Berkshire Healthcare NHS Foundation Trust

INFECTION PREVENTION AND CONTROL ANNUAL REPORT APRIL 2024 - MARCH 2025

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 UK 5-year national action plan for antimicrobial resistance (2024 to 2029) supports the UK 20-year vision for antimicrobial resistance (AMR). To confront AMR, the 2024 to 2029 national action plan has 9 strategic outcomes organised under 4 themes. Action will be taken across all sectors (human health, animal health, agriculture and the environment).

The IPC Board Assurance Framework outlines the ten criteria of the Act and forms the IPC programme which articulates the delivery of progress and ongoing workstreams including AMR. The annual programme is a live document and is reviewed by a number of forums within the Trust and presented regularly to the Quality Assurance Committee.

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

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. Increased IPC activity in safe management of the environment including building works, ventilation, water safety has been provided this year alongside consideration of safe sustainable initiatives. 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 practice, 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 2024 to 31 March 2025 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 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 2025-26 IPC annual work programme. (appendix 1)

2024-25 has been 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 continue to develop a dashboard which summarises key indicators and areas for improvement.

The UK 5-year national action plan for antimicrobial resistance (2024 to 2029) supports the UK 20-year vision for antimicrobial resistance (AMR). To confront AMR, the 2024 to 2029 national action plan has 9 strategic outcomes organised under 4 themes. Action will be taken across all sectors (human health, animal health, agriculture and the environment).

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.

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.

Learning form incidents and post infection reviews remains a focus for shared learning and identification of themes providing a focus for ongoing IPC promotion campaigns and resources. IPC mandatory training is 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. This has included collaboration and feedback from patient forums and an increased utilisation of social media for staff and public messaging. A successful and well evaluated IPC link practitioner annual study event was held. Digital initiatives continue to be maximised within IPC workstreams.
The IPCT presented four posters at the national Infection Prevention Society Conference in September, showcasing quality improvement projects for glove reduction, implementation of aseptic non touch technique, patient feedback specific to IPC and a joint band 6 networking programme.

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 2024-25 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 2025-26 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 from over 60 sites across Berkshire including inpatient beds on the Upton, St Mark's, Wokingham, Prospect Park and West Berkshire Community Hospitals.

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 Board Assurance Framework is a national tool and 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. This assurance framework is a live document which is presented to the full Board.

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

During 2024-25, several workstreams and criteria were upgraded from non-compliant to partially compliant and partially compliant to compliant.

Partially compliant areas will be rolling over to 2025-26 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) and national action plan for antimicrobial resistance. The Group provides assurance on infection prevention and control programmes, Board Assurance Framework, decontamination and other related issues to the Quality and Performance Executive Group via 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 IPC strategy 2022-2025 was evaluated and completed in 2025 and replaced by the Board Assurance Framework.

The IPCT vision is reflected in the Team plan on a page. Objectives for 2025-26 align with trust objectives for harm free care, good patient experience, supporting our people and efficient use of resources. Objectives are reviewed regularly and form part of team measurable objectives for the year.

The Infection Prevention and Control Programme

The infection prevention and control programme for 2024-25 has been completed.

The programme planned for the year 2025-26 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.

The NHS Standard Contract 2024/25 includes quality requirements for NHS trusts and NHS foundation trusts to minimise Clostridioides difficile (C. difficile) and Gram-negative Bloodstream Infections (GNBSIs) rates to threshold levels set by NHS England.

Trusts are required under the NHS Standard Contract 2024/25 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 UKHSA, ICB's 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.

Further information including surveillance data for 2024 - 25 can be found in appendix 2.

Clostridioides difficile (formerly Clostridium difficile)

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.

Gram-negative bacteraemia 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) - Is not categorised HOHA and the patient was most recently discharged from the same reporting trust in the 28 days prior to the specimen date (where day 1 is the specimen date)
- Community-onset, community associated (COCA) -Is not categorised HOHA and the patient has not been discharged from the same reporting organisation in the 28 days prior to the specimen date (where day 1 is the specimen date)

Meticillin Resistant *Staphylococcus aureus* (MRSA)

National guidance supports commissioners and providers of care to deliver zero tolerance on MRSA bloodstream infections.

