge a registered provider compliance in ensuring that systems to prevent healthcare associated infections and compliance with policies are embedded in practice and a corporate responsibility.

The Board Assurance Framework (BAF) is ordered by the ten criteria of the Act and allows for evidence of compliance, gaps in compliance, mitigations, and comments to be recorded. Ongoing criteria and workstreams identified will form part of the 2024-25 IPC annual work programme.

Covid-19 has remained a significant issue in healthcare, this is reflected in another busy year for Berkshire Healthcare in management of infections including incidence of respiratory infections and outbreaks, increase in cases of other infection and communicable disease and ongoing workstreams to reduce gram negative bacteraemia and other mandatory reportable infections. The IPCT have developed a dashboard which summarises key indicators and areas for improvement.

All members of staff have worked hard to deliver IPC requirements, maintain an outstanding CQC rating plus ensuring patient and staff safety and a positive patient experience. This has included a programme and offer of Influenza and Covid 19 vaccination for all staff. During 2023-24 in response to increasing cases of Measles in the UK, an action plan for management of Measles has been reviewed which includes staff immunity.

Berkshire Healthcare has continued to incorporate antimicrobial stewardship into its annual programmes and prevention strategies to address the increasing emergence of resistant organisms. This work has been built upon and developed further this year to address the burden of these organisms both locally and nationally. Collaboration with local Integrated Care Systems (ICS) continues in order to deliver a health-economy wide approach to prevention strategies and reduction in healthcare associated infection.

The IPCT with collaboration from pharmacy colleagues, participated in the national point prevalence survey (PPS) on healthcare associated infections, antimicrobial use and antimicrobial stewardship in England. This is the first time Community and Mental Health trusts have been included in PPS. Results received April 2024 are to be analysed and incorporated in the IPC annual programme.

Learning form incidents and post infection reviews remains a focus for shared learning and IPC promotion campaigns and resources. IPC mandatory training has been reviewed and aligned with the National Education Framework. In addition to mandatory training, the IPCT have undertaken bespoke training sessions and developed a range of resources and bitesize training to support staff.

The planned programme of prevention campaigns has been completed including World Antimicrobial Awareness Week, National IPC week, Glove reduction initiative and Oral Hygiene promoting safe care and prevention of infection. A successful and well evaluated IPC link practitioner annual study event was held.

The IPCT received a Green Award from the Southeast NHSE Chief Nurse for contribution to the Southeast Nursing and Midwifery Green Week 2024 presenting a project ‘Promoting safety & sustainability through reduction in overuse of non-sterile gloves.’

Berkshire Healthcare is responsible for the prevention and control of infection within all its services to minimise the risk of healthcare associated infections to patients, staff and visitors.

This report highlights the achievements, the work undertaken, and the progress made in 2023-24 by Berkshire Healthcare in relation to infection prevention and control Board Assurance Framework and other activities. The infection prevention and control Board Assurance Framework for 2024-25

outlines the priorities and objectives for the coming year.

Infection Prevention and Control Arrangements and Budget Allocation

Berkshire Healthcare provides a range of community and mental health services across Berkshire including inpatient beds on the Upton, St Mark's, Wokingham, Prospect Park and West Berkshire Community Hospital sites.

The team currently consists of:

Diana Thackray	1 WTE	Head of Infection Prevention & Control
Smitha Anil	1 WTE	Infection Prevention & Control Specialist Nurse
Samantha Gamanya	1WTE	Infection Prevention and Control & Antimicrobial Stewardship Nurse
Jennifer Ajnesjo	1 WTE	Infection Prevention & Control Nurse
Virginia Williams	1 WTE	Infection Prevention & Control Nurse
Ruksana Coser	0.6 WTE	Infection Prevention & Control Administrator

Support is also provided by a Consultant Microbiologists providing day to day clinical advice in relation to results and a Consultant Microbiologist based at Frimley Health providing strategic support, through attendance at the IPCSG and antimicrobial stewardship group meetings, ad-hoc clinical advice and signing-off relevant PGDs.

The role of Director of Infection Prevention & Control (DIPC) is undertaken by the Director of Nursing & Therapies who has board level responsibility for infection prevention & control.

Risk Management/Clinical Governance

The infection prevention and control governance arrangements are available on Nexus. Infection prevention and control | Nexus (berkshirehealthcare.nhs.uk) These arrangements are essential in working to resolve issues identified and ensure compliance with the Health & Social Care Act (2008) and other risk management legislation.

The Health & Social Care Act 2008/ Board Assurance Framework

Berkshire Healthcare has continued to maintain unconditional registration with the Care Quality Commission for infection prevention & control and other registration requirements across the organisation the overall rating from Care Quality commission remains outstanding.

The Health and Social Care Act 2008: code of practice on the prevention and control of infections and related guidance, was updated in December 2022. This guidance was updated to reflect the structural changes that took effect in the NHS from 1 July 2022 and the role of IPC (including cleanliness) in optimising antimicrobial use and reducing antimicrobial resistance.

The Covid 19 Board Assurance Framework was updated in March 2023 and replaced with a national Infection Prevention and Control Board Assurance Framework. This demonstrates the organisations level of compliance with the ten criteria of the Health and Social Care Act 2008. It provides evidence of compliance, gaps in compliance, to determine non-compliant, partially compliant, or fully compliant criterion.

A gap analysis has been undertaken which provides the IPC annual work plan. Ongoing workstreams are monitored, compliance criteria updated and reviewed quarterly.

During 2023-24, several criteria were upgraded from non-compliant to partially compliant and partially compliant to compliant.

Partially compliant areas will be rolling over to 2024-25 Board Assurance Framework, with plans for progressing to compliant. No non-compliant criteria identified.

Infection Prevention & Control Strategic Group (IPCSG)

This Group has been chaired by the Deputy Director of Nursing, as delegated by the Director of Nursing and Therapies / DIPC and meets quarterly. The aim of the group has been to ensure that robust systems are in place for managing infection prevention and control across Berkshire Healthcare and ensure compliance with the Health and Social Care Act (2008). The Group provides assurance on infection prevention and control programmes, Board Assurance Framework, decontamination and other related issues to the Safety, Experience & Clinical Effectiveness Group.

Infection Prevention & Control Working Group (IPCWG)

This group continues to act as the operational forum to facilitate the implementation, maintenance and review of effective systems and behaviours to support the prevention and control of infection and ensure compliance with the Health and Social Care Act 2008 and Board Assurance Framework. This is achieved through the completion of work programmes and delivery of the Infection Prevention & Control Strategy. The Infection Prevention Control Working Group (IPCWG), reports to the Infection Prevention and Control Strategic Group.

Infection Prevention & Control Strategy 2022-2025

The strategy outlines the vision for infection prevention and control practice and identifies objectives for services that are linked to the Berkshire Healthcare True North goals and IPC plan on a page. The IPCT have reviewed and updated the strategy in 2022, in conjunction with the IPC Working Group and IPC link practitioners and continue to work with services in implementing the Strategy.

The Infection Prevention and Control Programme

The infection prevention and control programme for 2023-24 has been completed.
The programme planned for the year 2024-25 will be monitored within the Board Assurance Framework.

Surveillance

There is a national mandatory requirement for trusts to report all cases of Clostridioides difficile infection (CDI), Meticillin Resistant Staphylococcus aureus (MRSA), Meticillin Sensitive Staphylococcus aureus (MSSA), Gram negative (including Escherichia coli, Pseudomonas and Klebsiella species) and Glycopeptide Resistant Enterococci (GRE) bacteraemia to United Kingdom Health Security Agency (UKHSA) These are reported by Berkshire & Surrey Pathology Services as part of the pathology contract.

Trusts are required under the NHS Standard Contract 2023/24 to minimise rates of both C. difficile and of Gram-negative bloodstream infections so that they are no higher than the threshold levels set by NHS England.

