Leicestershire Partnership NHS Trust

Meeting Name and date	Trust Board – 1 November 2019
Paper number	

Name of Report **Infection Prevention Biannual Report to Trust Board** **Appendix 1: NHSE & I Updated action plan** **Appendix 2: GAP analysis against the Hygiene Code** **Appendix 3: Flu Best Practice Checklist**

For approval		For assurance	x	For information	

Presented by	Anne-Maria Newham Director of Nursing, AHP and Quality	Author (s)	Emma Wallis Amanda Hemsley

Alignment to CQC domains:		Alignment to LPT priorities for 2019/20 (STEP up to GREAT):	
Safe	x	S – High Standards	x
Effective		T - Transformation	
Caring		E – Environments	x
Responsive		P – Patient Involvement	
Well-Led		G – Well-Governed	x
		R – Single Patient Record	
		E – Equality, Leadership, Culture	
		A – Access to Services	
		T – Trust-wide Quality improvement	
Any equality impact (Y/N)	N		

Report previously reviewed by	
Committee / Group	Date
Direct to Trust Board Report	

Assurance: What assurance does this report provide in respect of the Board Assurance Framework Risks?	Links to ORR risk numbers
This six monthly report provides assurance from the Director of Infection Prevention and Control (DIPaC) that the trust has a robust, effective and proactive infection prevention and control strategy and work programme in place, that demonstrates compliance with the Health and Social Care Act 2008 (updated July 2015) also referred to as the Hygiene Code.	1,9,18

The report provides an update on actions identified following the NHS England & Improvement (NHSE&I) Infection Prevention Control (IPC) visit to meet recommendations, including a GAP analysis against the hygiene code. The report outlines completion of the Healthcare worker flu vaccination best practice management checklist for public assurance via trust boards by December 2019.	

Recommendations of the report
The Trust Board is recommended to receive assurance that processes are in place to monitor and ensure compliance against the Health and Social Care Act 2008 (updated July 2015) and actions are in place to address gaps in compliance.

1. Introduction

1.1 This six monthly report provides assurance from the Director of Infection Prevention and Control (DIPaC) that the trust has a robust, effective and proactive infection prevention and control strategy and work programme in place, that demonstrates compliance with the Health and Social Care Act 2008 (updated July 2015) also referred to as the Hygiene Code.

1.2 The report provides an update on actions identified following the NHS England & Improvement (NHSE&I) Infection Prevention Control (IPC) visit to meet recommendations, including a GAP analysis against the hygiene code.

1.3 The report outlines completion of the Healthcare worker flu vaccination best practice management checklist for public assurance via trust boards by December 2019.

1.4 Leicestershire Partnership NHS Trust (LPT) is committed to promoting the highest standards of infection prevention and control by ensuring that appropriate measures are in place to reduce/remove the risk of acquisition of an infection for a patient who recieves any form of healthcare within LPT.

1.5 The Infection Prevention and Control (IPC) team is currently made of 4.3 WTE Infection Prevention and Control Nurses.

2. Aim

2.1 The aim of this report is to provide the Trust Board with assurance there is a robust, effective and proactive infection prevention and control programme in place, that demonstrates compliance with the Health and Social Care Act 2008 (updated July 2015).

3. Recommendations

3.1 The Trust Board is recommended to receive assurance that processes are in place to monitor and ensure compliance against the Health and Social Care Act 2008 (updated July 2015) and actions are in place to address gaps in compliance.

4. NHS England &Improvement (NHSE& I) IPC visit and action plan

4.1 On 7 August 2019, Dr Debra Adams, Senior Infection Prevention and Control Advisor for NHSE&I visited the trust following findings identified in the CQC inspection in 2018. The visit included a review of three of our service areas including; Adult Mental Health Services (Inpatients) Learning Disability services (group home) and Mental Health Services for Children and Young People (Outpatients).

4.2 The review included evaluation of Infection Prevention and Control policies, documents, discussions with staff and visits to three clinical areas. Whilst the Trust received lots of positive feedback; staff adhering to Bare below the elbows (BBE), wearing the appropriate Personal Protective Equipment (PPE) and good hand hygiene. There were significant key themes that required attention and actions were developed to address these concerns.

4.3 A copy of the updated action plan is included (Appendix 1). In summary; all actions are complete with the exception of;

- Oversight and governance – RAG rated AMBER as the IPC Committee (IPCC) Terms of Reference require review to strengthen the assurance framework and reflect the new Trust governance structure. To be agreed at the Infection Prevention and Control Committee (IPCC) on the 5 November 2019.
- Estates works; Agnes Unit Tap part replacement – rated RED as replacement is broken again, escalated to the Director of Estates and Facilities 15 October 19.
- Cleaner's cupboard and radiator cleaning Westcoates House; spot check completed on the 16 October 2019 and actions post visit not completed, escalated to the Trust Property and Facilities manager to be completed and will be re spot checked.