No cases of MRSA bacteraemia were identified from an inpatient. Input to reviews undertaken for two community patients identified to have had recent care provision from Berkshire Healthcare was provided by the IPCT.

Meticillin Sensitive *Staphylococcus aureus* (MSSA)

No cases of MSSA bacteraemia were identified from patients who were on inpatient units. This is a reduction in cases identified during 2023-24. Input to reviews undertaken for two community patients identified to have had recent care provision from Berkshire Healthcare was provided by the IPCT.

Gram negative Bacteraemia (GNB)

During 2024-25, cases identified in Berkshire Healthcare inpatient units reported, eight E. coli bacteraemia, one Klebsiella bacteraemia and zero Pseudomonas bacteraemia.

Compared to 2023-24, a decrease in GNB is noted for Berkshire Healthcare inpatient wards.

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

Glycopeptide Resistant Enterococci (GRE)

No cases of GRE bacteraemia identified.

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 2024-25. 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-Seven outbreaks of SARS CoV-2 (28 identified 2023-24), fourteen outbreaks of Influenza (4 identified 2023-24), Two outbreaks of RSV (Zero in 2023-24), Five outbreaks of Norovirus (Zero in 2023-24) and one outbreak of invasive group A streptococcus (iGAS) were identified from inpatient units within Berkshire Healthcare during 2024-25.

Further details of outbreaks, themes 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 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
- 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 2024-25.

The flu programme commenced this Autumn during the first week of October 2024. 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
Overall Actual Percentage	46.88	50.74	42.36	37.01

Covid -19 vaccination	Central services	Children, family and all age services	Community Health services	Mental Health services
Overall Actual Percentage	38.15	38.83	30.40	28.41

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 2024-25 monitoring programme was completed with following monitoring was undertaken:

- Hand hygiene observational check inpatients (monthly)
- Hand hygiene observational check community services (quarterly)
- Antimicrobial Stewardship
- Static Mattresses and cushions monitoring
- Management of Urinary Tract Infection (Community)
- Aseptic Non- Touch Technique

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.

Included in IPC compliance checklists completed by inpatient & community teams, IPC inpatient spot checks and community visits for 2024-25 include elements of standard and transmission precautions including:

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

The IPCT aimed to visit the inpatient units monthly and during 2024-25 have successfully undertaken a programme of community team visits to support colleagues and identify IPC issues or training requirements. 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. Bespoke training is offered to services.
During 2024-25, the annual IPC promotion campaign programme was completed. This included targeted educational campaigns across the trust covering several prevention initiatives including:

- 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 resources were developed to support learning from incidents and outbreaks. These included hydration, sharps safety, isolation and specimen collection.

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.
The IPCT presented four posters at the national Infection Prevention Society Conference in

September, showcasing quality improvement projects for glove reduction, implementation of aseptic non touch technique, patient feedback specific to IPC and a joint band 6 networking programme.

Sustainability
The IPCT remain committed to promoting sustainability and reducing our carbon footprint. During 2024-25, the glove reduction initiative continued in addition to a programme of identifying IPC sustainable project and product opportunities.

End of year training figures:

At the end of March 2025, 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 2024-25. Members are provided with an education programme including a half day and full day study event and annual newsletter led by the Infection Prevention and Control Team. An interactive Teams channel has been introduced.

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 including the UK 5-year national action plan for antimicrobial resistance (2024 to 2029) has remained a focus for the 2024-25 IPC programme. The AMS elements within the Board Assurance Framework and gap analysis from the AMS National Action Plan is reviewed and monitored by the AMSG.

During 2024-25 an AMS awareness poll was undertaken by the IPCT, this will highlight further resources required to support and promote AMS awareness within the organisation.

Infection Prevention and Control Policies

IPC policies have continued to be reviewed in line with the organisational policy and guideline 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.