NHS improvement launched resources to support the reduction of Gram-negative blood stream infections by 50% by 2023-2024. There is a specific focus on reducing healthcare associated E. coli bloodstream infections because they represent 55% of all Gram-negative BSIs.

Gram negative bacteraemia reduction is included as a key element in Berkshire Healthcare objectives.

Surveillance of infection is undertaken using laboratory data, information from wards and departments and liaison with Health Protection England, CCGs and local acute Trusts.

Reduction in incidents where learning identified will remain a priority for the organisation.

The focus will remain for the integrated care systems and boards (ICS & ICB) to work together to share learning to prevent avoidable cases.

The IPCT, with support of pharmacy colleagues, participated in the National Point Prevalence Study for healthcare associated infection, indwelling devices and antimicrobial stewardship. Final results are anticipated April 2024 and actions identified will be incorporated into the 2024-25 workstreams.

Further information including surveillance data for 2023 - 24 can be found in appendix 2.

Clostridioides difficile (formerly Clostridium difficile)

Since April 2017, reporting trusts have been asked to provide information on whether patients with C. difficile had been admitted to the reporting trust within the three months prior to the onset of the current case. This allows a greater granulation of the healthcare association of cases.

Cases reported to the healthcare associated infection data capture system are assigned as follows:

- Hospital-onset, healthcare associated (HOHA) - Date of onset is ≥3 days after admission (where day of admission is day 1)
- Community-onset healthcare-associated (COHA) - Date of onset is ≤ 2 days after admission and the patient was admitted to the trust in the 28 days prior to the current episode days (where day 1 is date of discharge)
- Community-onset, community associated (COCA) - Date of onset is ≤ 2 days after admission and the patient had not been admitted to the trust in the previous 28 days prior to the current episode.
- Community-onset, indeterminate association (COIA) - Date of onset is ≤ 2 days after admission and the patient was admitted in the previous 84 days, but not the previous 28 days (where day 1 is date of discharge) prior to the current episode

Acute provider objectives were set using these two categories:

- hospital onset healthcare associated: cases that are detected in the hospital three or more days after admission
- community onset healthcare associated: cases that occur in the community (or within two days of admission) when the patient has been an inpatient in the trust reporting the case in the previous four weeks.

The Trust has continued to have separate trajectories applied in the East and West for *Clostridioides difficile* for the year 2023-24. Thresholds are based on a reduction calculation based on previous annual data. Cases of C. difficile identified from Berkshire Healthcare inpatient units have decreased from 7 in 2022-23 to 3 in 2023-24 and remained within associated thresholds.

C. difficile cases are reviewed within the BOB and FH ICS IPC forums.

The separate East/West targets will continue due to there being two separate STPs / accountable care systems.

Meticillin Resistant *Staphylococcus aureus* (MRSA)

Guidance on the reporting and monitoring arrangements and post infection review process for MRSA bloodstream infections was last updated in 2016. This guidance supports commissioners and providers of care to deliver zero tolerance on MRSA bloodstream infections.

The trust trajectory for 2023-24 was no cases of MRSA bacteraemia within the inpatient units, in line with the national target of 'zero tolerance' for MRSA bacteraemia and will remain the same for 2024-25.

No cases of MRSA bacteraemia were identified from an inpatient. Input was provided for one community patient was identified to have had recent care provision from Berkshire Healthcare.

Meticillin Sensitive *Staphylococcus aureus* (MSSA)

Three cases of MSSA bacteraemia were identified from patients who were on inpatient units or at time of transfer to an acute trust. This is one more than identified during 2022-23.

Gram negative Bacteraemia (GNB)

For 2023-24 Berkshire Healthcare inpatient units, nine E. coli bacteraemia, two Klebsiella bacteraemia and one Klebsiella bacteraemia cases were identified.

Compared to 2022-23, an increase in GNB is noted for Berkshire Healthcare inpatient wards.

A post infection review (PIR) was undertaken for all cases to identify learning and identify opportunities where further education or resources are required to prevent and reduce incidence.

Glycopeptide Resistant Enterococci (GRE)

One case of GRE bacteraemia was identified. (Zero cases reported in 2022-23)

Carbapenemase - Producing Organisms (CPO)

These organisms are typically bacteria that live in the gut of humans and animals and include Enterobacteriaceae, E coli, Enterococci etc. These organisms are common causes of opportunistic urinary tract infections, intra-abdominal and bloodstream infections. Carbapenems are antibiotics normally reserved for serious infections caused by drug-resistant Gram-negative bacteria. Carbapenemases are enzymes that destroy carbapenem antibiotics, conferring resistance. They are created by a small but growing number of organisms. No cases were identified on inpatient units during 2023-24. Patient contacts identified from Acute organisations following transfer to Berkshire Healthcare inpatient wards were managed.

Outbreaks

An outbreak is defined as two or more symptomatic cases where an infectious cause is suspected, linked in time and space, without laboratory confirmation.

Twenty-Eight outbreaks of SARS CoV-2 and four outbreaks of Influenza were identified from inpatient units within Berkshire Healthcare during 2023-24.

Further details of outbreaks and learning are provided in appendix 2.

Shared Learning

When a patient develops a significant infection or an IPC related incident or outbreak is detected, a

level of investigation appropriate to the situation is undertaken. For mandatory reportable infections, a post infection review report is produced. These documents identify risk factors, likely causes for the infection, themes and other learning which may not be a cause of the infection but have been identified as an area for improvement as part of the investigation process. In addition to the IPC monthly report, a quarterly summary of lessons learned, and necessary actions are disseminated across the organisation in order to prevent re-occurrence.

The annual IPC programme reviews processes and procedures aimed at maintaining a safe environment for staff and patients are being adhered to and to identify potential themes. Any learning from audit findings is shared in a number of ways such as monthly reports, newsletters and patient case reviews.

Emergency Planning

The IPCT have continued to be involved in activities related to emergency planning. These include:

- Review and updating of the IPC service's Business Continuity Plan
- Pandemic plans as the Covid-19 situation continues to evolve.
- Water supply issues Business Continuity Plans
- IPC guidance for on call Managers and Directors

Staff Vaccination Campaigns:

Influenza and Covid-19 vaccination

Berkshire Healthcare was chosen as one of the national pilot sites to begin the Covid vaccination campaign for Health and Social Care staff. The campaign launched on 15th December 2020 and has continued during 2023-24.

The flu programme commenced this Autumn during the first week of October 2023. Since the launch there have been clinics run in every locality across Berkshire at varying times and venues, all of which have been able to successfully offer appointment slots and drop-in slots.
Also provided were ad hoc vaccination at sites and meetings that have requested support. Peer vaccinators were trained to support the immunisation team in delivery of the vaccination programme. Flu vouchers have continued to be offered to staff unable to access clinics.

One hundred per cent of staff were offered the Influenza vaccine and Covid-19 booster and a number of promotional campaigns were undertaken to reach out to the harder to reach staff using peer vaccinators.

Influenza vaccination	Central services	Children, family and all age services	Community Health services	Mental Health services	Other
Overall Actual Percentage	49%	52%	42%	37%	-

Covid -19 vaccination	Central services	Children, family and all age services	Community Health services	Mental Health services	Other
Overall Actual Percentage	42%	45%	33%	31%	71%

Hand Hygiene

Hand Hygiene is monitored through the monthly Hand Hygiene Observations for all inpatient units and quarterly in other departments. Non-compliance is dealt with locally at time of data collection through the production of action plans and on-going observational monitoring. Data is included in the monthly reports and discussed / reviewed at Locality Patent Safety and Quality Meetings, the Infection Prevention & Control Working Group and the Infection Prevention & Control Strategic Group.