5. Infection Prevention and Control Code of Practice GAP analysis and self-assessment tool

5.1 A key recommendation of the NHSE & I visit; to undertake a GAP Analysis/self-assessment against the IPC Hygiene Code of Practice. The self-assessment was completed initially on 20 August 2019, with the IPC team, Associate Director of Nursing & Professional Practice, Directorate IPC leads and Estates & Facilities Property Manager. Post assessment the Antimicrobial criterion was checked by the Trust pharmacy/AMR lead.

5.2 The full GAP analysis data is included (Appendix 2). This includes Trust percentage compliance against the ten criterions and an overall summary position outlined in the table below;

Criterion Number	Sections	Your Trusts Score	Maximum Score	Percentage Compliance
Criteria 1	Systems to manage and monitor the prevention and control of infection	33	42	79%
Criteria 2	Clean and appropriate environment that facilitates the prevention and control infection	13	14	93%
Criteria 3	Antimicrobial use to optimize patient outcomes and to reduce the risk of adverse events and antimicrobial resistance	5	8	63%
Criteria 4	Provide suitable accurate information on infection in a timely fashion	2	2	100%
Criteria 5	Identification of people who have or are at risk of developing an infection	3	3	100%
Criteria 6	Staff responsibilities in in the process of prevention and controlling infection	5	6	83%
Criteria 7	Provide or secure adequate isolation facilities	3	3	100%
Criteria 8	Adequate access to laboratory support	3	3	100%
Criteria 9	Policies which will help to prevent and control infections	24	25	96%
Criteria 10	Occupation health needs and obligations of staff in relation to infection	19	19	100%

5.3 Actions to improve compliance;

- To identify a process to capture data to provide assurance that every in-patient has a risk assessment with respect to IPC.
- To review and understand potential gaps identified due to the Trust not having a stand-alone Antimicrobial (AMR) stewardship committee. The Trust works in partnership and has representation at the LLR AMR working party.
- AMR consumption is not currently reported directly to Public Health England (PHE); to be reviewed with the Trust AMR lead and IPC Lead Nurse in conjunction with the Leicester Leicestershire & Rutland (LLR) PHE consultant and invite the LLR PHE representative to the IPCC.
- To identify a reporting structure for AMR consumption and audit compliance to include prescribing decisions and inappropriate practices to the IPCC (currently direct report to QAC).
- To enhance and agree all trust IPC metrics for 6 monthly board reporting including infection rates, cleanliness and audits.
- Sufficient resources to secure the effective prevention of infection – scoring in reference to (not limited) environmental constraints of the estate.
- Premises from which the organisation provides care are suitable for the purpose, kept clean and maintained in good physical repair and condition – scoring associated with the recent concerns escalated in relation to cleaning, cleaner's rooms and estate repairs and condition.
- To complete a review of procedures that require aseptic technique and identify staff training options and current available training, so that all staff who undertake procedures are adequately trained. To be presented to the IPCC meeting in February 2020
- To develop a policy for immunisation of service users. To be presented to the IPCC meeting in February 2020

6. External review with Northamptonshire NHS Foundation Trust IPC Lead Nurse

6.1 An external review was completed on the 16 October 2019 by the Lead Infection Prevention and Control Nurse from our 'buddy' trust Northamptonshire NHS Foundation Trust and Amanda Hemsley, Lead Infection Prevention and Control Nurse, LPT. The visit included review of two clinical in-patient areas; Langley and Kirby Ward, Bennion Centre. Review and sharing of Trust board reports, strategy, CQC service information report and IPCC Terms of Reference.

6.2 Post review report including shared good practice recommendations to be presented through the Trust Quality Surveillance report and to the IPCC.

6.3 Findings from this visit will be incorporated into the current NHSE & I action plan.

7. Reporting and Monitoring of HCAI Infections

7.1 There are four infections that are mandatory for reporting purposes:

- Meticillin Resistant Staphylococcus Aureus (MRSA) bloodstream infections.
- Clostridioides difficile infection (previously known as Clostridium difficile)
- Meticillin Sensitive Staphylococcus Aureus (MSSA) bloodstream infections.
- Gram Negative bloodstream infections (GNBSI)

7.2 **MRSA Blood stream infection rates**
The National trajectory is set at zero. LPT's performance for MRSA bacteraemia from April 2019 to September 2019 is zero.

7.3 **Clostridium difficile infection rates**
The agreed trajectory for 2019/20 is 12 and is set internally by the CCG (identified as EIA toxin positive CDI). LPT is not breaching the threshold set by the CCG. The table below outlines current data.

