Board of Directors - Public

SUMMARY REPORT	Meeting Date:	28 September 2022
	Agenda Item:	19

Report Title:	**Infection Prevention and Control Annual Report**	
Author(s):	Dana Wood, Interim Lead for Infection Prevention and Control	
Accountable Director:	Beverly Murphy, Director of Nursing, Professions & Operations	
Other meetings this paper has been presented to or previously agreed at:	**Committee/Tier 2 Group/Tier 3 Group**	Infection Prevention and Control Committee (IPCC) Quality Assurance Committee (QAC)
	Date:	IPCC – 28 July 22 QAC -10 August 2022
Key points/ recommendations from those meetings	Report was presented to the committee for review and endorsement. The following additional actions were requested by the committee to support improvements in IPC practice. 1. Support clinical areas to understand the foundation standards and undertake the following back to basics activity a. Regular Hand Hygiene and BBTE activity in clinical areas, utilising the UV light boxes to demonstrate robustness of staff existing practice. b. Communications to go to Ward Managers and Responsible Clinicians reminding them of the covid screening standards for transfer and on admission to inpatient settings.	

Summary of key points in report

This report has been to Quality Assurance Committee on 10 August 2022 and is presented to Board to provide information and assurance around the progress made against the annual programme for 2021/2022 in the 8 categories of the programme, including training and education, audit, surveillance and cleanliness. The paper also provides progress reporting against the 2021/22 annual plan and a copy of the 2022/23 IPC workplan.

The main risks highlighted within the report are:

- Poor sharps and waste management practices. Consideration regarding the potential legal and financial implications of failure to meet required standards.
- Staff not consistently Bare Below the Elbows (BBTE)
- During the annual audit activity, the majority of services received a caution (12) or fail (6) following audit. Fails are formally monitored through improvement plans.
- Problems with the utility of the information provided by the voluntary surveillance form (now

amended)

- Staffing issues in the IPC Team after resignation of the IPC Lead and IPC nurse and an Interim IPC Lead being employed at the end of February 2022 (Full team in place from Q1 of the next reporting year – June 2022)

The latter 2 issues have now been resolved therefore no ongoing risk. Issues identified through audit for services at Buckwood View and Birch Avenue have been shared with the appropriate provider for the service (Guinness and South Yorkshire Housing)

Assurance provided by the report include:

- Exceeded hand hygiene training target compliance target of 80% however despite achievement of this, issues with BBTE on inpatient areas.
- Introduction of Aeseptic Non Touch Technique training
- 74% uptake of Flu vaccination across SHSC services
- All but 1 action achieved on the 2021/22 annual plan.

Recommendation for the Board/Committee to consider:

Consider for Action		**Approval**		**Assurance**	**X**	**Information**	**X**

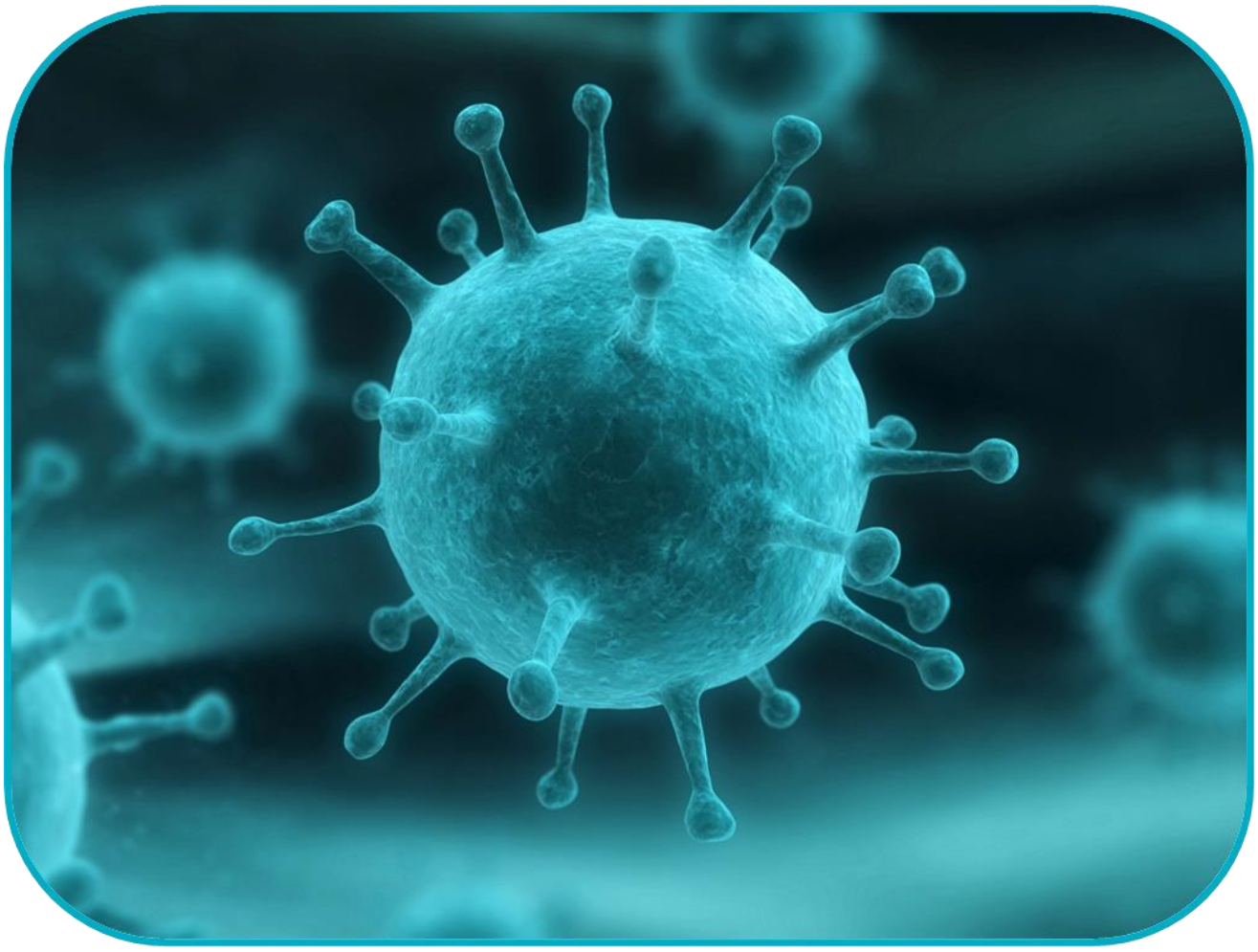
It is recommended that Board receive this report as an accurate reflection of the work undertaken against the 2021/2022 IPC programme. There is a new programme in place for 2022/2023 to build upon this progress for agreement.

Please identify which strategic priorities will be impacted by this report:				
Covid-19 Recovering Effectively	***Yes***		*No*	
CQC Getting Back to Good	***Yes***		*No*	
Transformation – Changing things that will make a difference	*Yes*		***No***	
Partnerships – working together to make a bigger impact	***Yes***		*No*	

Is this report relevant to compliance with any key standards ?					State specific standard
Care Quality Commission Fundamental Standards	***Yes***		*No*		
Data Security and Protection Toolkit	*Yes*		***No***		
Any other specific standard?					