Monitoring Activity

The 2023-24 monitoring programme was completed with following monitoring was undertaken:

- Hand hygiene observational check inpatients (monthly)
- Hand hygiene observational check community services (quarterly)
- Dental (Equipment Cleaning)
- Static Mattresses and cushions monitoring
- Standard precautions (PPE) monitoring
- Linen handling and disposal monitoring
- Management of Urinary Tract Infection
- Patient Equipment monitoring
- Aseptic Non- Touch Technique (Podiatry)
- Isolation facilities monitoring
- Sharps management monitoring

Non-compliance is dealt with locally at time of data collection through the production of action plans which are monitored at local level. Services are requested to confirm to the IPCT that they are taking any actions identified forward. If confirmation is not provided within a specified time frame, this is escalated to the Locality Clinical Directors. Reports are discussed / reviewed at Locality Patient Safety and Quality Meetings, the Infection Prevention & Control Working Group and the Infection Prevention & Control Strategic Group. Further details are available on request to the IPCT.

In addition to the monitoring work described above the team aim to visit the inpatient units monthly to spot check against key issues such as cleanliness and compliance with infection prevention and control practices. The IPC compliance tools were updated and continued for services to assess compliance with PPE and other IPC principles. The tools and action plans are reviewed by service and Clinical Directors.

Educational and Promotion Activities

Infection prevention and control mandatory training requirements are outlined within the statutory, mandatory and essential training framework. Infection prevention and control training is included within the Berkshire Healthcare induction and general mandatory update programmes, including the SMART week for Mental Health Inpatient Units.
During 2023– 24, IPC training was revised to reflect updates to the national IPC Education Framework. In addition, the annual IPC promotion campaign programme was completed. This included targeted educational campaigns across the trust covering several prevention initiatives including:

- Glove reduction initiative
- Mouthcare (preventing respiratory and other infection)
- Patient Equipment Cleaning
- Aseptic Non-Touch Technique
- Urinary Catheter Care
- Antimicrobial Stewardship
- International Infection Prevention and Control Week

Bitesize training resources were developed to support learning from incidents and outbreaks. The

IPCT have collaborated with patient forums to capture IPC experience and perceptions. This feedback has been utilised to develop resources and ongoing prevention workstreams, which include the use of social media platforms to promote IPC initiatives. The IPC page on Nexus has been updated to provide staff with easy access to resources.

Sustainability

The IPCT remain committed to promoting sustainability and reducing our carbon footprint. During 2023-24, the continuation of a glove reduction initiative resulted in a £50,000 cost saving and subsequent sustainability benefits. The team received Green Award from the South East NHSE Chief Nurse for contribution to the South East Nursing and Midwifery Green Week 2024 following presenting the project 'Promoting safety & sustainability through reduction in overuse of non-sterile gloves'.

A programme of identifying IPC sustainable project opportunities will continue during 2024-25.

End of year training figures:

At the end of March 2024, the organisation compliance with infection prevention and control mandatory training stood at 93% against a target of 85%.

Infection prevention and control training continues to be monitored at board level and bespoke targeted training provided for areas under the 85% target.

IPC Link Practitioner Programme

The IPC Link Practitioner Group has continued, and membership expanded during 2023-24., Members are provided with an education programme including a full day study event led by the Infection Prevention and Control Team.

Antimicrobial Stewardship (AMS)

The Antimicrobial Stewardship Group (AMSG) is a sub-committee of the Drug & Therapeutics Committee and is responsible for delivering the Berkshire Healthcare AMS agenda. The AMSG meets quarterly and is chaired by the Medical Director for the Out of Hours Service (WestCall).

Antimicrobial Stewardship has remained a focus for the 2023-24 IPC programme.

Infection Prevention and Control Policies

In January 2019 HM Government published the 20-year vision for tackling anti-microbial resistance (AMR), which is supported by the 5-year antimicrobial action plan. This sets out actions to be addressed nationally.

IPC policies have continued to be reviewed in line with the organisational policy review programme in alignment with the IPC national manual (England).

The Infection Prevention and Control Team also provide specialist infection control input to other clinical and environmental policies as required.

Decontamination

The contract for processing of podiatry and sexual health instruments remains with Synergy Health (trading as Steris Instrument Management Services) following a re- tender process during 2022-23.

The dental service continues to undertake decontamination in house. Dental staff continue to ensure safe practice within their clinics through agreed procedures.

The contract for specialist seating in the Wheelchair Service remains with Millbrook.

Service Level Agreements (SLA)

The Service Level Agreement with Frimley Health for the provision of professional advice and direction by the Consultant microbiologist continues to be included in the overarching pathology contract to cover the main functions required by Berkshire Healthcare. These functions include, but are not limited to, infection control doctor support, and support for antimicrobial stewardship.

The SLA with Sue Ryder has continued relating to IPC provision to the Duchess of Kent Hospice.

Committee/Group Membership

Infection Prevention & Control Strategic Group

Infection Prevention & Control Working Group

Operational Facilities Review Group (Non PFI sites)

ISS Liaison Meetings, Prospect Park Site

PLACE Meetings (WBCH site)

Infection Prevention & Control Link Practitioner Group

Policy Scrutiny Group

Waste Working Group

Water Safety Group

Berkshire West Health Economy HCAI meeting

Berkshire Healthcare Antimicrobial Stewardship Group

Berkshire Healthcare Medical Devices meeting

Frimley Health & Social Care System Infection Prevention & Control Group

Berkshire, Oxfordshire and Buckinghamshire ICS IPC Committee

Health, Safety and Environment Group

Other Activities

The IPCT have also been involved in:

- Providing IPC advice on building projects including relocation and reconfiguration of services.
- Prioritisation of services for ventilation review.

Appendix 1 Board Assurance Framework 2024-25 and
Berkshire Healthcare Infection Prevention and Control Annual Monitoring Programme 2024-25

Month	Description	Location	Undertaken by	Progress
Q1 April	Hand hygiene observational check	All wards	Ward staff	
Q1 May	Hand hygiene observational check	All wards	Ward staff	
Q1 May	Management of UTI	Community	IPCT	
Q1 June	Hand hygiene observational check	All services	All services	
Q2 July	Hand hygiene observational check	All wards	Ward staff	
Q2 August	Hand hygiene observational check	All wards	Ward staff	
Q2 September	Hand hygiene observational check	All services	All services	
Q2 September	Antimicrobial Stewardship	TBC	TBC	
Q3 October	Hand hygiene observational check	All wards	Ward staff	
Q3 November	Mattress monitoring	All Wards	Ward staff	
Q3 November	Hand hygiene observational check	All wards	Ward staff	
Q3 December	Hand hygiene observational check	All services	All services	
Q4 January	Hand hygiene observational check	All wards	Ward staff	
Q4 February	Hand hygiene observational check	All wards	Ward staff	
Q4 March	Hand hygiene observational check	All services	All services	
Q4 March	Aseptic Non-Touch Technique	TBC	TBC	

Included in IPC compliance checklists (inpatient & community), IPC inpatient spot checks and community visits for 2024-25:

Standard and transmission precautions including:

- Patient equipment cleaning
- Management of sharps (also reviewed quarterly via Datix incidents)
- Isolation facilities
- Management of linen and laundry

IPC Promotion Campaign 2024-25:

- IPC Link Practitioner Programme
- WHO Hand Hygiene Week
- Glove reduction initiative
- International Infection Prevention and Control week
- World Antimicrobial Awareness week
- Aseptic Non-Touch Technique
- Winter Health
- Urinary Catheter Care
- Hydration and prevention of UTI
- Antimicrobial Stewardship
- Sustainability in IPC
- Bitesize Training:
    - Hydration
    - Sharps safety
    - Isolation
    - Patient equipment cleaning

