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Public Trust Board – 29 June 2021

Infection Prevention and Control Six-Monthly Report to Trust Board

Introduction

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 (IPC) 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 Infection Prevention and Control (IPC) team is currently made of 5.5 WTE Infection Prevention and Control Nurses, supported and managed by the Associate Director of Nursing and Professional Practice/Deputy Director of Infection Prevention and Control (DDIPaC). Recruitment into the IPC team continues as part of the agreed plan and additional funding to support the pandemic response. The role of band 2 administrator 0.8 WTE was appointed to in January 2021.

Purpose of the report

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) and to assure the board that all IPC measures taken are in line with government COVID-19 IPC guidance.

The report provides an update on;

- Actions and compliance to the NHS England & Improvement (NHSE & I) IPC Board Assurance Framework (BAF) published 4 May 2020. This applies to all healthcare settings to assess and assure the DIPaC and trust board that all IPC measures taken, are in line with current Public Health England (PHE) COVID-19 guidance. The report provides information, quality improvement learning and actions for compliance in regard to Covid-19 outbreaks and nosocomial Covid-19 , including a trust wide aggregated review.
- Actions and compliance for the Carbepenamase Resistant Organism (CRO) outbreak management on Beechwood Ward, Community Hospitals in April 2021.
- Actions identified following NHS England & Improvement (NHSE&I) Infection Prevention Control (IPC) visits in August 2019 and January 2020 and the re-visit planned for August 2021, with actions to meet recommendations.

Analysis of the issue

1. NHS England IPC Board Assurance Framework (BAF)

1.1 The Infection Prevention and Control Board Assurance Framework (BAF) was updated on the 12/02/2021. The revised document added/updated a further 32 Key Lines of Enquiry (KLoEs). The BAF was reviewed and information and reports embedded within the plan (Appendix 1). The BAF

self-assessments and subsequent updates have been shared with both NHSE&I IPC leads and the Care Quality Commission (CQC).

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

2.1 Following the NHS E & I IPC visit on 7 January 2020 the Trust was rated a strong AMBER with a follow up visit scheduled for the 13 May 2020. Due to the pandemic this visit was postponed. NHSE&I have identified that an announced visit will take place in August 2021, no further details have been received to date and the trust compliance team are informed. The following work continues to support the associated work plan and compliance with IPC requirements.

2.2 IPC programme of clinical visits and audits are scheduled, with a timetable devised to ensure inpatient areas are visited and assessed on a minimum of a quarterly basis. In the months of April and May 2021; 32 clinical visits were carried out by members of the IPC team. A comprehensive IPC audit is undertaken on each visit and a report and items or issues for improvement included in a plan of action. The reports include photographs as a visual reminder, and form part of the learning for improvement.

Any potential themes are addressed and where possible actioned at the time of the visit and/or escalated to clinical leads, facilities and management for action as appropriate:

3. Carbapenamase Resistant Organism (CRO) Outbreak

3.1 On 13 April 21 a case of carbapenemase-producing klebsiella pneumonia OXA 48 (Kp OXA 48) was identified in two individual patients on Beechwood Ward, Evington Centre, Leicestershire Partnership Trust. One of the patients had been admitted to the ward with a known positive result. All patients on Beechwood ward and Clarendon ward (which is an inter-location ward with shared Allied Health Professional staff) were subsequently screened (rectal swabs) and a further four colonised patients were identified. Consequently an outbreak was declared on the 13 April 21. In total, seven patients were identified as carriers of Kp OXA-48, across two wards, two of which were previously positive for this organism.

3.2 OXA-48 is a carbapenemase gene initially identified in Turkey in 2004 and has subsequently spread across southern Europe and the Middle East.

3.3 This incident is the first OXA-48 outbreak in LPT. Experience from other cases and organisations have demonstrated the potential for rapid spread and the involvement of a significant number of patients due to high transmissibility. While intestinal carriage of OXA 48 Carbapenemase-producing bacteria doesnot have an immediate clinical impact, asymptomatic carriage has implications for patients undergoing surgery or other clinical procedures with a high risk of infection, since infection caused by these bacteria can be very difficult and costly to treat.

3.4 In line with LPT Policy a multi-professional and multi-agency Outbreak Committee(OC) was convened on the 13 April21. All affected patients have been managed in line with nationally recommended guidance.

3.5 All affected patients were managed in line with either source or enhanced isolation precautions, keeping colonised patients separate from non-colonised patients to reduce the risk of spread and acquisition by other patients. Isolation involved colonised patients being nursed within single rooms or being cohort nursed in designated bays or wards where the number of patients identified

exceeded side room capacity.