Decontamination of a single use item
On 07/10/2024, the IPCT were notified by the community dental service regarding unintentional reuse of single use finger guards following decontamination across the dental clinics. On identification of the issue, the finger guards in use were disposed and single use devices commenced. The IPCT sought further advice from consultant microbiologist and notified the situation to the UKHSA for further guidance and management. The medical devices group were notified, and an Internal incident management review was undertaken. The UKHSA have now concluded their incident management review and ascertained that there was no increased risk to patients. Medicines and Healthcare products Regulatory Agency (MHRA) were notified about the situation, and the manufacturer was approached for further information as per the incident

management review recommendations; they came to the conclusion that a fingerguard was not a medical device.

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

Core groups attended, including those where IPC attendance is quorate or DIPC represented:

Antimicrobial Stewardship Group

Berkshire Healthcare Antimicrobial Stewardship Group

Berkshire Healthcare Medical Devices meeting

Berkshire West Health Economy HCAI meeting

Berkshire, Oxfordshire and Buckinghamshire ICS IPC Committee

BSPS operational meeting

Frimley Health & Social Care System Infection Prevention & Control Group

Health, Safety and Environment Group

Infection Prevention & Control Link Practitioner Group

Infection Prevention & Control Strategic Group

Infection Prevention & Control Working Group

ISS Liaison Meetings, Prospect Park Site

Operational Facilities Review Group (Non PFI sites)

PLACE Meetings (WBCH site)

Policy Scrutiny Group

Waste Working Group

Water Safety Group

Other Activities

The IPCT have also been involved in:

- Providing specialist IPC advice on safe environment for an increasing number of building projects including new build, relocation and reconfiguration of services.
- Prioritisation of services for ventilation review.
- Provision of IPC business continuity for services during planned or unplanned water shutdown.
- Providing specialist advice in procurement of supplies and tenders to support sustainability & IPC principles.

Appendix 1:
Board Assurance Framework 2025-26
Berkshire Healthcare Infection Prevention and Control Annual Monitoring Programme 2025-26

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				3. 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.				3. 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.				3. 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.				3. 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.				3. 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.				3. 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 93%. Monitoring of service compliance and training provision.	2. 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	Monitoring of assurance of risk assessments reviewed at IPCSG.	2. 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	3. 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.				3. 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 services reviewed at IPCSG	Assurance for ongoing monitoring or gaps identified by services reviewed at IPCSG	2. 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 place for addressing all actions highlighted from water safety risk assessments in compliance with the regulations set out in HTM:04-01.	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. Monitoring of non-specialist mechanical and natural ventilation and ventilation plan.	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.	Trust/ NHSP & PFI policy and action plan for HTM:03-01 and HTM:04-01. Plans and progress with monitored at Waste, Water Safety, HSEG and IPCSG meetings.	2. Partially compliant