Infection Prevention and Control board assurance framework v0.1						
	Key Lines of Enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	**Comments**	**Compliance rating**
1. Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks their environment and other users may pose to them						
Organisational or board systems and process should be in place to ensure that:						
1.1	There is a governance structure, which as a minimum should include an IPC committee or equivalent, including a Director of Infection Prevention and Control (DIPC) and an IPC lead, ensuring roles and responsibilities are clearly defined with clear lines of accountability to the IPC team.	IPC policy (ICC001) & Governance structure IPC Strategy DIPC – Director of Nursing and Therapies IPCSG TOR and minutes				Compliant
1.2	There is monitoring and reporting of infections with appropriate governance structures to mitigate the risk of infection transmission.	IPC Monthly, Quarterly and Annual reports. Quality schedule. Mandatory reportable infection. IPC governance structure. IPC programmes.			2023-24 IPC annual report completed and presented to Board May 2024	Compliant
1.3	That there is a culture that promotes incident reporting, including near misses, while focusing on improving systemic failures and encouraging safe working practices, that is, that any workplace risk(s) are mitigated maximally for everyone.	Datix incident reporting. Monitoring of sharps incidents quarterly. Quarterly and annual monitoring of Datix incidents related to IPC. Post infection reviews for mandatory reportable infection. Shared learning summaries and patient stories.				Compliant
1.4	They implement, monitor, and report adherence to the NIPCM.	Training resources aligned to NIPCM. Policy review programme. IPC monitoring programme. IPC spot checks. Service IPC compliance tools. Completion of all IPC policies aligned as either policy, protocols or guidelines.				Compliant

1.5	They undertake surveillance (mandatory infectious agents as a minimum) to ensure identification, monitoring, and reporting of incidents/outbreaks with an associated action plan agreed at or with oversight at board level.	Reporting of mandatory infections. IPC monthly reports. Outbreak reports. QPEG and BAF review at Board. IPC monitoring programme. Enhanced surveillance for management of UTI and urinary catheters.			Collaboration with NHSE IPC cell and BOB ICS to align PSIRF for IPC.	Compliant
1.6	Systems and resources are available to implement and monitor compliance with infection prevention and control as outlined in the responsibilities section of the NIPCM.	Responsibilities set out in IPC policy (ICC 001). IPC responsibilities in generic job description. Development of IPC dashboard. IPC monitoring programme. IPC prevention & promotion campaigns.				Compliant
1.7	All staff receive the required training commensurate with their duties to minimise the risks of infection transmission.	IPC Mandatory training. eLearning, face to face sessions provided. Training aligned to IPC Manual. Compliance monitored monthly and non compliant areas targeted for support with increasing compliance of 85%. E Learning alignment to IPC national training framework. IPC mandatory training updated to align with the national framework.	Some areas below 85% trajectory.	Those scoring below 85% trajectory are reviewed monthly and bespoke training sessions provided by the IPCT. Review of IPC national training framework in progress.	End of year overall IPC mandatory training compliance was 89%.	Partially compliant
1.8	There is support in clinical areas to undertake a local dynamic risk assessment based on the hierarchy of controls to prevent/reduce or control infection transmission and provide mitigations. (primary care, community care and outpatient settings, acute inpatient areas, and primary and community care dental settings)	Service risk assessments. Service and trust. risk register. Hierarchy of controls.	Overview/ governance of compliance with risk assessment undertaken	Service managers to confirm risk assessments for IPC are in place and reviewed regularly		Partially compliant

2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections						
System and process are in place to ensure that:						
2.1	There is evidence of compliance with National cleanliness standards including monitoring and mitigations (**excludes some settings e.g. ambulance, primary care/dental unless part of the NHS standard contract** these setting will have locally agreed processes in place).	Implementation of NCS. Efficacy audits. Star ratings. EFM, NHSP and PFI monitoring. Deep cleaning programme. Pre planned maintenance programme. BHFT/NHSPS/PFI meeting minutes. EFM Governance structure. IPC compliance checklists by service.			NHSPS assurance	Compliant
2.2	There is an annual programme of Patient-Led Assessments of the Care Environment (PLACE) visits and completion of action plans monitored by the board.	PLACE visits, programme and action plan managed by EFM. Results reported to Board. Service user feedback. I want great care feedback.				Compliant
2.3	There are clear guidelines to identify roles and responsibilities for maintaining a clean environment (including patient care equipment) in line with the national cleanliness standards.	IPC responsibilities in generic JD. Specific role JD. Staff responsibilities outlined in ICC026 & ICC027. IPC compliance checklists and action plans reviewed at PSQ meetings. BHFT NSOHC cleaning responsibility framework and EFM monitoring of KPI's and star ratings. Update to JD's confirmed. Managers reminded to use updated templates rather than existing JD's	Governance/ overview of monitoring of cleaning standards by service leads	Assurance for monitoring by some services reviewed at IPCSG		Partially compliant
2.4	There is monitoring and reporting of water and ventilation safety, this must include a water and ventilation safety group and plan. **2.4.1** Ventilation systems are appropriate and evidence of regular ventilation assessments in compliance with the regulations set out in HTM:03-01. **2.4.2** Water safety plans are in	Water safety group TOR and minutes. Water safety plan. Water safety Policy. Ventilation safety reviewed at HSEG meeting. Ventilation plan & policy. HSEG minutes to IPCSG. AE (Water) audits. Authorised engineer for Ventilation, Risk prioritisation areas identified.	Assessment and update of Trust compliance with HTM:03-01. NHSPS & PFI compliance assurance.	Request for summary of compliance with HTM:03-01. BAF reviewed at EFM SLT meeting on a monthly basis.	Q1 - Ventilation policy being updated as part of 2 yearly review. To include non specialist mechanical and natural ventilation and ventilation plan.	Partially compliant

	place for addressing all actions highlighted from water safety risk assessments in compliance with the regulations set out in HTM:04-01.					
2.5	There is evidence of a programme of planned preventative maintenance for buildings and care environments and IPC involvement in the development new builds or refurbishments to ensure the estate is fit for purpose in compliance with the recommendations set out in HBN:00-09	PPM programme in place. HS028 Estate Services Management policy. IPC checklist produced for all new building/ reconfiguration projects (while national document awaited) IPC considerations for building work agreed and disseminated.	IPC considered in initial plans/ meetings for service redevelopment/ redesign/ reconfiguration & consultation when external or internal contracts prepared.	Work ongoing to ensure IPC considered at planning stages.		Partially compliant
2.6	The storage, supply and provision of linen and laundry are appropriate for the level and type of care delivered and compliant with the recommendations set out in HTM:01-04 and the NIPCM.	ICC 020 Management of linen and laundry. IPC monthly spot checks. PLACE visits. Contract monitoring minutes (EFM). Compliance with NHS Premises Assurance Model. (PAM)				Compliant
2.7	The classification, segregation, storage etc of healthcare waste is consistent with HTM:07:01 which contains the regulatory waste management guidance for all health and care settings (NHS and non-NHS) in England and Wales including waste classification, segregation, storage, packaging, transport, treatment, and disposal.	HS016 - waste management. IPC spot checks. IPC compliance checklists inpatient & community. Waste pre acceptance audits. Waste group TOR and minutes.	Review of requirements of Clinical waste strategy & updated HTM 07-01 management & disposal of healthcare waste published 08/03/2023	Review and assurance by Waste Group	HTM 07-01 under review, policy will be updated. Waste Management Audit draft received. Target completion April 24. Actions tracker under development.	Partially compliant