3.6 Stringent hand hygiene and strict use of personal protective equipment (PPE) included wearing of theatre scrubs by some staff when on an identified restricted ward or other PPE when dealing directly with patients such as gloves and long sleeved aprons. Senior Infection Prevention and Control team members provided expert and professional advice to the DIPaC and wards were visited daily.

3.7 The outbreak has identified a group of patients who are expected to remain carriers of OXA-48 for the long term, who consequently pose both a direct and indirect risk (potential transmission of the organism causing colonisation or cross infection) to the wider healthcare economy for some time to come.

3.8 Stringent hand hygiene and environmental cleanliness is crucial to the control of a CRO outbreak. A minimum of twice daily full cleaning of the affected environments was required with particular attention paid to touch points, toilets and bathrooms every two hours.

3.9 Once affected patients were either isolated or discharged, a deep clean for decontamination was implemented. The additional workload for both nursing and domestic colleagues was challenging. The logistics of achieving this level of cleaning cannot be underestimated, particularly in light of the Covid-19 pandemic currently.

3.10 It was agreed in conjunction with the Consultant Microbiologist from UHL that swabbing of the environment within Beechwood ward would not add anything to the outbreak management and control at that point. A number of Infection Prevention and Control audits were carried out over the course of the outbreak with daily visits from the IPC team, to offer support and advice.

3.11 No further cases of evident nosocomial transmission have been identified since the 13 April 21 and the OC agreed that a 28 day outbreak close out period could begin. As no further cases were identified the outbreak was closed on 12 May 21.

4. COVID-19 pandemic

4.1 The Covid-19 pandemic continues into its 16th month since being declared initially as a national level 4 incident within the United Kingdom.

4.2 Covid-19 is an infectious disease caused by a newly discovered coronavirus. Coronaviruses are a family of viruses that cause diseases in animals. Seven, including Covid-19 have made the jump to humans.

4.3 National guidelines and communications issued continue be logged through the Trust Incident Control Centre and action cards for staff are updated to ensure that as a Trust we have responded in an evidence-based way to maintain the safety of patients, staff, volunteers and contractors. A weekly Covid-19 bulletin is emailed out on a Wednesday afternoon with all recent updated guidance, advice and news and sent to all staff within the trust.

4.5 Lateral flow testing for all staff within LPT continues to be supported and has been successful in identifying a number of staff who had a positive result despite being asymptomatic.

4.6 LPT figures for Covid 30 March 2020 until 31 March 2021 are:

Total number of positive cases – 616
Total number of positive cases on the day of admission – 345

Total number of cases positive after admission – 271

The positives after admission are broken down as follows -

Positive result within 2 days (Community onset) - 26
Positive result between 3 and 7 days (Indeterminate Healthcare association) - 70
Positive result between 8 and 14 days (Probable Healthcare Onset) - 50
Positive result 15 days or later (Definite Healthcare association) - 125

4.7 **Aggregated outbreak and nosocomial review**

Between June 2020 and March 2021, LPT recorded twenty-five Covid-19 outbreaks, including incidents that occurred in non- clinical areas affecting staff only. Seventeen of the outbreaks occurred in Community Health Services and eight occurred in Mental Health Services.

The detailed report (appendix 2) provides an aggregated review of all Trust outbreaks and nosocomial infections between March 2020 and March 2021 adopting a system wide structure for the review. The report outlines the Trust system and processes for Covid-19 outbreak management and aggregated learning and actions taken to ensure a continuous quality improvement approach.

5. Season Flu vaccination programme

5.1 LPT is required to deliver an annual seasonal flu campaign, offering all staff the opportunity to have the seasonal flu vaccine.

5.2 For context, the flu vaccination programme runs between October and February every year. This year the peak adoption and uptake occurred in the initial months October and November 2020. There was also a national drive to ensure flu vaccination was completed by end of November 2020 to make way for the start of the Covid-19 vaccination programme in December 2020.

5.3 There was no Commissioning for Quality Innovation (CQUIN) attached to increase performance in 2020/21, however there was an expectation to achieve 90% uptake for FHCWs. The uptake position for FHCWs 2020/21;

Staff Due (FHCW)	Number Vaccinated	% Vaccinated	Number not vaccinated
4384	2622	59.80	1762

LPT Flu Vaccination Uptake Three Year Performance Chart

Year	% of FCHW uptake	% performance change
2020/21	59.80	0.13 ↓
2019/20	59.93	5.93% ↑
2018/19	54.00	**Baseline**

5.4 The seasonal flu vaccine for staff has been delivered using a multi pronged approach, dictated in the main by the restrictions of Covid -19. Peer vaccinators were a key driver and provider of flu vaccinations for staff which has been supported by bookable clinics based on the Covid antibody clinics which were developed and facilitated earlier in the year.