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. Capital Projects and IPC monthly meetings commenced. Estates and clinical project development group PPH.	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.		3. 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)				3. 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. Q1 update - July 2024 updated policy reviewed by Waste Group and HSEG. Audit Report has been circulated to Waste Group June 2024 Audit actions tracker to be submitted to July Waste Group. Waste Procedure Manual disseminated by EFM Team. Waste audit action plan in progress.	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	Audit action plan ongoing. Review of waste training for staff in progress.	2. 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. Monitoring of non-specialist mechanical and natural ventilation and ventilation plan.AE (D) audit completed and presented to new dental service leads March 24. Actions tracker developed and implemented. Report presented to HSEG April 24. Action Tracker Progress & review planned with CDS Leads and AE (D) 14/08/2024. - Dental decontamination processes being reviewed. October 2024 - update decontamination issue raised. UKHSA action log for incident maintained. Issue closed. Shared learning regarding single use products disseminated. Local actions for dental decontamination monitored		Implementation of best practice requirements set out in HTM 01-05. Dental staff due 3 yearly update of training (May 2024)	External CSSD being considered for dental services.	2. 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	3. 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.				3. 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. National UKHSA point prevalence survey undertaken 2023-24 preliminary results received, analysis in progress with IPCT, confirmed final results expected. Inpatient audit completed by pharmacy, report in progress. UCR audit completed, report in progress. - Annual inpatient antimicrobial prescribing audit completed by Pharmacy. Publication of national PPS awaited. Westcall OOH prescribing feedback is given to clinicians as part of audit to encourage good prescribing stewardship of antimicrobials	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	UCR annual antimicrobial prescribing audit. Point prevalence national report published. NAP gap analysis and action plan in progress & collaboration with ICB's.	2. 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				3. 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.	Micro guide 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. MS Pharmacist part of the SCAN group and is involved in reviewing / updating their guidelines. 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. - Micro guide replaced by Eolas	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 Micro guide.	Eolas based on national guidance and local trends.	Work underway to signpost antimicrobial PGD users to Target RCGP/NICE CKS and pharmacy first educational resources to optimise learning on antimicrobial use. Signposting will be added by WC and PGD group as renewals to existing antimicrobial PGDs occur.	2. 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 PP report published and under review to identify learning and development of workstreams.	2. 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)Planned promotion for WAAW November 2024. AMS part of IPC planned promotions for 2024-25. Gap analysis of National AMS Action plan being undertaken by IPCT.	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.	IPCT contributing to BOB ICS NAP gap analysis. Participation in NHSE AMS governance in Community Health, Mental Health and Health & Justice settings.	2. 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.	3. 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 pages on Nexus	3. 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.	Leaflet review programme in progress	Leaflets to be aligned to IPC National Manual (when available)	AMS patient leaflet in progress	AMS leaflet in final stages of approval	2. 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 comms campaign continues. Process for public comms in place. Patient feedback for comms campaigns. - IPC feedback discussed at Healthwatch meeting; action plan commenced.		IPC promotion campaign programme includes public messaging. Engagement with service user forums commenced.		3. 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. IHTF on Rio.	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 in progress.	2. 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 <u>NIPCM:</u>						
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. Prioritisation of isolation updated in IPC resources bitesize training. Shared learning disseminated. Awareness sessions for clinical services.	Assurance regarding patient infection status information on admission. Assurance within reach/discharge teams for IPC risk assessment.	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 (2025-26)	Monitoring of identification of risk and appropriate isolation included in IPC tools. Community and inpatient support visits included in programme to monitor. Development of specific care pathways.	2. 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.	Shared learning and development of resources to support documentation of status / decision-making in-patient notes.	2. 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.	Aligning admission assessment and transfer documentation to one tool.	2. 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.				3. 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.				3. 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 include 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.				3. 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.	3. 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.			Working with IT for development of interactive dashboard.	3. 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.				3. 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. Q1 update - Fit tester training sessions undertaken. Planned programme of implementing Portacount testing. Quarter 3 update - Portacount implemented, fit testing SOP and resources on Nexus updated	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	Ongoing programme of fit testing and review of product availability/ requirements for re testing.	2. 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 competency training under review. Resources added to IPC page on Nexus.	2. 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. Shared learning from outbreaks and incidents disseminated. Isolation bitesize training in progress. Prioritisation of isolation bitesize training disseminated.	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.	Aligning admission assessment and transfer documentation to one tool. Point prevalence for infection management monitoring planned for Q1 & Q3.	2. 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. shared learning from outbreaks and incidents disseminated. Isolation bitesize training and resources produced.	Rationale for patient non isolation recorded in patient notes	IPC advice log/ emails where advice given for non-isolation.	Shared learning and development of resources to support documentation of status / decision-making in-patient notes.	2. 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.				3. 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. IPC surveillance.				3. 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				3. 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		3. 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.			Contract meetings. BSPS IPC meeting - escalation of incidents where testing not undertaken in line with agreed contract.	3. 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.				3. 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		3. 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.				3. 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.				3. 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.	3. 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.				3. 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.				3. 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). Contract monitoring	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	Assurance around records of staff immunity status to communicable disease continues to be requested, based on incidents of exposure - e.g. TB, Chickenpox/ shingles. Ongoing iGAS outbreak monitoring and review meetings with OH provider.	2. Partially compliant