2.8	There is evidence of compliance and monitoring of decontamination processes for reusable devices/surgical instruments as set out in HTM:01-01, HTM:01-05, and HTM:01-06.	HS011 - purchase, use, operation maintenance and testing of local sterilisers and washer disinfectors policy. ICC006 - Decontamination of medical devices policy. Decontamination standard agenda item on Medical Devices Group. AE audits. External SSD contract and monitoring.		Implementation of best practice requirements set out in HTM 01-05. Dental staff due 3 yearly update of training (May 2024)	AE (D) audit completed and presented to new dental service leads March 24. Actions tracker developed and implemented. Report to be presented to HSEG April 24.	Partially compliant
2.9	Food hygiene training is commensurate with the duties of staff **as per food hygiene regulations**. If food is brought into the care setting by a patient/service user, family/carer or staff this must be stored in line with food hygiene regulations.	ICC024 Food hygiene policy	New food safety guidelines to be updated. Assurances regarding management of patient food being brought in	Existing policy in place. EFM update to policy in progress	Food hygiene policy updated	Compliant
3. Ensure appropriate antimicrobial stewardship to optimise service user outcomes and to reduce the risk of adverse events and antimicrobial resistance						
Systems and process are in place to ensure that:						
3.1	If antimicrobial prescribing is indicated, arrangements for antimicrobial stewardship (AMS) are maintained and where appropriate a formal lead for AMS is nominated.	AMS Group TOR. designated consultant who acts as the AMS lead within the Trust, implementing and monitoring the organisation's stewardship programme. DIPC responsibilities for AMS Strategy review. AMS pharmacist. IPCN AMS speciality.				Compliant
3.2	The board receives a formal report on antimicrobial stewardship activities annually which includes the organisation's progress with achieving the UK AMR National Action Plan goals.	Annual inpatient AMS audit report. AMS group and DTC group meeting minutes. Westcall OOH GP service monthly monitoring of prescribing. IPCSG minutes.	Formal reporting to Board on AMS activities and action plan. Regular monitoring of prescribing standards.	Annual inpatient AMS audit report. Westcall OOH GP service monthly monitoring of prescribing. Scan meetings. UCR AMS monitoring	National UKHSA point prevalence survey undertaken, results received, analysis in progress with IPCT. Inpatient audit completed, report in progress. UCR audit completed, report in progress.	Partially compliant

3.3	There is an executive on the board with responsibility for antimicrobial stewardship (AMS), as set out in the UK AMR National Action Plan.	DIPC Job description				Compliant
3.4	NICE Guideline NG15 'Antimicrobial Stewardship: systems and processes for effective antimicrobial medicine use' or Treat Antibiotics Responsibly, Guidance, Education, Tools (TARGET) are implemented and adherence to the use of antimicrobials is managed and monitored: • to optimise patient outcomes. • to minimise inappropriate prescribing. • to ensure the principles of Start Smart, Then Focus are followed.	Microguide reviewed in line with NICE and local resistance patterns. Prescribing standards (based on national guidance and Start Smart then Focus toolkit). Start Smart then Focus produced a checklist which is embedded into the guidelines and explained to all new Doctors on induction. Pharmacists and pharmacy technicians are also provided with training on the principles of good AMS and the antimicrobial prescribing guidelines.AMS Pharmacist part of the SCAN group and is involved in reviewing / updating their guidelines	Development of local antimicrobial stewardship policy. No formal antimicrobial stewardship policy. Antimicrobial prescribing guidelines are published on Difficulties identified with ongoing review and update of Microguide.	Microguide based on national guidance and local trends.	Sepsis guidance for UCR under review in collaboration with Acute Trusts. PGD update in process to go AMSG for noting, no new antimicrobial PGDs for sign off.	Partially compliant
3.5	Contractual reporting requirements are adhered to, progress with incentive and performance improvement schemes relating to AMR are reported to the board where relevant, and boards continue to maintain oversight of key performance indicators for prescribing, including: • total antimicrobial prescribing. • broad-spectrum prescribing. • intravenous route prescribing. • treatment course length.	AMS Group which encompasses criterion 3 of HSCA programme of work. AMSG work closely with DTC and when changes to current policies / procedures or new drugs are required, this is presented to DTC by the AMSG chair for approval.	KPI's for total antimicrobial prescribing. broad-spectrum prescribing. intravenous route prescribing. treatment course length. Regular monitoring of prescribing standards	Annual antimicrobial prescribing audit undertaken for inpatients.	National UKHSA point prevalence survey undertaken, results received, analysis in progress with IPCT. Inpatient audit completed, report in progress. UCR audit completed, report in progress.	Partially compliant

3.6	Resources are in place to support and measure adherence to good practice and quality improvement in AMS. This must include all care areas and staff (permanent, flexible, agency, and external contractors)	IPC surveillance, learning from incidents, IPC promotion campaign programme (prevention)	Review of requirement for provision of AMS training for designated staff groups (all health and care workers involved in prescribing, dispensing and administration on antimicrobials must receive induction and appropriate training. Process for review of trends and peer comparison. AMS patient leaflet development.	Review at AMS Group and DTC. Trust involvement in National initiatives - EAAD. AMS included in IPC promotion campaign programme 2022-23.	Planned promotion for WAAW November 2024. AMS part of IPC planned promotions for 2024-25.	Partially compliant
4. Provide suitable accurate information on infections to patients/service users, visitors/carers and any person concerned with providing further support, care or treatment nursing/medical in a timely fashion						
Systems and processes are in place to ensure that:						
4.1	Information is developed with local service-user representative organisations, which should recognise and reflect local population demographics, diversity, inclusion, and health and care needs.	Review by IPCT and Healthwatch leads. Information reviewed by Marcomms and alternative formats included	Review of all patient leaflets and information remains ongoing.	Existing leaflets and information in place on trust and public sites. Programme of review in place	BOB IPS project in place for alignment with generic IPC leaflets. Healthwatch incorporated into review.	Compliant
4.2	Information is appropriate to the target audience, remains accurate and up to date, is provided in a timely manner and is easily accessible in a range of formats (e.g. digital and paper) and platforms, taking account of the communication needs of the patient/service user/care giver/visitor/advocate.	As above		As above	Process in place for update to public pages and IPC page on Nexus	Compliant

4.3	The provision of information includes and supports general principles on the prevention and control of infection and antimicrobial resistance, setting out expectations and key aspects of the registered provider's policies on IPC and AMR.	Needs full review	Leaflets to be aligned to IPC National Manual (when available)	AMS patient leaflet in progress	AMS leaflet in final stages of approval	Partially compliant
4.4	Roles and responsibilities of specific individuals, carers, visitors, and advocates when attending with or visiting patients/service users in care settings, are clearly outlined to support good standards of IPC and AMR and include: • hand hygiene, respiratory hygiene, PPE (mask use if applicable) • Supporting patients/service users' awareness and involvement in the safe provision of care in relation to IPC (e.g. cleanliness) • Explanations of infections such as incident/outbreak management and action taken to prevent recurrence. • Provide published materials from national/local public health campaigns (e.g. AMR awareness/vaccination programmes/seasonal and respiratory infections) should be utilised to inform and improve the knowledge of patients/service users, care givers, visitors and advocates to minimise the risk of transmission of infections.	Visitor leaflets on Team Net /Nexus / external webpage Posters for wards and departments to be displayed in public areas. IPC annual promotion campaign programme. Visitor and patient posters and public messages. Visitor guidance updated to include roles and responsibilities of particular individuals, such as carers, relatives and advocates, in the prevention of infection, to support them when visiting service users.		IPC promotion campaign programme includes public messaging. Engagement with service user forums commenced.	IPC comms campaign continues. Process for public comms in place. Patient feedback for comms campaigns.	Compliant

4.5	Relevant information, including infectious status, invasive device passports/care plans, is provided across organisation boundaries to support safe and appropriate management of patients/service users.	Flagging on Rio. Urinary catheter passports. IPC care pathways. Catheter passport agreed for BOB ICS.	Review of amalgamating IPC assessment & patient transfer form in progress.	BHFT currently aligned to ICNet via RBFT. This will remain in place.	Review of IPC risk and transfer documentation.	Partially compliant
5. Ensure early identification of individuals who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to others.						
Systems and processes are in place to ensure that patient placement decisions are in line with the NIPCM:						
5.1	All patients/individuals are promptly assessed for infection and/or colonisation risk on arrival/transfer at the care area. Those who have, or are at risk of developing, an infection receive timely and appropriate treatment to reduce the risk of infection transmission.	Admission paperwork & IPC risks. Isolation policy. Outbreak Policy. Patient respiratory pathway. Single room prioritisation guidance. Alerts on Rio patient notes. IPC care pathways. Isolation monitoring for outpatient services completed.	Assurance regarding patient infection status information on admission	Awareness resource and support to services. Isolation monitoring as part of IPC spot checks. Development of care pathways available on Rio. Community visits incorporated into IPC annual monitoring programme (2024-25)	Measles action plan	Partially compliant
5.2	Patients' infectious status should be continuously reviewed throughout their **stay/period of care**. This assessment should influence placement decisions in accordance with clinical/care need(s). If required, the patient is placed /isolated or cohorted accordingly whilst awaiting test results and documented in the patient's notes.	Isolation policy. IPC spot checks. IPC surveillance.	Assurance of documentation of status / decision making in patient notes	IPC outbreak logs and minutes - documentation of decision making regarding single isolation or cohorting.		Partially compliant