5.5 The table below outlines the FHCW uptake by directorate teams for 2020/2021 and the numbers not vaccinated (to target for improvement);

Directorate	Staff Due	No. Vaccinated	% vaccinated	To target
Community Health Services (CHS)	1332	896	**67.30%**	436
Families, Young People & Children and Learning Disabilities (FYPC/LD)	1105	764	**69.10%**	341
Directorate for Mental Health (DMH)	1257	620	**49.30%**	637
Enabling	205	123	**60.00%**	82
Bank	484	218	**45.00%**	266
Hosted Services	1	1	**100.00%**	0
Totals	4384	2622		1762

5.6 The table below outlines the number of additional staff required to improve our performance overall for 2021/22 based on last season's denominator/staff due;

% vaccinated	Total No. Vaccinated	**No. required to meet target**
70%	3068	**446**
80%	3507	**885**
90%	3945	**1323**

5.7 Trust uptake data was further analysed including; high and low uptake teams, teams with higher staff numbers with low uptake with a greater potential to improve/impact overall Trust performance.

5.8 Reasons for higher vaccination uptake triangulated with national data include; key influencers within teams, committed leadership to the flu programme, flexibility and a strong local peer vaccinator. Analysis of the uptake data by staff group identified that Allied Health Professionals staff are more likely to have their flu vaccine in comparison to medical and nursing staff. The trend in LPT is that many of the highest uptake teams are AHP teams/services.

5.9 Planning for the flu campaign for 2021/22 is in progress, with recent identification that flu vaccinations will be available from September 2021.

6. Reporting and monitoring of HCAI Infections

6.1 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)

6.2 MRSA Blood stream infection rates

The national trajectory is set at zero. The Trust performance for MRSA bacteraemia from April 2020 to March 2021 was zero.

6.3 Clostridium difficile infection (CDI) rates

The agreed trajectory for 2020/21 was 12 and is set internally by the Clinical Commissioning Group (CCG) (identified as EIA toxin positive CDI). There was only one positive CDI case in this reporting year in April 2020, this reflects the national trend and is likely associated to the additional IPC precautions and measures for Covid-19. . The table below outlines the data for 2020-21.

6.4 All episodes of MRSA bacteraemia and CDI are identified and are subject to a Root Cause Analysis (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.

6.5 MSSA Blood stream infection rates

There is no identified trajectory for LPT for MSSA, with national requirements focused on acute trust services only. However the monthly data for this infection rate is submitted to the Clinical Quality Reporting Group (CQRG) as part of the quality schedule, this supports the overview of the infection rates and the potential of an increase which may need further review and investigation

6.6 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

6.7 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).

6.8 All partner organisations are expected to review their approach to reducing *E.coli* BSI by carrying out a self-assessment of progress against core standards. LPT is currently mapping its position against the core standards (which will include actions already addressed above). This information will be shared and best practice discussed at the LLR network group, the Lead IPC nurse for LPT attends this meeting. These meetings have been recommenced via virtual Microsoft teams and occur monthly, with an action plan identified to move forward with the gram negative ambition work. This meeting is now chaired by the Head of Quality & Safety, Nursing, Quality and Performance, Leicester City Commissioning Group.

7. Ventilation

7.1 As part of the Facilities Management (FM) transformation planning and in light of the ventilation requirements/restrictions relating to COVID, the Trust appointed an Authorising Engineer (AE) for ventilation directly rather than using the shared service (hosted by University Hospitals of Leicester (UHL)).

7.2 The AE undertook an initial assessment of all LPT owned and leased premises in order to provide information concerning the IPC BAF Key Line of Enquiry (KLOE) relating to ventilation in healthcare waiting/admissions areas. The full report was presented to the IPC group and forms part of the IPC BAF assessment and assurance

7.3 An initial Ventilation Safety Group took place in May 2021, where terms of reference were agreed and a work plan is under development. IPC, estates & facilities and health & safety are all represented at this group.

7.4 A full ventilation audit is required and a brief is being developed in order to obtain quotations.

7.5 Information regarding the maintenance and management of systems from the shared service – hosted by UHL is being reviewed by the AE.