Have these areas been considered ? YES/NO					If Yes, what are the implications or the impact? If no, please explain why
Service User and Carer Safety and Experience	*Yes*	*x*	*No*		Consideration of impact of inadequate IPC approaches on service user experience and outcomes
Financial (revenue &capital)	*Yes*	*x*	*No*		Best use of available resources. Risk identified in relation to potential fines from poor waste management in clinical areas.
Organisational Development /Workforce	*Yes*	*x*	*No*		Consideration of training required to meet standards and impact on workforce capacity.
Equality, Diversity & Inclusion	*Yes*		*No*	*x*	N/A
Legal	*Yes*	*x*	*No*		Consideration of legal implications of failure to meet required standards. Risk identified in relation to potential fines from poor waste management in clinical areas.
Sustainability	*Yes*		*No*	*x*	N/A

Infection Prevention & Control
Annual Performance Report
2021 – 2022



Produced by Dr Dana Wood, Interim Lead, Infection Prevention and Control

Proud to care in Sheffield

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1 Introduction

1.1 Infection prevention and control (IPC) is a practical, evidence-based approach which prevents service users and health workers from being harmed by avoidable infections. Preventing health care-associated infections (HCAI) avoids unnecessary harm and at times even death, saves money, reduces the spread of antimicrobial resistance (AMR) and supports high quality, integrated, people-centred health services.

1.2 The Annual Report of the Infection Prevention and Control Team provides a retrospective overview of the activities carried out to progress the prevention, control and management of infection within Sheffield Health and Social Care NHS Foundation Trust (SHSC) during the last year (April 2021 – March 2022).

1.3 The Infection Prevention and Control Team provide a service to all the Clinical and Corporate Services within SHSC and aims to optimise individuals' care; whilst protecting Service users, staff and others from the risk of cross contamination and outbreaks of infection.

1.4 The Infection Prevention and Control Team strive to promote and embed current evidenced-based best practice guidance regarding the prevention of infection and control when necessary in accordance with:-

- The Health & Social Care Act 2008 (2015): Code of Practice on the Prevention and Control of Infections and related Guidance. (Hereafter referred to as the 'Health Act 2008').
- Board Assurance Framework
- NHS Litigation Authority Standards for Mental Health and Learning Disabilities
- CQC Fundamental Standards

1.5 The core aim of the Infection Prevention and Control Team is to support the organisation at all levels, to deliver clean safe care and provide assurance that the Trust is complying with standards set out in the Health Act 2008 and the Care Quality Commissions' Fundamental Standards.

2. Governance Arrangements

It is noted within the Health Act (2008) that the Board of Directors has a duty to have in place *"Appropriate Management Systems for Infection Prevention and Control".*

The NHSLA Risk Management Standards for Mental Health and Learning Disability Trusts specifies that the Trust must *"Have a Process for Managing the Risks associated with Infection Prevention and Control. Infection Prevention and Control should be an integral part of Clinical and Corporate Governance".*

The overall monitoring of the Infection Control programme is via:-

- Trust Boards Monthly Quality and Safety Dashboard
- Quarterly Infection Prevention & Control Committee.
- Quarterly and Annual Report to the Quality Assurance Committee
- Quarterly performance reporting to the Clinical Care Networks Governance Meeting.

2.1 The Role of the Infection Prevention and Control Team (IPCT)

2.1.1 The role of the Infection Prevention and Control Team (IPCT) is to provide expert advice to minimise the risk of infection. Its primary functions are to:

- Minimise the risk of infection to Service Users, staff and visitors.
- Produce and review infection prevention and control policies.
- Provide an infection control annual report, which incorporates the infection control work programme.
- Develop audit tools and facilitate the audit programme.
- Lead on the educational content of the Trust's infection control curriculum.
- Provide expert advice regarding infection control in the built environment and support the appropriate purchase and decontamination of medical devices, supporting the Trust's Medical Device Officer and Decontamination Lead.
- Provide expert advice regarding hygiene standards and cleaning frequencies, cleaning materials and equipment, and input on contracts/specifications for healthcare waste and laundry, in conjunction with Hotel Services Manager
- Advise the Trust regarding government guidance and legislation (in relation to infection prevention and control) and measure compliance and support the development of an improvement plan when required.
- Work with Public Health England and the Sheffield Clinical Commissioning Group regarding surveillance and notification of infections.
- Provide advice to all areas of the Trust and to all people who are involved in providing services or in receipt of our care. The advice given is varied, ranging from estate issues to the management and control of infections.
- Play an active role on a number of Trust-wide groups including the Water Safety Group.
- Provide advice to Estates and clinical teams regarding refurbishments, new builds and issues around water quality, healthcare waste and linen management.
- Have close contact with Procurement and provide advice on any infection control related issue pertaining to equipment and devices to be purchased by the Trust by supporting the Medical Devices Officer.

2.1.2 The IPCT have worked creatively and currently the team consists of one WTE Lead clinical nurse specialist Permanent staff member left in February 2022, Interim Lead until June 202, one WTE registered nurse who joined the trust in December 2020 (and left in December 2021) and via a Service Level Agreement with Sheffield Teaching Hospitals, Consultant Microbiology / Infection Control Medical input from Professor Rob Townsend. The team is supported by an administrator.

2.2 Infection Prevention and Control Committee

2.2.1 The role of this committee is to oversee delivery of an effective framework to promote and provide a safe clean environment for staff, services and visitors in terms of infection prevention and control risk, within the scope of current evidence-based practice and knowledge.

The committee provides assurances to the Board, Quality Assurance Committee, and Director of Infection Prevention & Control (DIPC); whilst supporting Service Lines to demonstrate compliance with the legislative & regulatory standards.

3. Performance Summary - Annual Infection Control Programme for 2021 – 2022

3.1 Hand Hygiene

Hand hygiene facilities and practices continue to be monitored via the annual IPC audits which has a section on hand hygiene and the inpatient monthly hand hygiene audits. Hand hygiene standards are also assessed monthly as part of the Tendable Programme which has now been rolled out to all inpatient areas.

3.2 Education and Training

3.2.1 The Health and Social Care Act 2008 (2015) requires that all staff require appropriate on-going education which should incorporate the principles and practice of prevention and control of infection. Clinical staff should have an on-going understanding of the risk from existing, new and emerging infectious diseases and take this into account when assessing Service Users.

3.2.2 The Trust's education and training needs matrix contains the infection prevention and control requirements for all staff groups/disciplines. Managers continue to be provided with information on who is compliant with the minimal level of hand hygiene and infection prevention education on a monthly basis via colleagues in the Training Department.

3.2.3 The minimum standards are for all new staff to receive training on corporate induction (known as Core Mandatory training); which covers the basic principles of Standard Infection Control Precautions (SICP). SICP training includes appropriate hand hygiene with soap & water and alcohol handrubs, the use of Personal Protective Equipment (PPE), decontamination of equipment, sharps safety, healthcare waste management, laundry management, spillage management and isolation precautions. All staff with direct care contact receives an IPC refresher session delivered by colleagues in the training department known as 'Mandatory Update' annually. This ensures a robust process to training the workforce regularly regarding IPC practices for assurance purposes and improved recording of training data.

3.2.4 The Quality Account target set by NHS Sheffield Commissioning Group is to have trained 80% of staff in hand hygiene (HH) practices. The Trust has met this target by achieving **91%** by the end of Quarter 4. This is a substantial improvement whereby only 52%-57% compliance has been reported for several years prior to 2015.

3.2.5 IPC training (like many other mandatory subjects) has had to be delivered online virtually this year due to the Coronavirus pandemic. The induction session was moved virtually and consisted of a PowerPoint presentation with a voiceover to accompany the slide deck. Knowledge was tested via passing a written short answer/multiple choice assessment returned to the training department with a pass rating of 80% required, otherwise retaking the test was a requirement. Early in the pandemic the Lead Nurse delivered face to face sessions

on IPC, Coronavirus and the Personal Protective Equipment (PPE) needed based upon national guidance issued at the time. The Training Department now utilises the elfH online training through NHS England as an approved NHS training provider. From Q4, training attendance is now reported differently with completion of either level 1 or level 2 IPC online training.