IPC Monitoring Programme 2025-26

Month	Description	Location	Undertaken by	Progress
Q1 April	Hand hygiene observational check	All wards	Ward staff	
Q1 April	AMS awareness poll	All services	IPCT	
Q1 May	Hand hygiene observational check	All wards	Ward staff	
Q1 June	Hand hygiene observational check	All wards	Ward staff	
Q1 June	Infection Point Prevalence	All wards	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	Dental Decontamination	Dental	Dental Team/IPCT	
Q3 October	Hand hygiene observational check	All wards	Ward staff	
Q3 October	Hand hygiene basin etiquette	Inpatient and Outpatient departments	IPCT	
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	

Month	Description	Location	Undertaken by	Progress
Q4 February	Hand hygiene observational check	All wards	Ward staff	
Q4 March	Hand hygiene observational check	All services	All services	
Q4 March	Urinary Catheter monitoring	Inpatients	IPCT	

Included in IPC compliance checklists (inpatient & community), IPC inpatient spot checks and community visits for 2025-26:

Standard and transmission precautions including:

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

IPC Promotion Campaign 2025-26:

- 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
- Antimicrobial Stewardship
- Sustainability in IPC

Appendix 2 – Summary of Surveillance Data 2024-25

Berkshire Healthcare NHS Foundation Trust 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.

Infection Prevention and Control [IPC] remains a high priority for all NHS Trusts. The implementation of the Health and Social Care Act 2008 (revised 2022) has set a duty to ensure that systems to prevent healthcare associated infections and compliance with policies are embedded in practice and a corporate responsibility.

The UK 5-year national action plan for antimicrobial resistance (2024 to 2029) supports the UK 20-year vision for antimicrobial resistance (AMR). To confront AMR, the 2024 to 2029 national action plan has 9 strategic outcomes organised under 4 themes. Action will be taken across all sectors (human health, animal health, agriculture and the environment). The new NAP targets mean that appropriate thresholds to support achievement will not be comparable to those set in previous years.

The NHS Standard Contract 2024/25 includes quality requirements for NHS trusts and NHS foundation trusts to minimise Clostridioides difficile (C. difficile) and Gram-negative Bloodstream Infections (GNBSIs) rates to threshold levels set by NHS England.

Trusts are required under the NHS Standard Contract 2024/25 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.

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 (associated cases), or where a non-reportable blood stream infection or C difficile is identified.

Compliance is monitored through the Trusts IPC Board Assurance framework and IPC programmes. This monthly report provides an overview of mandatory reportable infections, IPC surveillance, incidents and local reduction strategies and includes an update on compliance with hand hygiene, mandatory training figures and the IPC monitoring programme.

Mandatory reportable infection summary Berkshire Healthcare 2024-25:

Mandatory HCAI Berkshire Healthcare Cases	Mandatory Enhanced Surveillance 2024/25 per Month													
	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	TOTAL	Learning identified
C-diff	0	0	1	1	1	0	1	1	0	0	0	1	6	4
E coli BSI	1	0	0	1	0	1	4	0	0	0	1	0	8	4
MRSA BSI	0	0	0	0	0	0	0	0	0	0	0	0	0	
MSSA BSI	0	0	0	0	0	0	0	0	0	0	0	0	0	
Klebsiella BSI	0	0	0	0	0	0	0	0	0	0	1	0	1	1
Pseudomonas aeruginosa BSI	0	0	0	0	0	0	0	0	0	0	0	0	0	
VRE BSI	0	0	0	0	0	0	0	0	0	0	0	0	0	
Carbapenemase-producing Enterobacteriaceae (CPE)	0	0	0	0	0	0	0	0	0	0	0	0	0	
TOTAL	1	0	1	2	1	1	5	1	0	0	2	1	15	9

Mandatory Enhanced Surveillance 2024/25 per Ward																TOTAL
Ascot Ward	Windsor Ward	Oakwood Unit	Donnington Ward	Highclere Ward	Henry Tudor Ward	Jubilee Ward	MH & LD inpatient wards									
1	1	1		2	1											6
	3		1	1	3											8
																0
																0
		1														1
																0
																0
																0
1	4	2	1	3	4	0	0	0	0	0	0	0	0	0	0	15

Associated cases 2024-25:

Associated Cases	April	May	June	July	August	September	October	November	December	January	February	March	Total
C-difficile	1	0	0	1	3	1	0	0	0	0	0	2	8
E coli BSI	1	0	2	0	0	0	1	0	1	0	1	0	6
MSSA BSI	0	1	0	0	0	1	0	0	0	0	0	0	2
MRSA BSI	0	0	0	0	0	0	0	2	0	0	0	0	2
Klebsiella BSI	0	0	0	0	0	0	0	0	0	0	2	0	2
Pseudomonas BSI	0	0	0	0	0	0	0	0	0	0	0	0	0
VRE BSI	0	0	0	0	0	0	0	0	0	0	0	0	0
IGAS	0	0	0	0	0	0	0	0	0	0	0	0	0
TOTAL	2	1	2	1	3	2	1	2	1	0	3	2	20

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	2024-25
C-diff	15	5	5	7	10	6	7	7	6	9	12	7	3	6
E coli BSI	1	3	4	7	4	6	9	7	16	11	11	4	9	8
MRSA BSI	1	0	0	2	0	0	0	0	0	1	1	0	0	0
MSSA BSI	0	0	0	0	0	3	0	6	2	2	2	2	3	0
Klebsiella BSI	0	0	0	0	0	0	0	1	3	1	4	2	1	1
Pseudomonas aeruginosa BSI	0	0	0	0	0	0	0	0	4	1	1	0	2	0
VRE BSI	0	0	0	0	0	0	0	0	1	1	1	0	1	0
Carbapenemase-producing Enterobacteriaceae (CPE)	0	0	0	0	0	0	0	0	0	1	0	0	0	0

Period of increased incidence of *Clostridioides difficile* (PII) 2024-25:
During March -April 2025, two patients were identified to have Non toxin producing (non-reportable) C. difficile on Henry Tudor Ward.

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.

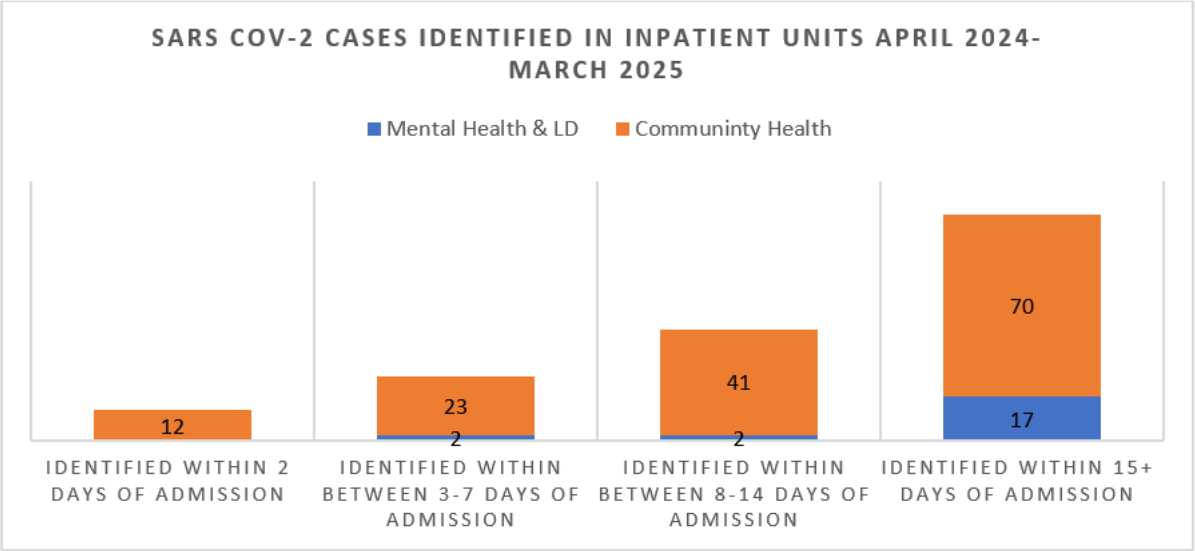
Discussion was undertaken with the ward manager and shared learning identified from review of the cases and the weekly monitoring disseminated to the ward team and included in the IPC training and IPC shared learning processes. The period of increased incidence was concluded on 12/05/2025 due to no further 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 a ward (for example those patients admitted known to be positive)



48 cases of Influenza, 8 cases of Respiratory Syncytial Virus (RSV) and 21 cases of Norovirus were reported from inpatient units during 2024-25.