7.6 The AE provides advice and recommendations to individual queries raised and work has been undertaken at the Electro Convulsive Therapy (ECT) suite at the Bradgate Unit to ensure that services can continue in a COVID-19 safe way.

7.7 There are no emerging or immediate risks identified for action.

8. Water Management

8.1 Precautionary water treatment work is now under way at the Bradgate Unit following routine testing on Bosworth Ward, which is closed for modernisation work. Water samples taken from Bosworth Ward as part of our building work to refit outdated dormitory accommodation indicated the presence of legionella. As a precaution, we took immediate action across the whole Bradgate building, with advice and support from our water safety group and an independent water advisor (the authorising engineer).

8.2 While the immediate issue at the Bradgate Unit is being managed and monitored through the ICC & other governance routes, the Trust has identified that due to the lack of information available from the shared service host - UHL, it is unable to assure itself that the water systems Trust wide are being maintained and managed appropriately. A number of actions have been identified to review existing information, update risk assessments where applicable and undertake remedial works to provide the Trust with the assurance required.

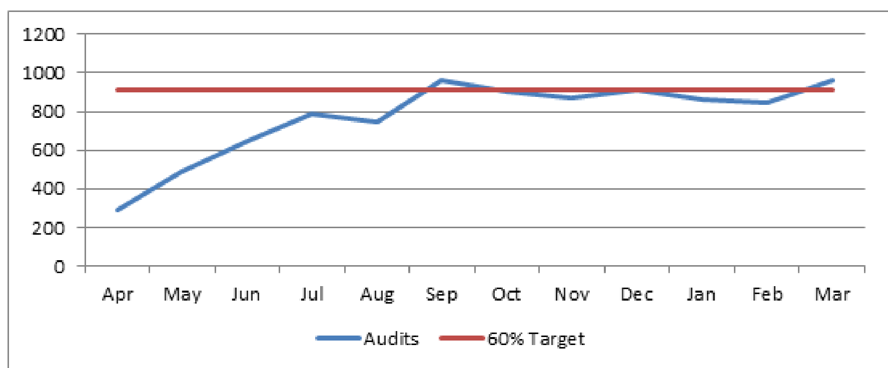
8.3 Risk 4777 has been escalated as an organisational risk and the actions are being monitored through the Organisational Risk Register review process.

9. Hand hygiene

9.1 The total number of audits required per month by all teams equates to 1516 audits per month to ensure more robust representative auditing. The aim in 2020/21 was to improve the total number of audits from 561 (37%) to 909 audits (60%). This was a priority within the 2020/21 Quality Account.

9.2 In quarter 1 audits returned rose from 292 to 648 a month giving an average of 475 or 31% for the quarter. Quarter 2 showed an increase from 788 to 965 audits giving an average of 834 or 55% for the quarter. Quarter 3 returns ranged between 868 to 912 audit returns giving an average of 893 or 59%. Quarter 4 ranged between 849 to 964 audit returns giving an average of 891 or 59%.

9.3 This shows an improving picture for quarters 1 and 2 which has been maintained in quarters 3 and 4 which is 1% below the desired target. Work continues to improve and sustain the number of audits and representativeness acknowledging the impact of staff working from home.



9.4 The quality improvement project aimed to improve adherence in handwashing as part of safe infection prevention and control practice across services in the organisation and for the Trust to increase the number of audits whilst maintaining an 85% compliance rate. The project is being supported through the Trust Quality Improvement Knowledge hub. The improvement interventions focused on data cleansing and quality, working with the directorates to improve accuracy of recording and governance monitoring. It l also aimed to refocus mind sets and behaviours and the importance of hand hygiene.

9.5 In terms of practice and results of the audits, there has been sustained compliance performance for the year at 99%. It is anticipated and expected that as the number of audits increase there may be a decline in the overall performance as it is a more reflective representation of clinical practice.

9.6 The Trust Infection Prevention and Control team have commenced in-patient clinical support visits that include a quality assurance review of hand hygiene practice and adherence to Personal Protective Equipment (PPE).

10. Cleaning and Decontamination

10.1 Cleaning

Cleaning scores are audited bi-monthly and reported through the Trust IPC Group. Exceptions are highlighted with mitigation and actions to remedy included in the report. Work continues to ensure clinical leaders are present at the time of the audits to confirm and challenge as appropriate. In line with the national recommendations, two hourly touch point cleaning was implemented within inpatient areas. This process supported the reduction in outbreaks of infection, with specific reference to Covid-19. This process has been documented and audited in order to provide assurance. A business case was developed and a roving team for cleaning supported the introduction of a third clean as well as a quick response to outbreak/cleaning requirements.