3.2.6 IPC staff intranet page has been updated considerably over the last year whereby the resources offered to staff on a variety of IPC issues can be located centrally for easy access and reference. In addition to this, the Lead Nurse has been supporting/writing/updating the content on a high proportion of the information located on the Covid19 Knowledge Hub maintained by the Communications Team.

3.2.7 As part of the link between IPC and the Physical Health agenda, aseptic non-touch technique (ANTT) training was offered to in-patient areas within the organisation. This has already begun and will continue into the next annual programme

3.2.8 One of the major issues identified during the annual IPC audits in inpatient settings is that the majority of staff were not aware and were not practicing the PPE donning and doffing procedures implemented early in the covid 19 pandemic. To address this, virtual sessions looking at donning and doffing and what constitutes a breach have begun and these will continue into Q1 of the 2022-2023 programme

3.3 Surveillance – Mandatory & Voluntary

3.3.1 The Health & Social Care Act 2008 (2015) requires organisations to provide quality information on Health Care Associated Infection (HCAI), antimicrobial resistant organisms and infectious diseases. This information is essential to monitoring the progress, investigating underlying causes and instigating prevention measures. The IPCT have developed a simple monitoring process for collecting voluntary data that involves a monthly surveillance survey, plus ad hoc reporting directly into the team by inpatient areas and care home settings. However, this does not extend to monitoring in the Clover Group GP practices under the Trust as this is undertaken by the Syndromic Surveillance Systems established by Public Health England (PHE).

3.3.2 The IPCT acknowledge that the data provided is not statistically robust, due to areas not complying fully with the requirement to gather the requested surveillance information or submit it in a retrospective timely manner. To try and improve this, the Lead Nurse met with the inpatient Governance Officers. The tables below identify the level of compliance by Clinical teams in providing the relevant information and shows a comparison to last year's data. If the areas provide data more than 75% **(GREEN)** of the time (over the 12-month period April - March); they are deemed as compliant. Returning data 50% - 75% of the time during the year equates to a caution **(AMBER)** and areas providing data less than 50% of the time are recorded as non-compliant with data returns and colour-coded **(RED).** Areas highlighted in **(BLUE)** have consistently submitted their data every month and in the required timeframe.
These tables clearly show where areas have either improved or fallen below expected standards. The level of compliance has been shared at the Infection Control Committee and reported quarterly in the IPC performance report. Late submission is escalated to the Heads of Nursing and General Managers to address directly in the areas of which they are responsible. There has been an overall reduction in returns being on time but there have been staff changes, illness and so on which have contributed to this in some areas.

Table 1a and 1b Surveillance completion compliance

Surveillance Compliance April 2021 – March 2022	
Area	**Compliance %**
Acute	
Burbage	67%
Dovedale	58%
Forest Close	83%
Forest Lodge	92%
Endcliffe	83%
Maple	67%
Stanage	33%
Specialist	
Birch Avenue	100%
G1	92%
Woodland View	
Beech	closed
Oak	100%
Willow	100%
Community	
Wainwright Crescent	100%
Learning Disability	
Buckwood View	92%
Firshill Rise	CLOSED

Surveillance Compliance April 2020 – March 2021	
Area	**Compliance %**
Acute	
Burbage	50%
Dovedale	100%
Forest Close	94%
Forest Lodge	92%
Endcliffe	100%
Maple	75%
Stanage	83%
Specialist	
Birch Avenue	100%
G1	100%
Woodland View	
Beech	Closed
Oak	100%
Willow	100%
Community	
Wainwright Crescent	100%
Learning Disability	
Buckwood View	83%
Firshill Rise	100%

3.3.4 Mandatory surveillance of Alert organisms continues to be collected and the table below shows the number of positive cases we have had for each organism this year.

Table 2 Alert Organism Annual Cumulative Cases

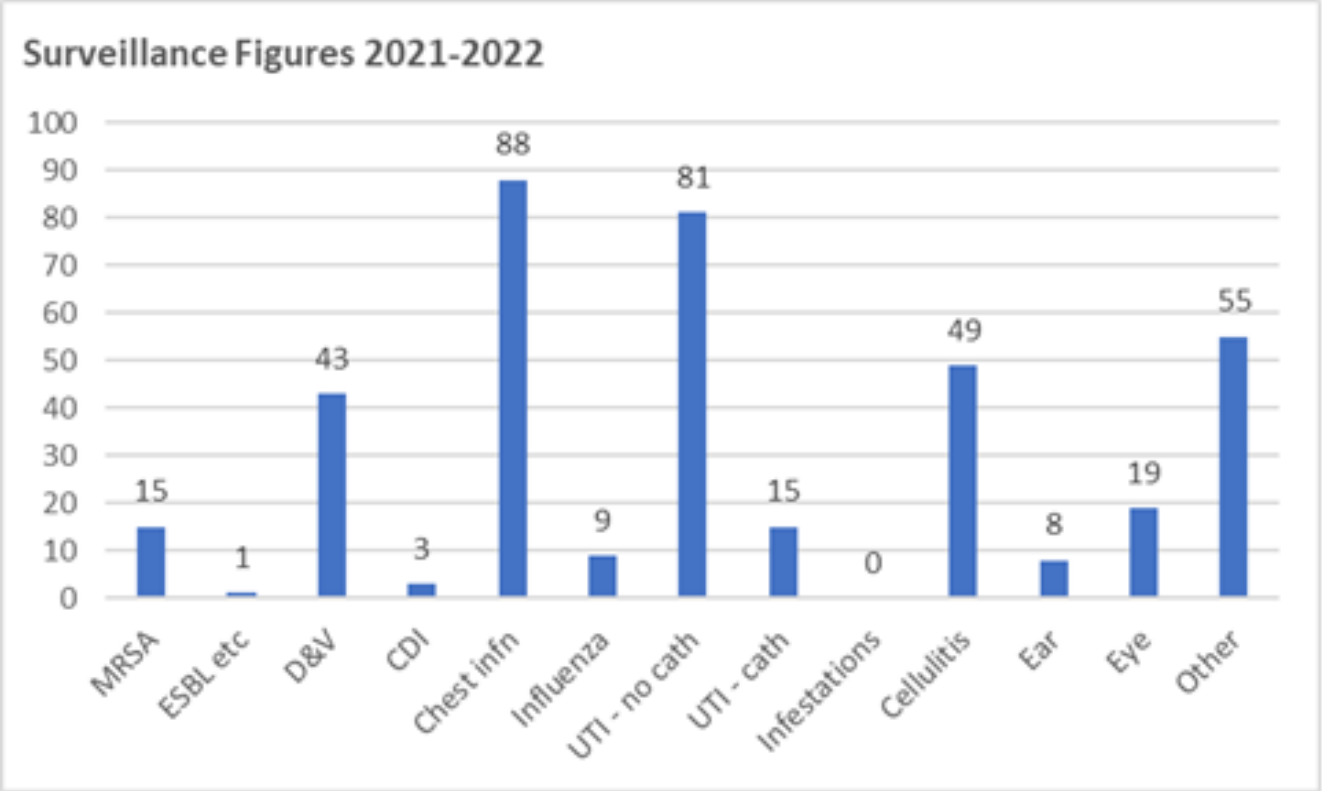
Alert Organism	Annual Cumulative Case Total
MRSA Bacteraemia	0
MSSA Bacteraemia	0
***Escherichia Coli* Bacteraemia**	0
***Clostridium difficile* Toxin producing diarrhoea**	3

3.3.5 81 Urinary Tract Infection (UTI) cases (Service User who are not catheterised) and 14 cases in those with a urinary catheter insitu have been reported. Reported chest infections are recorded as 88.

3.3.6 The surveillance form has now been reviewed and updated so that it provides information specific to infections acquired whilst in the Trust as opposed to collecting information about factors which might impact on infections and infections that patients arrived at the Trust with. This will provide more useful information for the IPCT in terms of trends and areas of concern.