5.3	The infection status of the patient is communicated prior to transfer to the receiving organisation, department, or transferring services ensuring correct management/placement.	IHTF in place	Review of IHTF monitoring	Review in progress of alignment of infection risk admission assessment and IHTF for discharge/ transfer.		Partially compliant
5.4	Signage is displayed prior to and on entry to all health and care settings instructing patients with respiratory symptoms to inform receiving reception staff, immediately on their arrival.	Patient and Visitor posters.				Compliant
5.5	Two or more infection cases (or a single case of serious infection) linked by time, place, and person triggers an incident/outbreak investigation and this must be reported via governance reporting structures.	Outbreak policy. IPC outbreak reporting on monthly reports. Outbreak minutes. IPC surveillance.				Compliant
6. Systems are in place 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						
Systems and processes are in place to ensure:						
6.1	Induction and mandatory training on IPC includes the key criteria (SICPs/TBPs) for preventing and controlling infection within the context of the care setting.	All IPC training (eLearning & face to face) cover required elements.				Compliant

6.2	The workforce is competent in IPC commensurate with roles and responsibilities.	ICC001 IPC policy.		Current standard IPC responsibilities in JD updated	Service IPC risk assessment Staff risk assessments (induction and ongoing) OH review/ assessment (induction and ongoing). take into account the needs of staff and service users, and particularly those with learning disabilities, dementia, specific vulnerabilities or protected characteristics, to ensure working arrangements are equitable.	Compliant
6.3	Monitoring compliance and update IPC training programs as required.	Trust dashboard. Training compliance reported in IPC monthly reports and non compliant areas supported/ offered bespoke training. IPC dashboard.				Compliant
6.4	All identified staff are trained in the selection and use of personal protective equipment / respiratory protective equipment (PPE/RPE) appropriate for their place of work including how to safely put on and remove (donning and doffing) PPE and RPE.	Induction and mandatory training. PPE competency checklist. PPE resources on Nexus. IPC compliance checklists.				Compliant
6.5	That all identified staff are fit-tested as per Health and Safety Executive requirements and that a record is kept.	Fit testing programme in place. Managed within EFM. SOP in place and quarterly review meetings.	All staff are tested for at least 2 masks. Compliance with recording fit testing on ESR. Implementation of porta count fit testing as alternative to hood method.	Fit testing process in place. Register of fit testers. Fit testing recorded on ESR		Partially compliant

6.6	If clinical staff undertake procedures that require additional clinical skills, for example, medical device insertion, there is evidence staff are trained to an agreed standard and the staff member has completed a competency assessment which is recorded in their records before being allowed to undertake the procedures independently.	Training IV therapy, catheterisation, venepuncture, tissue viability Competency Assessment where staff transfer training / updates	ANTT competency process	ANTT policy and resources in place. To be reviewed and aligned with updated national guidelines - in place.	ANTT implementation in progress	Partially compliant
7. Provide or secure adequate isolation precautions and facilities						
Systems and processes are in place in line with the NIPCM to ensure that:						
7.1	Patients that are known or suspected to be infectious as per criterion 5 are individually clinically risk assessed for infectious status when entering a care facility. The result of individual clinical assessments should determine patient placement decisions and the required IPC precautions. Clinical care should not be delayed based on infectious status.	Admission and transfer guidelines. IPC surveillance. IPC pathways. Link to IPC manual. Isolation and movement of patient's policy (includes isolation guidelines) IPC patient pathways. SIPC/TBP risk assessment for clinics/ outpatient settings.	Assurance for isolation risk assessment and prioritisation.	Included in IPC mandatory training. Service risk assessments. Risk register. Bitesize training for prioritisation for isolation, supportive visits to inpatient and community services part of 2024-25 IPC programme.		Partially compliant

7.2	Isolation facilities are prioritised, depending on the known or suspected infectious agent and all decisions made are clearly documented in the patient's notes. Patients can be cohorted together if: • single rooms are in short supply and if there are two or more patients with the same confirmed infection. • there are situations of service pressure, for example, winter, and patients may have different or multiple infections. In these situations, a preparedness plan must be in place ensuring that organisation/board level assurance on IPC systems and processes are in place to mitigate risk.	ICC011 -Communicable disease and outbreak management policy ICC030 MDRO management policy IPC National Manual (England). Single room prioritisation guidelines. IPC inpatient spot checks. IPC page on Nexus updated. Resources re disseminated to support single room prioritisation	Rationale for patient non isolation recorded in patient notes	IPC advice log/ emails where advice given for non isolation.		Partially compliant
7.3	Transmission based precautions (TBPs) in conjunction with SICPs are applied and monitored and there is clear signage where isolation is in progress, outlining the precautions required.	IPC mandatory training and resources IPC compliance checklists. Resources on Nexus. Signage.				Compliant
7.4	Infectious patients should only be transferred if clinically necessary. The receiving area (ward, hospital, care home etc.) must be made aware of the required precautions.	IPC policies. IHTF monitoring. IPC surveillance.				Compliant
8. Provide secure and adequate access to laboratory/diagnostic support as appropriate						
Systems and processes to ensure that pathogen-specific guidance and testing in line with UKHSA are in place:						

8.1	Patient/service user testing for infectious agents is undertaken by competent and trained individuals and meet the standards required within a nationally recognised accreditation system.	Contract with Berkshire & Surrey Pathology Services. KPI contract monitoring				Compliant
8.2	Early identification and reporting of the infectious agent using the relevant test is required with reporting structures in place to escalate the result if necessary.	IPC surveillance systems. Daily Covid and Influenza lab reports. Weekly surveillance lab reports. Weekly Mandatory infection reports from RBFT. ICNet (West) ICE laboratory system. Assurance for out of hours (9-5) respiratory testing for Berkshire Healthcare requested from BSPS confirmed during Q1 (updated to compliant)		Process agreed for out of hours Covid testing. Ongoing monitoring with BSPS		Compliant
8.3	Protocols/service contracts for testing and reporting laboratory/pathology results, including turnaround times, should be in place. These should be agreed and monitored with relevant service users as part of contract monitoring and laboratory accreditation systems.	KPI contract monitoring. Datix incident reporting.				Compliant
8.4	Patient/service user testing on admission, transfer, and discharge should be in line with national guidance, local protocols and results should be communicated to the relevant organisation.	Epidemiological surveillance policy. IPC surveillance.				Compliant

8.5	Patients/service users who develops symptom of infection are tested / retested at the point symptoms arise and in line with national guidance and local protocols.	Patient Pathway and screening guidelines. ICC 012 Surveillance of infection policy (includes notifiable diseases) SI reporting. Reporting of HCAI Health Protection England, as directed by DH undertaken on BHFTs behalf by acute trusts ICC010 safe collection, handling and transportation of laboratory specimens ICC030 Multi drug resistant organisms policy. Assurance for out of hours (9-5) respiratory testing for Berkshire Healthcare requested from BSPS received during Q1.Bitesize training for specimen collection disseminated during Q1. Updated to compliant Q1.		Process agreed for out of hours Covid testing. Ongoing monitoring with BSPS		Compliant
8.6	There should be protocols agreed between laboratory services and the service user organisations for laboratory support during outbreak investigation and management of known/ emerging/novel and high-risk pathogens.	BSPS contract.				Compliant
8.7	There should be protocols agreed between laboratory services and service user organisations for the transportation of specimens including routine/ novel/ emerging/high risk pathogens. This protocol should be regularly tested to ensure compliance.	BSPS contract. KPI monitoring. ICC010 Safe Collection, Handling, and Transportation of laboratory specimens policy.				Compliant
9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections						