10.2 The audits of the cleaners room and equipment within LPT buildings has identified a number of improvements and works to bring them to the level deemed acceptable and in line with national specifications. A programme of work and actions are in place to address the issues, with updates reported through the IPC group monthly meetings, with assurance or items for escalation.

10.3 The Trust has a twelve month rolling deep clean programme in place and progress is monitored at the IPC Group and LPT monthly cleaning meeting, again this has been delayed due to the pandemic. Monitoring continues through the IPC group meeting.

10.4 Patient Led Assessment of the Care Environment (PLACE) assessments continue to be delayed due to the Covid-19 pandemic. National standards for cleanliness 2021 has been launched in May, work is underway to review these documents with a working group to look at how this can be introduced into the trust. National webinars are in place to support this implementation with a lead time of 6 months to provide plans and twelve months for full integration.

11. Decontamination

11.1 The Trust medical devices group has resumed meeting virtually via Microsoft teams during 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. Antimicrobial stewardship

12.1 Antimicrobial stewardship is now reported to the Trust IPC group every six months, with any associated annual reports and audits including prescribing and consumption.

Proposal

This six monthly report outlines assurance from the Director of Infection Preventon and Control (DIPaC demonstrating compliance with the Health and Social Care Act 2008 (updated July 2015) also referred to as the Hygiene Code. The report also highlights the impact of the COVID-19 pandemic to the business as usual IPC work programme and quality improvement in response to NHSE & I IPC visits.

The report provides updates on the self-assessment and compliance to the NHSE&I Infection Prevention and Control Board Assurance Framework published 4 May 2020 and updated February 2021; applied to all healthcare settings to assess and assure the DIPaC and Trust board that all IPC measures taken, are in line with current Public Health England (PHE) COVID-19 guidance.

Decision required

The board is asked to confirm a level of assurance that processes are in place to monitor and ensure compliance with the Health and Social Care Act 2008 (updated July 2015) also referred to the as the Hygiene Code and NHS England IPC Board Assurance Framework to ensure that all IPC measures are taken in line with PHE Covid-19 guidance to ensure patient safety and care quality is maintained.

Governance table

For Board and Board Committees:	Public Trust Board 29th June 2021	
Paper sponsored by:	Anne Scott – Director of Nursing, AHP and Quality	
Paper authored by:	Amanda Hemsley – Lead Infection Prevention and Control Nurse Emma Wallis – Associate Director of Nursing and Professional Practice	
Date submitted:	18 June 2021	
State which Board Committee or other forum within the Trust's governance structure, if any, have previously considered the report/this issue and the date of the relevant meeting(s):	Direct to trust board	
If considered elsewhere, state the level of assurance gained by the Board Committee or other forum i.e. assured/ partially assured / not assured:		
State whether this is a 'one off' report or, if not, when an update report will be provided for the purposes of corporate Agenda planning	6 monthly report	
STEP up to GREAT strategic alignment*:	High **S**tandards	x
	Transformation	
	Environments	x
	Patient Involvement	
	Well **G**overned	x
	Single Patient **R**ecord	
	Equality, Leadership, Culture	
	Access to Services	
	Trustwide Quality Improvement	x
Organisational Risk Register considerations:	List risk number and title of risk	5
Is the decision required consistent with LPT's risk appetite:	Yes	
False and misleading information (FOMI) considerations:	Yes	
Positive confirmation that the content does not risk the safety of patients or the public	Yes	
Equality considerations:		

Appendix 1

Publications approval reference: 001559

Infection prevention and control board assurance framework

February 12th, 2021. V1.6

Updates from V1.5 highlighted

Foreword

NHS staff should be proud of the care being provided to patients and the way in which services have been rapidly adapted in response to the COVID-19 pandemic.

Effective infection prevention and control is fundamental to our efforts. We have developed this board assurance framework to support all healthcare providers to effectively self-assess their compliance with PHE and other COVID-19 related infection prevention and control guidance and to identify risks. The general principles can be applied across all settings; acute and specialist hospitals, community hospitals, mental health and learning disability, and locally adapted.

The framework can be used to assure directors of infection prevention and control, medical directors and directors of nursing by assessing the measures taken in line with current guidance. It can be used to provide evidence and as an improvement tool to optimise actions and interventions. The framework can also be used to assure trust boards.