Table 3. Surveillance data – Infections 2021-2022

Infection	Quarter 1	Quarter 2	Quarter 3	Quarter 4	ANNUAL TOTAL
MRSA	1	5	5	4	15
ESBL etc.	0	0	1	0	1
Diarrhoea & vomiting	11	7	10	15	43
Clostridium difficile	0	2	1	0	3
Chest infection	13	36	20	19	88
Influenza	1	6	1	1	9
UTI – no catheter	16	21	22	22	81
UTI – catheter	2	4	4	5	15
Infestations	0	0	0	0	0
Cellulitis	7	10	18	14	49
Ear	1	2	2	3	8
Eye	9	2	4	4	19
Others	16	7	12	20	55



3.4 Coronavirus Pandemic (Covid19)

In late December 2019 a new (novel) coronavirus was identified in China causing severe respiratory disease including pneumonia. The virus causing the infection has been named - severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) this is a new strain of coronavirus causing Covid19. SARS-CoV-2 infections are spreading between people globally, and the situation was declared a pandemic on the 12th March 2020. Since 19 March 2020 Covid19 is no longer categorised as a High Consequence Infectious Disease (HCID) in the UK. The situation was declared a pandemic on 12th March 2020. As a newly identified virus there was no known human immunity to it and no vaccine was available to prevent infection. As a viral infection, antibiotics are not an effective treatment.

It was a fast-paced evolving situation and as with any new strain of virus, the guidance for healthcare workers and health and social care services was rapidly being developed and updated frequently. This reflects the need to take a view of the global situation as well as the situation across the UK. Alongside a growing understanding of the infection risk of this new virus; incubation time, infectiousness, severity of the infection for some individuals alongside specific demographic and ethnicity risk factors, many significant challenges were faced in the early days in supporting the trust's response to the pandemic. It must be acknowledged that for the vast majority of this reporting period (April 21 to December 22), there were staffing issues within the Team, with the Band 6 being away from her post from the end of December 2021 and the Lead leaving in February 2022 to be replaced by an interim Lead with no band 6 support.

The exact response to the pandemic will reflect the nature, scale and location of infection as the situation developed over the course of last year and now continues, with caution as

trepidation of a further wave later this year. Due to the significant spread and infection rates in the local Sheffield population, it was inevitable to see cases of Coronavirus admitted and identified within our inpatient settings, care home facilities and staff.

3.4.1 Covid19 Outbreak Summary

Birch Avenue
Outbreak Jan 2022 involving 1 patient and 6 staff
Cluster involving 3 staff members March 2022

Maple
Outbreak involving 5 patients and 5 staff Jan 2022
Outbreak involving 1 patients and 3 staff March 2022

G1
Outbreak involving 3 patients August 2021
Outbreak involving 12 staff and 4 patients Dec 2021

Dovedale 1
Outbreak involving 9 staff and 1 patient Dec 2021

Woodland View
Outbreak involving 13 staff and 2 residents Dec 2021

Forest Close Ward 2
Outbreak involving 8 staff and 4 patients Dec 2021
Outbreak involving 3 patients and 10 staff in Jan 2022

Fitzwilliam Centre
Outbreak involving 6 staff Sept 2021 6 patients and 5 staff in Jan 2022

Endcliffe
Outbreak involving 11 staff Jan 2022]

Stanage
Outbreak involving

In addition, Birch Ave had an outbreak involving 4 staff in April 2022, Forest Lodge had an outbreak involving 4 staff and 7 patients in April 2022, G1 had an outbreak of diarrhoeal illness in April 2022 and G1 subsequently had an outbreak involving 4 staff and 7 residents in April and May 2022.

3.5 Summary of Meticillin Resistant *Staphylococcus aureus* (MRSA) screening

People admitted to Mental Health Trusts do not need to be screened routinely for MRSA as there is no evidence of any significant risk of MRSA bacteraemia in this service user group. However, Service Users may have other clinical conditions that may put them at an increased

risk of MRSA (see below) and thus a Bacteraemia; in this instance offering screening will be required

The overall annual screening compliance is recorded as **57.39**%, which is a slight reduction on last year. Concerns were raised about staff being unclear about who required screening which was affecting the accuracy of data. Information was sent out via comms and the Inpatient Managers' Meeting about this issue.

3.6 Annual Audit Programme

3.6.1 The infection prevention and control audit programme is fundamental in monitoring and measuring standards within the Trust. The different audit tools utilised enable a robust picture to be demonstrated and encompasses the following domains: environment, care practices e.g. sharps practice, hand hygiene facilities, waste & linen management, decontamination of equipment, laundry rooms and personal protective equipment provision.

3.6.2 A total of **21** observational site visits were undertaken during 2021-2022.

3.6.3 Compliance with the IPC audit is set at 90% and above; positively at the time of preparing this report, **3** areas are achieving a pass rating. **12** areas are achieving a caution rating. This means that those areas are reaching an audit score between 80% - 89%. However, **6** areas have failed their audit and Improvement action plans are in place for these areas; progress formally monitored by the Infection Control Committee and locally by General Managers, Governance Officers and additional support from Heads of Nursing.

3.6.4 Where audit deficits have been identified, areas/services are responsible for producing their own improvement plans to address these issues. Should any challenges hindering completion of improvement plans be identified at a local level, they are escalated to the Infection Control Committee by the Heads of Nursing for their respective areas. All improvement plans are formally monitored by the Committee in their quarterly meetings. A further announced supportive follow-up visit is made to the area three months after submission of the improvement plan to check on progress and some of these have taken place in Q4. Of these eight revisited, all have improved their scores except one area which remains the same and all but one are in the 'caution' category after revisit with the remaining one passing.

3.6.5 The audit results have highlighted some examples of common themes Trust-wide which require attention and improvement, these are:

- Poor sharps management practices leading to an increase in reported sharps incidents and near misses – a Blue Light alert was distributed regarding this
- Poor waste segregation with PPE being disposed of in the household waste stream in several areas and household waste being disposed of in offensive, infectious and recycling waste streams
- Staff not being BBTE which has been a consistent theme for some time. Comms have since gone out about this and a handwashing roadshow across the Trust took place at the end of May / beginning of June 2022.

3.7 Patient-Led Assessment of the Care Environment (PLACE)

Due to the national pandemic, NHSE/I suspended the PLACE programme.

3.8 Mattress Audits

3.8.1 Currently the mattresses are audited monthly by the individual Wards / Nursing homes and remain their responsibility. To monitor this compliance areas are asked to complete the relevant section on the Surveillance returns which should be submitted monthly to the IPCT.

3.8.2 Mattresses have always been fundamental medical devices in healthcare; but often very unappreciated and overlooked. Mattresses remain the most consistently utilised service user surface, and without effective cleaning, maintenance protocols, and inspection regimes pose a serious risk to infection control practices and standards in the care environment. To ensure mattresses remain 'fit for purpose' and clinically effective it is recommended that their condition should be checked on a regular basis.

3.9 Antimicrobial Stewardship

3.9.1 An antimicrobial is a substance that kills or inhibits the growth of microorganisms (germs) such as bacteria, fungi, and viruses; and covers the effective use of antimicrobials (i.e. antibacterial, antiviral, antifungal and antiparasitic medicines) to reduce the emergence of antimicrobial resistance (loss of effectiveness of antimicrobials) to treat infections.

3.9.2 Antibiotic stewardship refers to a set of coordinated strategies (supported via NICE Guidance and DHSC Tackling antimicrobial resistance 2019–2024 The UK's five-year national action plan); to improve the use of antimicrobial medications with the goal of enhancing patient health outcomes, reducing resistance to antibiotics and decreasing unnecessary costs. The Trust antimicrobial guidelines were updated and approved in November 2019. The updated guidelines include the requirement for all Trust prescribers, pharmacists, and pharmacy technicians to complete an E-Learning course titled 'Introduction to antimicrobial resistance package'.