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 2024-25, 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 confirmed or suspected infection also identified, 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 2024-25:

Berkshire Healthcare Inpatient outbreaks	OUTBREAKS												
	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	TOTAL
COVID-19	1	4	2	3	1	5	3	1	2	2	0	3	27
Influenza	0	0	0	0	0	0	0	1	6	6	1	0	14
RSV	0	0	0	0	0	0	0	0	2	0	0	0	2
Norovirus	0	0	1	0	0	0	0	0	1	0	1	2	5
PII (CDI)	0	0	0	0	1	0	0	0	0	0	0	0	1
iGAS	0	0	0	0	0	0	1	0	0	0	0	0	1

Tuberculosis

Two cases of Tuberculosis were identified at Prospect Park Hospital requiring contact tracing of patients and staff. Review remains ongoing in conjunction with UKHSA and Occupational Health services.

Invasive Group A Streptococcus (iGAS) outbreak

On 9th October 2024, the clinical team on Henry Tudor Ward were notified by both the consultant microbiologist and the UKHSA about a male patient reporting invasive Group A Streptococcus **(iGAS)** bacteraemia from a blood culture obtained on 8th October 2024.This patient was initially admitted on 24/09/2024 and the blood culture was obtained due to clinical deterioration and symptoms. The patient was moved into a single room with isolation precautions on receipt of the results. As per the UKHSA guidance staff and patients contacts were identified and warn and inform letters were provided. Enhanced surveillance period was commenced and enhanced cleaning was continued. Patient contacts were reviewed, and post exposure prophylaxis provided. On 18th October 2024, a female patient was identified to have **iGAS** from a blood culture obtained on 15/10/2024.This patient was transferred to acute trust on 16th October 2024 for further management.

An outbreak was declared on 18/10/2024 by the UKHSA and an incident review meeting was held on 23/10/2024.Patients and staff screening was recommended to understand the extent of the situation. An internal action plan was commenced in collaboration with the clinical service and the OH provider was assigned to lead staff screening. Ongoing review continued with an enhanced surveillance period of six months implemented. To date, no further cases identified. The outbreak was stepped down following a final IMT meeting 29/04/2025.

Shared learning from outbreaks and incidents:

- Prioritisation of single rooms is to be undertaken in line with clinical indication and the IPC patient pathway.
- Clinical specimens must be obtained promptly when clinically indicated.
- Specimen requests must be labelled in full for accurate and timely reporting of results.
- A process for reviewing and actioning available results during out of hours must be in place.
- The IPCT must be notified about outbreaks and incidents for further guidance & support.
- Staff must be aware of the single use icon, and that single use items are to be used once and disposed of.
- Patients with unexplained onset of type 5-7 stool must be isolated and specimen obtained in a timely manner.
- Visitors must be informed of and supported with guidance for avoiding visitation with infectious symptoms.

Appendix 3 – Summary of Learning from Datix Incidents 2024-25

Review of Datix incidents
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 and disseminated in a quarterly IPC shared learning document.
During April 2024-March 2025, a total of 490 Datix incidents were reviewed by the IPCT.

Key messages identified
Staff must ensure to immediately dispose all used sharps into the sharp's bins.
Safety mechanism must be applied prior to disposing used safety needles.
Sharps bins must be assembled correctly to prevent spillage of sharps.
Staff must use safety blood sugar monitoring needles
Staff must be vigilant when undertaking sharps procedures to reduce the risk of injury.
Sharps bins must be assembled correctly to prevent spillage of sharps.
Staff must use safety blood sugar monitoring needles
Patients' rooms must be thoroughly cleaned following discharge to prevent transmission of infections
Staff must be vigilant when dealing with body fluids to prevent exposure
The need for indwelling catheter must be reviewed and removed when patients are reporting clinical signs of infections.
Sharps bins must be closed and labelled prior to disposal.