Using this framework is not compulsory, however its use as a source of internal assurance will help support organisations to maintain quality standards.

Ruth May

Ruth May
Chief Nursing Officer for England

1. Introduction

As our understanding of COVID-19 has developed, PHE and related guidance on required infection prevention and control measures has been published, updated and refined to reflect the learning. This continuous process will ensure organisations can respond in an evidence- based way to maintain the safety of patients, services users and staff.

We have developed this framework to help providers assess themselves against the guidance as a source of internal assurance that quality standards are being maintained. It will also help them identify any areas of risk and show the corrective actions taken in response. The tool therefore can also provide assurance to trust boards that organisational compliance has been systematically reviewed.

The framework is intended to be useful for directors of infection prevention and control, medical directors and directors of nursing rather than imposing an additional burden. This is a decision that will be taken locally although organisations must ensure they have alternative appropriate internal assurance mechanisms in place.

2. Legislative framework

The legislative framework is in place to protect service users and staff from avoidable harm in a healthcare setting. We have structured the framework around the existing 10 criteria set out in the Code of Practice on the prevention and control of infection which links directly to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Health and Safety at Work Act 1974 places wide-ranging duties on employers, who are required to protect the 'health, safety and welfare' at work of all their employees, as well as others on their premises, including temporary staff, casual workers, the self-employed, clients, visitors and the general public. The legislation also imposes a duty on staff to take reasonable care of health and safety at work for themselves and for others, and to co-operate with employers to ensure compliance with health and safety requirements.

Robust risk assessment processes are central to protecting the health, safety and welfare of patients, service users and staff under both pieces of legislation. Where it is not possible to eliminate risk, organisations must assess and mitigate risk and provide safe systems of work. In the context of COVID-19, there is an inherent level of risk for NHS staff who are treating and caring for patients and service users and for the patients and service users themselves in a healthcare setting. All organisations must therefore ensure that risks are identified, managed and mitigated effectively.

Infection Prevention and Control board assurance framework – 12 February 2021 v1.6

Updates from V1.5 highlighted

LPT IPC BAF self-assessment – 19.3.21 – updated 27.05.21

1. Systems are in place 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 posed by their environment and other service users			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**

Systems and processes are in place to ensure:
• there are pathways in place which support minimal or avoid patient bed/ward transfers for duration of admission unless clinically imperative
 	
• that on occasions when it is necessary to cohort COVID or non-COVID patients, reliable application of IPC measures are implemented and that any vacated areas are cleaned as per guidance.
 	
• monitoring of IPC practices, ensuring resources are in place to enable compliance with IPC practice
  ○ staff adherence to hand hygiene?
  ○ Staff social distancing across the
	Patient pathways in place to support Covid-19 risk management as per the IPC care pathways. Action card in place to support admission protocols for IPC following transfer to the acute care sector or patient home leave
	
	Managed through the outbreak meeting. IPC measures implemented, patient and staff cohorting & increased cleaning
	
	Monthly Hand hygiene audits reported to the IPC group, Quality Forum and QAC
	
	The audit tool is part of the management for use of as part of the outbreak process which is daily, and weekly for		

workplace o Staff adherence to wearing fluid resistant surgical facemasks (FRSM) in: a) Clinical b) Non-clinical setting • monitoring of staff compliance with wearing appropriate PPE, within the clinical setting • implementation of twice weekly lateral flow antigen testing for NHS patient facing staff, which include organisational systems in place to monitor results and staff test and trace • additional targeted testing of all NHS staff, if your trust has a high nosocomial rate, as recommended by your local and regional infection prevention and control/Public Health team.	general audit purposes Covid-19 observational audit tc 84.1% of staff have completed the donning and doffing training which is reported through the learning and development system in the trust Staff are requested to complete twice weekly lateral flow testing and is part of the audit tool above. Oversight of results with HR and ICC For outbreak areas/high nosocomial cases and identified risk points. PCR testing is carried out for asymptomatic staff for a baseline, repeated in conjunction with PHE as advised		

• there are visual reminders displayed communicating the importance of wearing face masks, compliance with hand hygiene and maintaining physical distance both in and out of the workplace • robust IPC risk assessment processes and practices are in place for non COVID-19 infections and pathogens	IPC-HWB-poster-reviewed-18.02.21.pdf 501534_NHS_Staff_face_mask_poster_A4_A Reception-social-distancing-poster-A4.pdf social-distancing-2m-poster.pdf Policies, guidelines and processes in place for non-Covid-19 infections. Reported monthly to the IPC group and six monthly to the Trust Board		