3.9.3 Antimicrobial stewardship is a core responsibility for all Trust and the Pharmacy Department take a lead on this to ensure antibiotic compliance. An overview of the numbers of Service User receiving antibiotics throughout the year is recorded by the pharmacy team on a spreadsheet, this system has replaced the previous one which was highlighted to have some gaps in collation.

3.10 Incident Reporting: Sharps Practice & Audit

3.10.1 A total of **154** incidents have been reported to the IPCT during this reporting period. This is a significant reduction from last year (201).

3.10.2 Frequent types of incidents reported summarised below:

- Deliberate biting and spitting of saliva towards staff

- Exposure to bodily fluids including deliberate spillage of bodily fluids by individuals

3.10.3 There have been **12** contaminated/dirty sharp related incidents reported. These relate to poor sharps practice, for example leaving sharps discarded in clinic rooms after use and staff not adhering to Insulin administration protocol, for those patients who self-administer. These incidents were addressed by ward managers and the Lead Nurse reiterated the correct procedures to be followed when administering Insulin and has raised the issue with Physical Health Team colleagues. In addition to these injuries there have been 6 sharps related incidents where an injury was not sustained

Table 4 Contaminated (Inoculation Injuries)

Date	2018 - 2019	2019- 2020	2020 - 2021	2021 - 2022
Contaminated Needlestick injuries sustained by staff	5	8	7	12

3.10.4 Daniels Healthcare facilitated an annual Trust-wide sharps container audit in May 2021. The audit report was presented to the Infection Control Committee in October 21. A total of **47** sharps containers audited across **24** areas/departments of the Trust. The main areas of concern which requires action by clinical teams are:

- 1 sharps container had the wrong-coloured lid on the wrong base
- 7 sharps containers had significant inappropriate non sharp contents. Staff should be advised not to put packaging or non-sharp items in sharps containers
- 12 sharps containers did not have the temporary closure in place when the container was left unattended or during movement.

3.10.5 Since this audit, sharps management has been audited again in inpatient areas as part of the annual IPC audit programme. During these audits, poor practice has been identified including bins not being assembled correctly, being overfilled, not being labelled and being in use for more than the 3 months. This is what led to the Blue Light alert being distributed and a video being produced linked to this.

3.11 Staff Influenza Vaccination Campaign

3.11.1 Influenza can cause a spectrum of illness ranging from mild to severe, even among people who consider themselves as previously well, fit and healthy. The impact on the general population varies from year to year depending on how many people are susceptible, any changes to the influenza virus and the severity of the illness caused by the strain in circulation. The capacity for the virus to mutate/change and the duration of the protection from the vaccine (about one season), are the reasons that the vaccine is tailored each year to protect against the most commonly circulating strains and why annual vaccination is necessary.

3.11.2 Every year influenza vaccination is offered free to NHS staff as a way to reduce the risk of staff contracting the virus and transmitting it to the Service Users in their care, protecting themselves and their own families. This year a small task and finish group co-ordinated by the Deputy Chief Operating Officer delivered the campaign to our staff. The Trust achieved an uptake rate of **74%** which is down from last year's 82% but much higher than the previous year's of 52%

3.11.3 Encouraging more staff to get vaccinated remains a significant challenge to the Trust and as with previous years there continues to be a core cohort of staff that refuses the vaccine due to personal attitudes that they believe that the annual influenza vaccine will not be of benefit to them. Traditionally we are one of the lowest performing Trusts in the country; and have been for a considerable number of years, but this year we have significantly improved our uptake rate.

3.12 Cleanliness of the Environment

3.12.1 While significant progress has been made in improving cleanliness across the Trust standards must be maintained and improvements sustained. All staff should be aware of their roles and responsibilities regarding cleaning and decontamination. Clinical and support staff undertaking the cleaning of reusable equipment must be trained in the correct cleaning and decontamination procedures.

3.12.2 When new items of equipment are considered for purchase, the manufacturer's advice on cleaning must be sought and training if required must precede use. The IPCT promote that careful consideration should be given to the consequences of the purchase of any item of equipment that is not capable of being cleaned or decontaminated to appropriate IPC standards, unfortunately this is not always the case in the Trust. However, the Medical Devices and Therapeutic Equipment Group has been supporting this coupled with the new Procurement Policy which should help to improve processes regarding standardisation, purchasing and decontamination issues. Additionally, last year the Trust successfully recruited to the role of Medical Devices Officer who is responsible for progressing this agenda.

3.12.3 A visibly clean environment will provide reassurance to Service Users that they are receiving safe care in a clean environment. A clutter-free environment and the adoption of local 'clean as you go' attitude will provide the foundation for delivering high-quality care in a clean, safe place. Due to Covid19, all areas were expected to increase the daily frequency of cleaning 'high touch' items to help prevent the spread of infection. This involved all staff taking an active collective responsibility in cleaning the workplace and not just reliant upon the housekeeping workforce to complete this. This has been stepped down to twice daily in areas where there is no active infection and back to pre-pandemic levels in non-clinical sites such as Fulwood.

3.12.4 The Hotel Services Manager has been proactively supporting staff with the monthly Environmental Cleaning Audit process. The Senior Housekeepers undertake peer review on a quarterly basis and the Lead Nurse and Hotel Services Manager would usually undertake an annual 'management review' to validate/review the consistency of the audit process and monitor the standards of cleanliness. Cleanliness scores are reported quarterly via the IPC Performance reports which are received by the Clinical Care Networks.

3.12.5 Inspections of main kitchen environments are now audited as a separate process by the Hotel Services Manager on an annual basis. These audits supplement any inspections carried out by the Local Authority's Environmental Health Officers.

3.13 Water Quality & Safety –

3.13.1 Annual Audit by a Trust-Appointed Independent Water Consultant:

- All Trust-owned and leased properties have up-to-date legionella risk assessment, this is to be reviewed determined on Compass ppm completion. Due to the pandemic, limited access to Ward areas, availability of contractors and in house staff, completion of ppm has not been completed to the required level, this will be analysed over the next 6 months to determine is some sites do require a new risk assessment.
- Estate services management and maintenance personnel have completed training and have the expertise to fulfil statutory requirements. There is a requirement to carry out awareness training for Trust staff and this is scheduled to take place later in the year. Later in the year senior Estates staff will have to have their Responsible Person Water revalidated by completing the required course.
- The Trust's appointed Water Quality consultants and Authorising Engineer (AE) reported that the Trust has a robust system in place to prevent the build-up of organisms such as legionella and pseudomonas in its water systems; but does have concerns about the level of completed ppm. Robust efforts are ongoing to streamline the Compass monitoring system so that not as many jobs appear to be uncompleted.
- The Water Quality Steering Group (WQSG) has continued throughout the year in the main virtually via MS Teams, unfortunately clinical attendance has been sporadic but it is hoped that this will change over forthcoming meetings. The group was set up to comply with recent legislation and implement actions to ensure water quality is maintained throughout trust premises. The group also comments and makes recommendations as a result of Audit findings and Risk Assessments. Crucially it provides advice and input into Capital Schemes. It is hoped that the group will be attended by a range of representatives from Trust Directorates. Reports are received at the ICC.
- A Water Safety Plan has been developed and its requirements enforced.
- Sampling for Pseudomonas continues to be carried out on an annual basis as agreed at the ICC.
- Action plans have been drawn up for all remedial work highlighted in Risk Assessments and is on going
- The recording of flushing via the electronic online system (Compass) has been a success story throughout the year, with over 90% compliance completed throughout the year.