9.1	Systems and processes are in place to ensure that guidance for the management of specific infectious agents is followed (as per UKHSA, A to Z pathogen resource, and the NIPCM). Policies and procedures are in place for the identification of and management of outbreaks/incidence of infection. This includes monitoring, recording, escalation and reporting of an outbreak/incident by the registered provider.	IPC programme and monitoring programme. IPC policy review programme. IPC promotion campaign. Post infection review. Monthly reports (outbreak summaries) Shared learning. Review of IPC programme and BAF at quarterly IPCSG. ICC001 IPC policy. IPCLP programme and study events. IPC promotion campaign programme incorporating |Glove reduction, Hydration, Mouthcare, Patient equipment cleaning, ANTT, Management of UTI and Catheter care.	Antimicrobial prescribing and stewardship policy.	Programme of work includes alignment of policy programme to IPC National Manual. Participation in BOB and FH ICB Healthcare Associated Infection Reduction workstreams.	Policy programme remains ongoing.	Partially compliant
10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection						
Systems and processes are in place to ensure that any workplace risk(s) are mitigated maximally for everyone. This includes access to an occupational health or an equivalent service to ensure:						
10.1	Staff who may be at high risk of complications from infection (including pregnancy) have an individual risk assessment.	OH contract managed by HR. KPI review. Individual staff risk assessment. OH assessment on induction. OH and HR policy.				Compliant
10.2	Staff who have had an occupational exposure are referred promptly to the relevant agency, for example, GP, occupational health, or accident and emergency, and understand immediate actions, for example, first aid, following an occupational exposure including process for reporting.	Datix incident reporting. Monitoring of sharps injury quarterly. Shared learning disseminated. Medical Devices meeting minutes. ICC005 Management of inoculation and prevention of sharps injury policy.				Compliant

10.3	Staff have had the required health checks, immunisations and clearance undertaken by a competent advisor (including those undertaking exposure prone procedures (EPPs).	Staff communication regarding processes to check immunity if unsure (specifically measles/ chickenpox)	OH assurance that records are up to date for relevant immunisations for all staff.	confirmation that new staff in a patient facing role are checked at the pre-placement stage for immunity and vaccination records	Checking of staff immunity for measles in progress. Regular monitoring of progress by HR.	Partially compliant

Appendix 2 – Summary of Surveillance Data 2023-24

Introduction:

Berkshire Healthcare is responsible for the prevention and control of infection within its services to minimise the risk of healthcare associated infections to patients, staff and visitors.

The pathology and laboratory service to Berkshire Healthcare is provided by Berkshire and Surrey Pathology Services.

Surveillance of infection is undertaken using laboratory data, information from wards and departments and liaison with UKHSA, ICBs and local acute Trusts.

A healthcare associated infection (HCAI) can be defined as an infection resulting from medical care or treatment in hospital (in- or out-patient), nursing homes, or even the patient's own home (UKHSA 2013). Previously known as 'Hospital Acquired Infection' or 'Nosocomial Infection', the current term reflects the fact that a great deal of healthcare is now performed outside the hospital setting.

Surveillance is an essential part of the role of the Infection Prevention and Control Team (IPCT) in order to identify, manage and where possible prevent infection in high-risk patients both in inpatient settings and patients receiving care in their own homes.

There is a national mandatory requirement for trusts to report all cases of *Clostridioides difficile* infection, Meticillin Resistant Staphylococcus Aureus (MRSA), Meticillin Sensitive Staphylococcus Aureus (MSSA), Gram negative (including Escherichia coli, Pseudomonas and Klebsiella) and Glycopeptide-resistant Enterococci (GRE) bacteraemia to UKHSA. From May 2015, all laboratories and NHS trusts were encouraged to take part in the enhanced surveillance of Carbapenemase-producing Gram-negative bacteria (UKHSA 2015).

In 2018, the national ambition to reduce healthcare associated Gram-negative bloodstream infections was revised to achieve a 25% reduction by 2021 – 2022 with the full 50% by 2023 - 2024. Approximately three-quarters of E. coli blood stream infections (BSIs) occur before people are admitted to hospital. Reduction therefore requires a whole health economy approach. There is a focus on reducing healthcare associated E. coli bloodstream infections because they represent 55% of all Gram-negative BSIs.

The IPCT undertake a post infection review (PIR) for mandatory reportable infections, where identified with the inpatient units. A final report detailing good practice and learning (where identified) is disseminated to clinical teams and resources produced or updated to support clinical care if indicated.

Additionally, a review is undertaken for patients who have developed mandatory reportable infection whether identified on admission to acute trusts or in the community and who have had recent input form Berkshire Healthcare inpatient or community teams., or where a non-reportable blood stream infection or C difficile is identified.

Mandatory reportable infection summary Berkshire Healthcare 2023-24:

Mandatory HCAI Berkshire Healthcare Cases	Mandatory Enhanced Surveillance 2023/24 per Month														
	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	TOTAL		
C-diff	0	1	0	1	0	0	0	0	1	0	0	0	3		
E coli BSI	0	1	1	0	1	0	1	1	1	1	1	1	9		
MRSA BSI	0	0	0	0	0	0	0	0	0	0	0	0	0		
MSSA BSI	0	1	0	0	0	0	0	1	0	1	0	0	3		
Klebsiella BSI	0	0	0	0	0	0	0	0	0	0	1	0	1		
Pseudomonas aeruginosa BSI	0	0	0	0	0	0	0	1	0	1	0	0	2		
VRE BSI	0	0	0	0	0	0	0	0	1	0	0	0	1		
Carbapenemase-producing Enterobacteriaceae (CPE)	0	0	0	0	0	0	0	0	0	0	0	0	0		
TOTAL	0	3	1	1	1	0	1	3	3	3	2	1	19		0

Mandatory reportable infection by ward:

Mandatory Enhanced Surveillance 2023/24 per Ward														
Ascot Ward	Windsor Ward	Oakwood Unit	Donnington Ward	Highclere Ward	Henry Tudor Ward	Jubilee Ward	MH & LD inpatient wards							TOTAL
0	1	1	1	0	0	0	0							3
0	2	0	0	1	2	4	0							9
0	0	0	0	0	0	0	0							0
1	0	1	1	0	0	0	0							3
0	0	0	1	0	0	0	0							1
0	0	0	0	1	0	1	0							2
0	0	0	0	0	0	1	0							1
0	0	0	0	0	0	0	0							0
1	3	2	3	2	2	6	0	0	0	0	0	0	0	19

Mandatory reportable infection comparison by year:

Berkshire Healthcare Cases Summary	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23	2023-24
C-diff	15	5	5	7	10	6	7	7	6	9	12	7	3
E coli BSI	1	3	4	7	4	6	9	7	16	11	11	4	9
MRSA BSI	1	0	0	2	0	0	0	0	0	1	1	0	0
MSSA BSI	0	0	0	0	0	3	0	6	2	2	2	2	3
Klebsiella BSI	0	0	0	0	0	0	0	1	3	1	4	2	1
Pseudomonas aeruginosa BSI	0	0	0	0	0	0	0	0	4	1	1	0	2
VRE BSI	0	0	0	0	0	0	0	0	1	1	1	0	1
Carbapenemase-producing Enterobacteriaceae (CPE)	0	0	0	0	0	0	0	0	0	1	0	0	0

Period of increased incidence of *Clostridioides difficile* (PII) 2023-24:

During 2023-24, one period of increased incidence was identified on Windsor Ward. In October 2023, two patients were identified as having C. difficile on Windsor Ward. Both cases are non-toxin producing and therefore, non-reportable.