• that Trust Chief Executive, the Medical Director or the Chief Nurse approves and personally signs off, all daily data submissions via the daily nosocomial sitrep. This will ensure the correct and accurate measurement and testing of patient protocols are activated in a timely manner. • This Board Assurance Framework is reviewed, and evidence of assessments are made available and discussed at Trust board	T23a IPC Report inclusive of Covid-19 T23a IPC Report inclusive of Covid-19 2 The ICC Director of the day signs off all daily data submissions Nosocomial Covid-19 data submitted on a weekly basis to the ICC (Tuesday) Outbreak information updated daily Monday to Friday and escalated to the ICC Submitted to the Trust Board through the six monthly reports and regular updates Trust Board Biannual IPC report 27 May 20 IPC BAF Update Trust Board Septemb	To review CE, MD and DoN sign off process	

• ensure Trust Board has oversight of ongoing outbreaks and action plans • there are check and challenge opportunities by the executive/senior leadership teams in both clinical and non-clinical areas	Trust Board 6 monthly report 22Dec Outbreak updates included in the Director of Nursing monthly report to the QAC and Trust Board and Flash report Executive visits including DoN, senior clinical and operational leadership check and challenge opportunities – HoN/dep HoN, matron, IPC team visits. Check and challenge opportunities at Senior Leadership Forums Weekly system check and challenge at DIPC meetings	Aggregated Covid report in progress and to be submitted to the June 2021 Trust Board meeting	
2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
• monitor adherence environmental decontamination with actions in place to mitigate any identified risk	Back to basics campaign Cleaning with Confidence Introduced increased touch		

• monitor adherence to the decontamination of shared equipment with actions in place to mitigate any identified risk	point cleaning Local records in the IPC assurance folders PPE Guidance - Amber Zone.pdf PPE Guidance - General Areas Office PPE Guidance - Green Zone.pdf PPE Guidance - Red Zone.pdf		
3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance			
No update			
4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion.			
No update			
5. Ensure prompt identification of people 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 other people			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**

• face masks are available for all patients and they are always advised to wear them	Action-Card-CHS.DMH-and-FYPC-Adult-Com		Action cards do advise that patients being transferred or moved round the area wear a face mask if their condition allows
• monitoring of Inpatients compliance with wearing face masks particularly when moving around the ward (if clinically ok to do so)	Due to the risks in MH, CAMHS & LD this is risk assessed and not always appropriate	There is no formal audit in place to monitor compliance for inpatients wearing face masks	
• there is evidence of compliance with routine patient testing protocols in line with Key actions: infection prevention and control and testing document	.LPT Self-assessment completed and routine patient testing implemented and continues weekly for long stay patients IPC BAF GAP analysis and actions l		
6. Systems 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			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
• all staff providing patient care and working within	Donning and Doffing training		Local induction and support

the clinical environment are trained in the selection and use of PPE appropriate for the clinical situation and on how to safely don and doff it. • adherence to PHE national guidance on the use of PPE is regularly audited with actions in place to mitigate any identified risk • hygiene facilities (IPC measures) and messaging are available for all patients/individuals, staff and visitors to minimise COVID-19 transmission such as: ○ staff maintain social distancing (2m+) when travelling to work (including avoiding car sharing) and remind staff to follow public health guidance outside of the workplace ○ clear visually displayed advice on use of face coverings and facemasks by patients/individuals, visitors and by staff in non-patient facing areas ○	is mandatory for all staff, current update reported as 01/03/21 at 84.1% PPE adherence audit tool as in section 1. Currently being piloted on AMAT in 3 areas Action-Card-Car sharing - including stu 501534_Face_Cover_ Pulic-Facing-Poster_A4 Learning Board from outbreaks 2020-21.pd		training for new starters and temporary staff.
7. Provide or secure adequate isolation facilities			
No update			