LPT CDT Data	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	**Total to date**
	0	0	**1**	0	**1**	**1**	**3**

7.4 Currently our figures for MRSA and CDI are within trajectory, however work continues to look at service improvements to reduce or maintain this position. All episodes of MRSA bacteraemia and CDI are identified and are subject to an RCA investigation. All action plans developed as part of this process are presented through the divisional IPC meetings which support the sign off of the completed actions.

7.5 The Trust CDT policy has been reviewed to include the national changes to the CDI reporting algorithm (NHS Improvement, 2019), and the recommended review tool has also been adopted to capture and interpret the data and care delivery information.

7.6 **MSSA Blood stream infection rates**
There is no identified trajectory for LPT for MSSA. However the monthly data on for this infection rate is submitted to the Clinical Quality Reporting Group as part of the quality schedule.

7.7 **Gram Negative Blood Stream Infection (GNBSI) rates**
In 2017 the Secretary of State for Health launched an important ambition to reduce healthcare associated Gram-negative bloodstream infections by 50% by 2021 and reduce inappropriate antimicrobial prescribing by 50% by 2021.

From April 2018 the Gram Negative Bloodstream Infection rates include:
- E-Coli
- Klebsiella pneumonia
- Pseudomonas aeruginosa

7.8 There is no LPT trajectory for GNBSI, however monthly data for this infection rate is submitted to the Clinical Quality Report Group (CQRG) as part of the quality schedule reporting (Please note this captures E-Coli infection rates only).

7.9 All partner organisations review their approach to reducing *E.coli* BSI by carrying out a self-assessment of progress against core standards. LPT is currently mapping position against the core standards (and include actions already addressed above). This information is shared and discussed at the LLR MADG group to share best practice and learning. The Lead IPC nurse for LPT attends this meeting.

7.10 LPT Lead IPC Nurse is a member of the national working group and participated in the NHS Improvement: Gram-negative Bloodstream Infection (GNBSI) group to develop a national policy (practice guide) for hand hygiene. This is now complete and was presented at the Chief Nursing Officer Conference. The next phase of the project includes development of a suite of national hand hygiene campaign resources, a national competency tool, compliance monitoring competency resource(s); and a standardised hand hygiene audit tool with quality metrics for measuring the effectiveness of a system-wide hand hygiene programme.

8. Reducing the Incidences of Catheter Associated Urinary Tract Infections (CAUTI)

8.1 In collaboration with University Hospitals Leicester (UHL) LPT participated in the Urinary Tract Infection (UTI) NHS Improvement (NHSi) CAUTI project. However due to position at the time of an increase in patients with multi drug resistance and the impact on time management for IPC issues, it was agreed with NHSi to delay presentation of the work to the national group. Work identified through the improvement project forms part of the ongoing work and agenda to reduce UTIs.

8.2 The catheter passport, updated management of urinary catheter patient leaflet and policy were launched in May and June 2019. Monitoring of the impact of this work is proposed to be included in the future IPC Quality Improvement programme.

8.3 A Urinary Catheter e-learning package has been developed and is now live for staff to access. All new starters and preceptees (with urinary catheterisation role essential) will complete the training package, competency assessment and attend a face to face study event prior to undertaking urinary catheterisation.

9. Sepsis

9.1 LPT continues to work towards achieving compliance with the national Sepsis agenda, and has developed an action plan to support implementation against the NICE guidance for Sepsis, based on the baseline assessment tool and GAP analysis.

9.2 The LPT action plan will form the LPT section of the wider LLR Sepsis improvement plan. A number of actions are in progress or completed including:

- Development of a policy for the recognition and management of patients with a potential sepsis diagnosis
- Patient leaflet for safety netting (as part of the LLR work stream)

- Identification of Sepsis champions in key in patient areas
- Training needs analysis to inform the required level of awareness training for staff in the organisation.

10. Hand hygiene

10.1 Currently, all in-patient areas are required to undertake and report monthly hand hygiene audits, with quarterly reporting for community teams.

10.2 Submission and compliance is varied across the services; in part due to the collection system of data recognised as labour intensive. Observational audit forms require manual data inputting, with no centralised service to complete this task. Data received has identified areas of compliance and areas for improvement, a process which is supported by the Trust IPC link workers.

10.2 To strengthen assurance and improve data collection a hand hygiene audit electronic application (app) has been developed and launched on 4 October 2019. The app will enable real time capture of hand hygiene audits, all data entered will be captured in a centralised database, from which compliance reports will be generated, identifying gaps, capture staff groups, categories and the reasons why a staff member failed enabling the Trust to focus on areas which require improvement.

11. Trust five markers

11.1 The Trust IPCC opted to focus on five key markers of good infection prevention and control in the environment, audited monthly, recommended in all in-patient wards and clinics. Compliance data as with hand hygiene has been varied across services.