A period of increased incidence was declared and PII audit commenced as both new cases occurred >48 hours post admission, were not a relapse in a 28-day period and patients were in the same bay.

Ribotyping undertaken for both cases identified similar ribotyping suggesting potential transmission. Discussion was undertaken with the ward manager and shared learning identified from review of the cases and the weekly monitoring disseminated to the ward team and included in the IPC training and

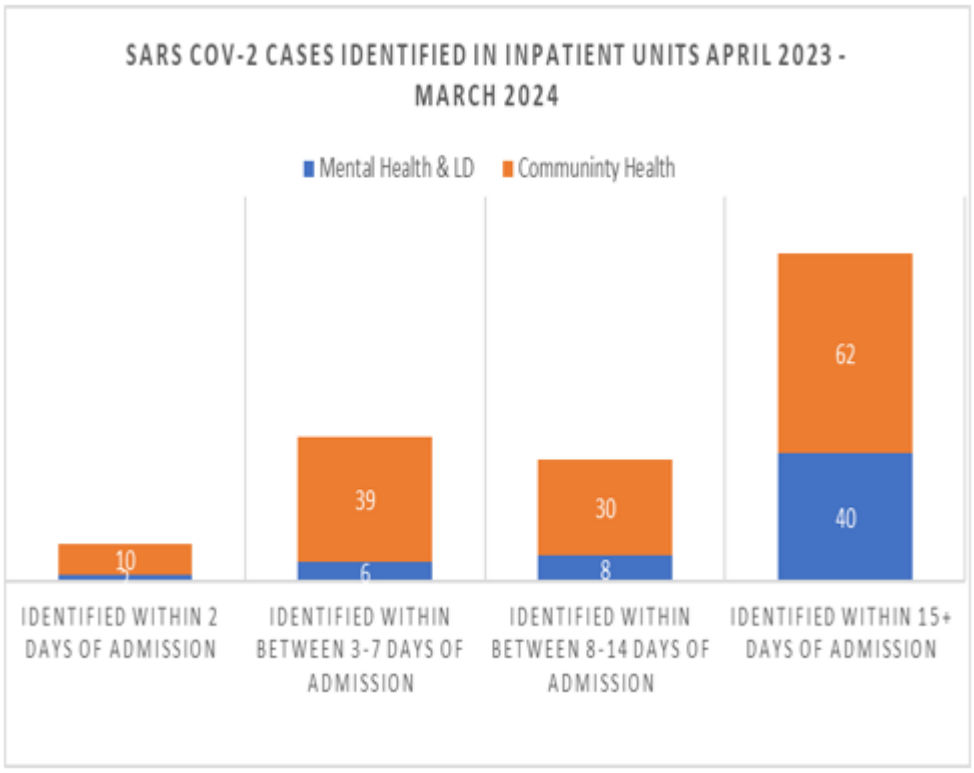
IPC shared learning processes. The period of increased incidence was concluded on 21/11/2023 due to no further patients identified and completion of weekly enhanced monitoring.

SARS CoV-2

Categorisation for acquisition of SARS CoV -2 is based on time between first positive specimen and admission to trust. The first day of admission counts as day one. In the event of patients testing positive on the day of admission this also counts as day one.

- Community-Onset – First positive specimen date <=2 days after admission to trust
- Hospital-Onset Indeterminate Healthcare-Associated – First positive specimen date 3-7 days after admission to trust.
- Hospital-Onset Probable Healthcare-Associated - First positive specimen date 8-14 days after admission to trust.
- Hospital-Onset Definite Healthcare-Associated – First positive specimen date 15 or more days after admission to trust.

The following data details SARS CoV-2 cases identified on Berkshire Healthcare inpatient units. This does not include total number of cases on the ward (for example those patients admitted known to be positive)



Twenty-Seven cases of Influenza, eight cases of Respiratory Syncytial Virus (RSV) and one case of Norovirus were reported from inpatient units during 2023-24.

Outbreaks

An outbreak is defined in UKHSA guidance as an incident in which 2 or more people experiencing a similar illness are linked in time or place or a greater than expected rate of infection compared with the usual background rate for the place and time where the outbreak has occurred.
During 2023-24, outbreaks of SARS CoV-2 and Influenza were identified on Berkshire Healthcare inpatient units. When an outbreak is declared, daily review and planning is undertaken by the IPCT in conjunction with ward and service leads to ascertain the index case and prevention of further transmission.

Individual inpatients with respiratory and gastrointestinal infection were also identified between admission to post 15 days of admission, potentially requiring contact tracing, contact isolation or monitoring resulting in subsequent restriction to admission activity in bays or wards.

Summary of outbreaks identified in inpatient wards 2023-24:

OUTBREAKS													
Berkshire Healthcare Cases	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	TOTAL
COVID-19	1	2	0	0	4	4	4	5	3	1	1	3	28
Flu	0	0	0	0	0	0	0	0	2	2	0	0	4
RSV	0	0	0	0	0	0	0	0	0	0	0	0	0
Norovirus	0	0	0	0	0	0	0	0	0	0	0	0	0
PII (CDI)	0	0	0	0	0	0	1	0	0	0	0	0	1

Tuberculosis

A case of Tuberculosis was identified requiring contact tracing of patients and staff. Review remains ongoing in conjunction with UKHSA and Occupational Health services.

Shared learning from outbreaks and incidents:

Staff Immunity:

- Staff who do not know their immunity to Chickenpox and Measles to be aware of how to access their immunity information via occupational health.

Care Planning and Documentation:

- The use of invasive devices such as catheters and wounds must be documented as part of the care plans.
- Care plans and pathways where indicated, must be completed on Rio.

Patient testing and isolation:

- Patients must be assessed for isolation promptly at the onset of symptoms.
- Staff awareness of prioritisation for isolation of patients in single rooms.
- Review of risk factors for source and protective isolation must be undertaken.
- If patients are unable to be isolated based on risk assessment (e.g. falls) or single room capacity, to be documented in patient Rio notes.
- Specimens must be obtained promptly when clinical signs of infection are reported, and specimen request form must be completed with patients' details and correct location.

- Prompt review of suitability for Flu Influenza antiviral therapy and prophylaxis must be undertaken for both high-risk staff and patient contacts.

Other:

- Staff to be familiar with recommended cleaning products
- Safe management of sharps guidance including sharps containers.
- A process must be in place to review the expiry dates of facemasks and Covid swabs.

Appendix 3 – Summary of Learning from Datix Incidents 2023-24

The Infection Prevention and Control Team (IPCT) are copied into Datix incidents reported under the following categories:

- Infection
- Ill Health
- Medical Emergencies
- Sharps Incidents
- Exposure to Harmful Substances
- Any other incidents forwarded to the team for IPC input

The IPCT review these incidents, to identify learning, liaise with individual areas to provide advice if required and share the learning widely. Any learning identified during post infection reviews of reportable bacteraemia / C. difficile or during outbreaks of infections not included in this summary is included in a quarterly IPC shared learning document.

During April 2023 - March 2024, a total of **391 Datix** incidents were reviewed by the IPCT.

Key messages identified
Staff to adhere to the waste management policy and dispose sharps in to sharps bin and not clinical waste streams/used equipment.
Used gloves and sharps must be disposed into correct waste streams
Staff to ensure to be vigilant when handling sharp items.
Staff must encourage patients to dispose used insulin needles immediately after use.
Staff must assemble sharps bin in line with the policy.
Staff must ensure to immediately dispose all used sharps into the sharps bins.
Staff to ensure to use recommended devices when disposing used scalpel to prevent injury
Staff must safely store unused boxes of sharps in line with the sharps policy.
Staff must ensure to apply the temporary closure mechanism of the sharps bins when not in use.
Staff to use safety needles when undertaking blood glucose monitoring.
Staff to ensure to be vigilant around the presence of used sharps outside the Berkshire Healthcare sites disposed by the public.