8. Secure adequate access to laboratory support as appropriate			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
• regular monitoring and reporting that identified cases have been tested and reported in line with the testing protocols (correctly recorded data) • screening for other potential infections takes place • that all emergency patients are tested for COVID-19 on admission. • that those inpatients who go on to develop symptoms of COVID-19 after admission are retested at the point symptoms arise. • that those emergency admissions who test negative on admission are retested on day 3 of admission, and again between 5-7 days post admission. • that sites with high nosocomial rates should consider testing COVID negative patients daily. • that those being discharged to a care home are being tested for COVID-19 48 hours prior to discharge (unless they have tested positive within the previous 90 days) and result is communicated to receiving organisation prior	LLR-Transfer-from-an-Acute-provider-to-Co LPT-Inpatient-Wards-swabbing-Contact-witl LPT-Inpatient-Wards-Units-swabbing-on-adı Additional asymptomatic testing has been undertaken in specific areas to the admission and weekly testing swabbing-prior-to-discharge-from.pdf		

to discharge • that those being discharged to a care facility within their 14 day isolation period should be discharged to a designated care setting, where they should complete their remaining isolation. • that all Elective patients are tested 3 days prior to admission and are asked to self-isolate from the day of their test until the day of admission.	Patients admitted to Langley Ward who are planned advised to self-isolate and PCR test 48 hours prior to admission		No elective surgery provided by the trust
9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections			
No update			
10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection			
No update			

Further supporting Evidence for Assurance

Nosocomial infection rates reveiw mar20-f

Appendix 2

Learning from our Covid outbreaks

NHS
Leicestershire Partnership
NHS Trust

Key learning findings	What we have done
Individuals are not always remembering to wear PPE when not in 'clinical' environments for example stairwells, corridors and toilets.	All staff must wear the appropriate PPE in all areas i.e. fluid resistant surgical face mask in shared offices and when moving around buildings/sites including stairwells, corridors and toilets. PPE poster is available on StaffNet. Staff are reminded the importance of hand, face and space messaging. Please remind colleagues.
Staff are continuing to come to work feeling unwell or if they have a family member at home who is symptomatic or awaiting PCR swab results. Staff have said this is because they feel bad letting colleagues down.	Staff should be encouraged to remain away from work if they are feeling symptomatic or awaiting test results for either themselves or a household contact. Leicestershire Partnership NHS Trust has an open and honest culture.
Staff are sometimes spending their whole break period in a shared break room without a mask as they have not replaced when they finish eating/drinking.	Staff should only spend a maximum of 15 minutes without a mask if sharing the break room with a colleague along with a minimum of two metres social distancing. (Setting a mobile phone reminder may help)
Sometimes it has been identified that staff are not wearing the appropriate PPE for the task/ circumstance to be undertaken.	Staff have been made aware of the appropriate PPE in relation to the patient pathways. Poster available on the StaffNet page on the staff room. Weekly PPE observational audits are taking place.
Staff have been car sharing to work without following appropriate IPC precautions for example wearing face masks in the car.	Car sharing should be avoided if at all possible. If staff feel they have no alternative they should discuss with their manager and review the requirements if car sharing is essential via the action card on StaffNet.
Remembering to clean personal work space and items and touch points areas multiple times a day.	Back to basics poster outlining our collective cleaning responsibilities. Swithland Ward use an alarm clock set to go off every 2 hours to remind all staff.
Through looking at outbreaks and talking to staff we have found staff are not clear on all of the Covid guidelines.	We have held listening events, huddles and have regular updates with clinical leaders and Infection Prevention and Control team following outbreaks.
Not all Non clinical areas have completed a Covid risk assessment.	Health and Safety teams are working with leads to support with Covid secure risk assessments. Over 300 risk assessments are complete
Staff are not fully complying with being bare below the elbow. Particularly wearing cardigans in clinical areas as staff report being cold or items on their wrists preventing full hand washing.	Increased hand hygiene audits, commenced PPE audits. Regular Communications showing what is acceptable or not with local Clinical oversight. IPC visits and screening of communications for non-compliance.

Version 1 - 17 December 2020

Reporting, reviewing, and investigating Hospital-Onset COVID-19 cases and COVID-19 deaths

Patient Covid Infection

Inform IPC

8+ days since admission

Probable nosocomial (positive specimen 8-14 days after admission)

No

- Report to relevant National COVID-19 Data Collections
- Complete an Incident Form

Yes

- Complete an EIRF - Include 'COVID' in the description of the incident
- Notify Patient Safety and agree initial degree of harm
- Duty of Candour engaged **(not required for 'no/low harm' but complete being open as best practice)**

Patient HCAI RCA to be commenced by Ward Sister & Consultant, or nominated representative (when completed the RCA will be reviewed by IPC)

Hospital Onset COVID RCA Master

No / low harm (not permanent)

Moderate harm e.g increase in treatment or possible surgical intervention

Severe harm e.g the patient requires life-saving intervention such as transfer to acute/CPR

OR Death

- Inform Patient Safety who will report to StEIS
- Consider Section 42 (safeguarding)

Receive any learning and close Duty of Candour