11.2 The aim was to add the trust five markers to the electronic application, however due to clinics being utilised by different teams this has not been successful due to the lack of audit trail and accountability. The plan is to continue to report manually whilst the AMAT system is considered for these audits.

12. Cleaning and Decontamination

12.1 **Cleaning**
Cleaning scores are audited monthly and reported quarterly through the IPCC, this will change to bi-monthly from 2020. Exceptions are highlighted and mitigation and actions to remedy are reported. Work is on-going to ensure that clinical leaders are present at the time of audit to confirm and challenge.

12.2 The NHSE& I action plan reflects actions taken and shared at the CQC progress meetings in relation to cleanliness and an updated toy cleaning guidance and assurance process.

12.3 The Trust has a twelve month rolling deep clean programme in place and progress is monitored at the IPCC and LPT monthly cleaning meeting.

12.4 PLACE assessments were delayed nationally due to a change in system reporting and are currently underway for the month of October 2019.

12.5 **Decontamination**
The Trust medical devices group meets monthly with representation from IPC to ensure that equipment and items purchased for the trust meet the needs of the service and are able to be cleaned and decontaminated as per trust policy.

12.6 The implementation of traceability for podiatry instrumentation is in place within the Trust Podiatry Service. Development of the hub and spoke system of cleaning and decontamination for podiatry instruments is to be reviewed at the IPCC on 5 November 19 in line with best practice requirements for transportation of instruments.

13. Water Management

13.1 The Trust Water Safety Group is a formal sub-group of the IPCC. A meeting was held in October 19 with the newly appointed Authorised Engineer.

13.2 Key actions included review of the current Trust Water Management policy to be replaced with an overarching water policy and separate water management plan. Terms of reference have been agreed for dissemination to the IPCC on 5 November 19.

13.3 Legionella awareness has now been added to the IPC Level 2 e-learning training.

14. Season Flu vaccination programme

14.1 LPT is required to deliver an annual seasonal flu campaign, offering all staff the opportunity to have the seasonal flu vaccine. The aim of the campaign which runs from October to February is to protect patients and other staff from seasonal flu.

14.2 NHS England recommends that Trust Flu groups meet monthly from September through to March. The LPT Flu group has met monthly since February 2019. It is noted that Directorate attendance has not been consistently maintained throughout the year, we ask for support to ensure attendance is prioritised to support ownership of the Trust action plan and maintain momentum and drive.

14.3 The LPT 2019/20 seasonal flu vaccination programme for staff 2019/20 was launched on 1 October 2019. The vaccination is available to all LPT staff. There is a Trust CQUIN to vaccinate 80% of Frontline Healthcare Workers (FHCWs). The baseline denominator is 4,609 staff. 80% equates to 3,688 staff.

14.4 Vaccine uptake data is to be collected and reported internally by Occupational Health on a weekly basis. All Trusts are responsible for submitting uptake data on the vaccination of FHCWs involved with direct patient care on a weekly basis to NHS Improvement (NHSi) and on a monthly basis to Public

Health England (PHE), starting from the 1 November 2019 through to March 2020.

14.5 Training sessions for peer vaccinators was delivered by a core group of LPT staff over August, September & October 2019, a total of 28 training sessions (compared to three last season by Occupational Health).

14.6 A total of 82 staff have accessed the peer vaccinator training (compared to 58 last season). Three have dropped out leaving a total of 79 peer vaccinators, however 30 staff have yet to return their competency framework and written instruction a requirement in order to peer vaccinate.

14.7 From 1 October 19 to the 17 October 19 we have delivered 18 flu clinics across services including team meetings and large events. A flu calendar is currently being populated by peer vaccinators and requests to be advertised through communications and flu messages.

14.8 One WTE roving peer vaccinator commences on 28 October 2019, together with a number of bank peer vaccinators the aim is to widen access to clinics in evenings and weekends to improve access and uptake.

14.9 All Trusts are required to complete the Healthcare worker flu vaccination best practice management checklist for public assurance via trust boards by December 2019. Completed by the Trust Flu Group (Appendix 3).

15. Conclusion

This six monthly report provides assurance from the Director of Infection Prevention and Control (DIPaC) that the trust has a robust, effective and proactive infection prevention and control strategy and work programme in place, that demonstrates compliance with the Health and Social Care Act 2008 (updated July 2015) also referred to as the Hygiene Code.

The report has provided progress against the actions taken in response to the NHS England & Improvement (NHS E& I) Infection Prevention Control visit and recommendations, including a GAP analysis against the hygiene code and subsequent improvement actions.

The report also outlines completion of the Healthcare worker flu vaccination best practice management checklist for public assurance via trust boards by December 2019.