3.13.2 Annual Site Summary in Brief

<u>Michael Carlisle Centre</u>
Decommissioned the site heating main and installed 4 new boilers. This will provide resilience of heating and hot water for Stanage, Dovedale 1 and the Administration block.
Estates are currently servicing and overhauling the four plate heat exchangers which provide hot water for the site.
All cold water storage tanks are to be cleaned in the next few weeks.

Burbage ward is currently being refurbished. Scheduled to be completed end of July 2022. Hydrop have consulted on the installation.

Stanage will decant to Burbage ward and Stanage will then be refurbished.
SAANS unit has had a new hot water generator installed.
The site is to have a new CLO2 (Chlorine Dioxide Unit) installed, to replace the existing unit.

Grenoside Grange
Cold water storage tanks have been cleaned and disinfected.
Two new hot water generators have been installed to replace existing. N+1 to provide resilience.
One tank is currently drained down but will be brought back into commission if there is a demand on water usage.

Longley Centre and PICU
Water tanks are due to be cleaned in the next few weeks.
Site continues to be occupied after previously being vacated. New pipework is installed and chlorinated. There are plans for Liaison Psychiatry to move into the now vacated University department.
The water system appears to be under control with no bacterial counts from recent samples. The water supply to Hawthorn and Pinecroft remains isolated with the exception of the kitchen corridor. One of the Cold-Water Storage Tanks remains isolated. Work on Maple Ward to create single rooms has been undertaken, pipework, wash hand basins and showers disinfected and sampled.

Woodland View Nursing Home
Water tanks are to be cleaned and disinfected.
Beech Cottage has been refurbished. New pipework installed throughout. Hydrop consulted on installation. Remedial works following Hydrop inspection to be completed by the contractor.
PPM, Chlorination and regular sampling continues to provide an assurance that the water system is at an acceptable level of control. Beech Cottage is undergoing a complete renovation to provide single en-suite room accommodation. Hydrop are the water consultants, who on completion of the works, will ensure the system will be handed back with a full suite of compliance reports.

Forest Lodge
PPM and sampling confirmed that the water quality has been maintained.

Forest Close
Bungalow 3 is currently unoccupied and all outlets are flushed on a daily basis. Still waiting for confirmation that refurbishment will take place this financial year.

Longley Meadows
The unit remains unoccupied - Estates colleagues continue to carry out flushing of all outlets.

Wardsend Road
The site has undergone a complete renovation - again Hydrop have been the consultants. The building is now fully occupied. Defects still need to be rectified by the contractor. Capital team are aware. Meeting to be arranged with contractor to ascertain how many defects have now been rectified.

Cold Water Storage Tanks

All cold-water storage tanks were inspected over the past 12 months. Currently waiting to be cleaned.

Risk Assessments
Hydrop have been commissioned to carry out risk assessments across sites. This will take place before the end of Quarter 2 2022-23.

Sampling
Water sampling continues and during 2021-22 identified the out of specification results at:-
Dovedale 2 Ward - Pseudomonas aeruginosa was identified on Dovedale 2 Ward. The problem is localised - from a sink in the service users' WC. 60°C thermal disinfection was been carried out and clear results achieved.

Grenoside Grange - Kitchen cold water tap

Forest Close 1a – raised coliforms

Woodland View – Legionella Pneumophilea detected – Willow entrance bathroom

All outlets cleaned, disinfected and resampled retuning clear results. Sampling regime continues.

- Grenoside Grange – Kitchen cold drinking tap – now clear
- Forest Close 1a – raised coliforms – clear on 16/11
- Woodland View – Willow entrance bathroom – Legionella Pneumophilia – outlet cleaned and disinfected – resampled on 10/12 – awaiting results

4 Acknowledgements

The Interim IPC Lead wishes to acknowledge the following colleagues in providing the information & data used to produce this report:

- Mark Gamble – Head of Estates / Water Responsible Person
- Janet Mason - Hotel Services Manager
- Paul James - Information Assistant, Risk Management Team
- Karen Wynn -

Appendix 1

INFECTION PREVENTION & CONTROL 2021 - 2022 ANNUAL PLAN

	= Work not commenced
	= Work not completed
	= Work in progress
	= Action on-going
	= Complete

Objective Area (38)	Action/Activity – to support CQC Fundamental Standards and Health & Social Care Act, Code of Practice	Timescale	Lead	Annual Progress/Assurance	RAGB
Training & Education ***Providing opportunities for all staff to fulfil mandatory requirements to receive IPC training.(6)***	Continue to facilitate Corporate Induction & Mandatory IPC session along with Education Departmental Trainers	March 22	E&T / GH	Session has been fully revised and re-recorded due to T&E dept delivering mandatory training annually via the elfh programme	
	Start to plan, organise & facilitate a full day's IPC & PH conference on behalf of the Trust	March 22	IPC & PH team	No lead nurse as yet for PH, lead IPC nurse left in Feb 22, interim lead in place, new permanent lead starts June 22	
	Provide ad-hoc sessions on a variety of IPC related elements/topics as and when approached by services/areas	March 22	KG /DW/ GH	Band 6 left at beginning of Q4, video produced for sharps management, other ad-hoc sessions carried out throughout the year	
	Facilitate IPC-themed session for newly qualified nurse preceptees	March 22	KG / GH	Carried out in Q3	
	Facilitate IPC session for matrons once in post	Aug 21	KG	Delivered in July 21	
	Develop draft IPC competency framework for band 5 staff nurses	April 22	KG / DW	Draft completed and sent to Liz Lightbown. Since reviewed by Beverley Murphy and need rewriting	
	Asses the need for and develop an ANTT training and competency framework for Nursing staff	March 22	GH / DW	ANTT training began in Q4 and is being rolled over to 22/23 programme	

Objective Area (38)	Action/Activity – to support CQC Fundamental Standards and Health & Social Care Act, Code of Practice	Timescale	Lead	Annual Progress/Assurance	RAGB
Audit ***Monitor compliance with IC policies & guidance through a Programme of audit.(7)***	Develop and carry out a unannounced programme of audit, including across Care Networks for example services in: • Single Point & Crisis & Emergency Care • Scheduled & Planned • Acute Bedded Based Services • Care Homes x3 **Areas where suboptimal compliance is identified; areas must produce a remedial improvement plan to address findings.* **Services/areas to take ownership regarding progression of an improvement plans and to report issues hindering completion both at a care network governance level and via the ICC*	March 22	GH / DW	Programme of audit commenced in Sept 21. GH left beginning of Q4, audits recommenced at end of Q4 by DW. 5 audits rolled over to 22/23 programme and these were completed in May 22	
	Local Audit Tool to be reviewed	Sept 21	KG	Tool reviewed – covid standards included	
	To receive the audit data collected by Daniels in relation to Sharps Policy & practice. **Daniels Healthcare dependent**	Oct 21	KG	Completed Q1 (May) and reported to IPCPH committee	
	To carry out an audit of the hypodermic safety needle practice used within the Trust (EU Safer Sharps Directive)	Feb 22	DW	Audit completed alongside main audit programme in Q4	
	To receive the quarterly audit data collated by pharmacy in relation to antibiotic prescribing findings and make recommendations for improvements in antibiotic stewardship (Antimicrobial Resistance Strategy DH,2013). **To promote prudent antimicrobial prescribing for the management of antibiotic resistance and reducing antibiotic related Clostridium difficile Infection and other Healthcare Associated Infections*	Quarterly Until March 22	Pharmacy Medicines Safety Officer	Audit process reviewed and data collected by Pharmacy and presented to IPCPH committee	
	Develop & carry out a programme of audit on mattresses across the Trust to ascertain how mattresses are performing	Dec 21	KG	External audit not carried out due to Herida availability / covid cases. Internal mattresses audits carried out monthly at each site by housekeeping staff	
	Participate in the multi-disciplinary PLACE Assessments trust wide	Feb 20	Hotel Services	PLACE lite visits all carried out in Q3	
Surveillance – Mandatory & Voluntary	Continue to collate & monitor the voluntary prevalence data to understand how many individuals are affected by a disease or infection at a particular time, and monitor any trends which develop.	March 22	KG /DW/ GH	Data collected & reported	

Objective Area (38)	Action/Activity – to support CQC Fundamental Standards and Health & Social Care Act, Code of Practice	Timescale	Lead	Annual Progress/Assurance	RAGB
In line with National/Local requirements and designed to achieve reduction in HCAI (2)	Continue to monitor & report against the Mandatory Alert Organisms (MRSA, MSSA, E-coli Bacteraemia's & Clostridium difficile) **Supporting the reduction in Gram Negative infections*	March 22	KG / DW/GH	Data collected & reported	
Policies & Protocols ***Ensure compliance with current guidance & legislation to promote quality, evidence based best practice (2)***	To review the IPC policy	May 21	KG	Completed and ratified, available on JARVIS	
	To contribute to all policies or protocols that has relevance to infection prevention and control.	March 22	KG / DW	Input as required including SOP for accepting covid cases onto the DU	
Preventative & Case work ***Activities to demonstrate that effective IPC is central to providing safe, high, quality service user-centred healthcare (11)***	Facilitate *Clostridium difficile* Root Cause Analysis (RCA) Investigations in a timely manner as required. *Lessons Learned to be shared within the service and brought to the attention of the ICC and Care Network via quarterly reporting*	As cases arise	KG / RT KG	No cases reported	
	Complete MRSA Bacteraemia Post Infection Reviews (PIR) within the timescales specified by the DH. *Lessons Learned to be shared within the service and brought to the attention of the ICC and care Network via quarterly reporting*	As cases arise	KG / RT KG	Nil to report – zero cases this year	
	To work collaboratively across the Trust in continued efforts to support the response to the Covid 19 pandemic	March 22	KG / DW / GH	The IPCT remain fully engaged in supporting the Trust. IPC Lead is a member of Silver Command and the Covid CAG	
	To work collaboratively with the H&S Lead and wider MDT regarding IPC related Safety Alerts.	As released	KG	Since Covid, the Incident Control Centre has been dealing with all CAS Alerts. IPC issued CAS alerts dealt with as required	
	To review and interpret any new IPC national guidance for its relevance and introduction into the Trust (e.g. NICE)	As released	KG	An abundance of PHE IPC guidance on the management of Covid has been received, interpreted and issued to staff in conjunction with CAG, Silver and Gold Commands and Comms	
	IPC related incidents to be monitored and lessons shared appropriately.	March 21	KG	Incidents as report – see relevant section in the report.	
	IPC risks being appropriately reported/escalated for inclusion on the Directorate Risk Register.	March 21	KG	Risk registered updated quarterly. 3 IPC risks currently on register	
	Support in collaboration with Matrons and Heads of Nursing all areas whereby facilitating outbreak management	March 22	KG/DW/GH	Outbreak areas supported as they occur	

Objective Area (38)	Action/Activity – to support CQC Fundamental Standards and Health & Social Care Act, Code of Practice	Timescale	Lead	Annual Progress/Assurance	RAGB
	Support all areas whereby facilitating outbreak management and to promote appropriate 'terminal cleaning' prior to re-opening to admissions	On-going	KG /DW / GH	Outbreak areas supported with Hotel Services Manager re: enhanced cleaning and terminal cleaning arrangements	
	All service user results are management as a priority e.g. MRSA Bacteraemia's / C-diff / CPE. Liaise with appropriate services/clinicians/GP's	On-going	KG	All results managed appropriately	
	To ensure that there is IPC involvement into the procurement process to confirm that equipment & therapeutic devices can be appropriately cleaned & decontaminated.	On-going	KG / Procurement	Medical Devices officer now in post who will be responsible for moving this agenda forward. IPC Lead on Medical Devices Group	
Design, Planning refurbishments & New Premises ***To ensure that premises are designed & furbished to enable IPC practices to flourish. (1)***	Provide specialist advice and decontamination requirements of all proposed capital refurbishments and new developments from design, planning through to final commissioned state. **To ensure that the fabric of the environment facilitates the cleaning process & that IPC is 'designed-in'.*	March 22	KG / DW /GR / JB/RT	IPC Lead a member of Therapeutic Group overseeing refurbishment work at Michael Carlisle Centre	
Estates Functions Water Quality & Safety **Promoting holistic management towards water systems to control waterborne pathogens, the ongoing maintenance of our healthcare premises and waste disposal (3)**	Support Estates with monitoring Water Quality including active participation in the Water Safety Group	March 22	MG / KG /DW/ RT	Continue to be an active member of the WQSG	
	Support Estates with quarterly reviewing the Water Quality risk assessments	March 21	MG / KG / RT	Nil to report by the Water Responsible Person	
	Collaborative Estate visits to all areas to identify IPC issues relating to the *'fabric of the building'* before they become problematic	Quarterly as required	DM / KG	As required	
Environmental Cleaning & Decontamination ***Activities to demonstrate that IPC & cleanliness are an integral element of the quality agenda (6)***	Support Hotel Services with reviewing standards of cleanliness across sites; report monthly environmental audit scores and Senior Housekeeper 'peer review' auditing cycle	March 22	JM	Hotel Services Manager continues to collate and support areas undertaking their monthly audit scored and facilitated peer review process.	
	Support the introduction of the new national Standards of Cleanliness across the Trust.	March 22	KG / JM / DW	See section 7.1. MICAD delayed due to IT issues	
	Support Hotel Services with annual Kitchen inspections to all main food producing sites	March 22	JM / GH	LA EHO have been carrying out unannounced inspections	
	Support Hotel Services in finding an alternative to Virusolve	March 22	JM / KG	Nil to report, it was not appropriate to change cleaning	

Objective Area (38)	Action/Activity – to support CQC Fundamental Standards and Health & Social Care Act, Code of Practice	Timescale	Lead	Annual Progress/Assurance	RAGB
				product during a national pandemic.	
	'Strictly Come Cleaning' 2 study day for senior housekeepers	March 22	KG / GH / JM	Introductory session completed for SHK staff delivered in Oct 21	
	Review of the Housekeeping Specification Document **Dependent of release of newly revised NHSE Cleaning Manual expected 2020*	TBC	JM / KG	Revised specification presented to the IPCPH committee in Oct 21 for approval. Approved and cascaded to Matrons and senior Housekeepers for implementation from Nov 21	

APPENDIX 2

Sheffield Health and Social Care NHS Foundation Trust

INFECTION PREVENTION & CONTROL SERVICE 2022 - 2023
ANNUAL WORK PROGRAMME

Key – work completed	
	Work not commenced
	Work not completed
	Work in progress
	Action on-going
	Complete

Key - personnel			
BM	Beverley Murphy	AA	Abiola Allinson
AH	Angela Hendzell	RT	Dr Rob Townsend
DW	Dr Dana Wood	DB	Derek Bolton
JS	Jill Singleton	JB	Julian Bentley
JM	Janet Mason		
MG	Mark Gamble		

Objective Area (38)	Action/Activity – to support CQC Fundamental Standards and Health & Social Care Act, Code of Practice	Timescale	Lead	Quarterly Progress/Assurance	Completed
Training & Education ***Providing opportunities for all staff to fulfil mandatory requirements to receive IPC training.(7)***	Continue to facilitate Corporate Induction & Mandatory IPC session along with Education Departmental Trainers	March 23	Education & Training		
	Start to plan, organise & facilitate a full day's IPC & PH conference on behalf of the Trust – TBC	March 23	IPC & PH Team		
	Provide ad-hoc sessions on a variety of IPC related elements/topics as and when approached by services/areas	March 23	AH/JS		
	Facilitate IPC themed sessions for newly qualified nurse preceptors	March 23	JS		
	Facilitate IPC sessions for Matron colleagues when in post	March 23	AH		
	Continue ANTT training for nursing staff	July 22	DW		

Objective Area (38)	Action/Activity – to support CQC Fundamental Standards and Health & Social Care Act, Code of Practice	Timescale	Lead	Quarterly Progress/Assurance	Completed
Audit ***Monitor compliance with IC policies & guidance through a Programme of audit.(7)***	Develop and carry out an unannounced programme of audit across Directorates / Service Lines • Single Point & Crisis & Emergency Care • Scheduled & Planned • Acute Bedded Based Services • Care Homes x3 Prioritise audits moved over from 21/22 programme **Areas where suboptimal compliance is identified; areas must produce a remedial action plan to address findings.* **Services/areas to take ownership regarding progression of action plans and to report issues hindering completion both at care network performance, operational & governance level and via the ICC*	March 23	DW / JS		
	Lead Nurse, IPC, to undertake a comprehensive review of the audit programme including processes for reporting/escalation; to enable the annual IPC audit programme to provide assurance of services. The review includes: • Delay commencement of the 2022-23 audit programme until post review to enable the audit outcomes to be measurable and achievable. • Audit assurance to be included in the quarterly IPC report to IPC Committee for monitoring by the Committee. • Provide greater assurance on a quarterly basis via the IPC Committee as a standing agenda item and for monitoring by the Committee against the annual work programme, gaps and mitigation.	End Sept 22	AH		
	DIPC and Lead Nurse, IPC to facilitate the internal audit of IPC by 360 Assurance.	Jan 23	BM/AH		
	To receive the audit data collected by Daniels in relation to Sharps Policy & practice. **Daniels Healthcare dependent**	Sept 22	IPC Team Daniels		
	To receive the quarterly audit data collated by pharmacy in relation to antibiotic prescribing findings and make recommendations for improvements in antibiotic stewardship (Antimicrobial Resistance Strategy DH,2013).	Quarterly Until March 23	Pharmacy		

Objective Area (38)	Action/Activity – to support CQC Fundamental Standards and Health & Social Care Act, Code of Practice	Timescale	Lead	Quarterly Progress/Assurance	Completed
	**To promote prudent antimicrobial prescribing for the management of antibiotic resistance and reducing antibiotic related Clostridium difficile Infection and other Healthcare Associated Infections*				
	Annual audit of mattresses across the Trust to ascertain how mattresses are being managed by inpatient facilities	Dec 22	JS/Herida Health Care		
	Participate in the multi-disciplinary PLACE Assessments trust wide	TBC	JM		
	Assess new ways of auditing hand hygiene compliance to replace attendance at training as the indicator of compliance	Feb 23	DW/AH		
Surveillance – Mandatory & Voluntary ***In line with National/Local requirements and designed to achieve reduction in HCAI (2)***	Continue to collate & monitor the voluntary prevalence data to understand how many individuals are affected by a disease or infection at a particular time and monitor any trends which develop.	March 23	AH / JS		
	Investigate different ways of undertaking infection surveillance to improve reliability of data collected	Dec 22	DW/AH/JM		
	Continue to monitor & report against the Mandatory Alert Organisms (MRSA, MSSA, E-coli Bacteraemia's & Clostridium difficile) **Supporting the reduction in Gram Negative infections*	March 23	AH / JS		
	To contribute to the review/consultation process to all policies or protocols that has relevance to infection prevention and control.	March 23	AH/DW		
Preventative & Case work ***Activities to demonstrate that effective IPC is central to providing safe, high, quality service user-centred healthcare (10)***	Facilitate *Clostridium difficile* Root Cause Analysis (RCA) Investigations in a timely manner as required. *Lessons Learned to be shared within the service and brought to the attention of the ICC and Directorates via quarterly reporting*	As cases arise	AH/ RT AH		
	Complete MRSA Bacteraemia Post Infection Reviews (PIR) within the timescales specified by the DH. *Lessons Learned to be shared within the service and brought to the attention of the ICC and care Network via quarterly reporting*	As cases arise As cases arise	AH / RT AH		

Objective Area (38)	Action/Activity – to support CQC Fundamental Standards and Health & Social Care Act, Code of Practice	Timescale	Lead	Quarterly Progress/Assurance	Completed
	To work collaboratively across the Trust in continued efforts to support the recovery from the Covid19 pandemic	March 23	DW / AH / JS / RT / BM		
	To work collaboratively with H&S, Medical Devices Safety Officer & Procurement Team and wider MDT regarding IPC related Safety Alerts.	As released	AH/DW		
	To review and interpret any new IPC national guidance for its relevance and introduction into the Trust (e.g. NICE)	As released	DW/AH		
	IPC related incidents to be monitored and lessons shared appropriately.	March 23	DW/AH		
	IPC risks being appropriately reported/escalated for inclusion on the Directorate Risk Register.	March 23	DW/AH		
	Support all areas whereby facilitating outbreak management in collaboration with Heads of Nursing	On-going	DW / AH / JS		
	All service user results are managed as a priority e.g. MRSA Bacteraemia's / C-diff / CPE. Liaise with appropriate services/clinicians/GP's	On-going	DW/ AH/ JS		
	To ensure that there is IPC involvement into the procurement process to confirm that equipment & therapeutic devices can be appropriately cleaned & decontaminated.	On-going	DW/AH / Procurement / Medical Devices		
Design, Planning refurbishments & New Premises ***To ensure that premises are designed & furbished to enable IPC practices to flourish. (1)***	Provide specialist advice and decontamination requirements of all proposed capital refurbishments and new developments from design, planning through to final commissioned state. **To ensure that the fabric of the environment facilitates the cleaning process & that IPC is 'designed-in'.*	March 23	AH / DB / JB		
Estates Functions Water Quality & Safety **Promoting holistic management towards water systems to control waterborne pathogens & the ongoing maintenance**	Support Estates with monitoring Water Quality including active participation in the Water Safety Group (WQSG)	March 23	MG / AH / RT		
	Support Estates with quarterly reviewing the Water Quality risk assessments	March 23	MG / AH / RT		
	Collaborative Estate visits to all areas to identify IPC issues relating to the *'fabric of the building'* before they become problematic	Quarterly as required	DM / AH		

Objective Area (38)	Action/Activity – to support CQC Fundamental Standards and Health & Social Care Act, Code of Practice	Timescale	Lead	Quarterly Progress/Assurance	Completed
of our healthcare premises (3)					
Environmental Cleaning & Decontamination ***Activities to demonstrate that IPC & cleanliness are an integral element of the quality agenda (6)***	Support Hotel Services with reviewing standards of cleanliness across sites; report monthly environmental audit scores and Senior Housekeeper 'peer review' auditing cycle	March 23	JM / DW/AH		
	Continue with annual Management Review Cleanliness Inspections/ walk-rounds.	March 23	AH / JM		
	Support Hotel Services with annual Kitchen inspections to all main food producing sites	March 23	JM / AH		
	Support Hotel Services in exploring the introduction of Chlorine to Housekeeping teams	March 23	JM / AH		
	TBC – facilitate 'Strictly Come Cleaning 2 study day for the Senior Housekeepers	March 23	AH / JS		
	Review of the Housekeeping Specification Document	ongoing	JM / AH		
IPC assurance reporting	Provide assurance within SHSC's governance structures, up to and including Board of Directors on IPC compliance via: • Quarterly report to IPC Committee • IPC BAF • Annual Audit programme report • Annual IPC report				
		July 22, Oct 22, Jan 23	AH		
		July 22, Oct 22, Jan 23	AH		
		March 23	AH		
		March 23	AH		